Professional SOLUTIONS INSURANCE COMPANY

Physician Roster

To be used in conjunction with the Corporation and Partnership Professional Liability Application

A. PLEASE COMPLETE

Corporation Name: ____

Physician's Name (first name MI last name MD/D0)	Social Security Number	Gender	Date of Birth MO/DAY/YR	Number of hours per week practice time	CM Retro Date MO/DAY/YR	Any Claims in Past 5 Years?	Any conviction of crime, sexual misconduct allegations or condition that impairs ability to practice?	Notes
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	
							❑ Yes ❑ No	

This roster addendum forms part of the application

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Mail to:
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Clive, Iowa 50325-8258
Email: submissions@psicinsurance.com

Questions:
Phone: 800-788-8540
Fax: 800-510-6370