INSURANCE ATTESTATION AND AGREEMENT:

A. I do hereby warrant the truth of all statements and answers made in this Application for Appointment and that I have not knowingly withheld or misstated any information that could influence the judgment of The University of Toledo Underwriting Committee considering the application for professional liability coverage. Erroneous, omitted and/or material misrepresentation on the application may immediately render any contract of insurance null and without effect, and subject to immediate rescission by the Underwriting Committee.

B. I understand that this insurance being applied for does not cover the liability of any third parties or persons that I may have assumed under any other contract or agreement.

C. I agree that this insurance coverage is only available during my employment by The University of Toledo ("UT") or the University of Toledo Physicians, LLC ("UTP"), and my continued appointment as a faculty member of UT. In the event any of these contingencies ceases to apply, my professional liability policy under The University of Toledo insurance program will automatically and immediately terminate.

D. I agree that this coverage will not be provided for or in the following circumstances:

1. Acts or omissions that constitute malicious purpose, bad faith, or are wanton and reckless in nature;
2. Acts outside of the Applicant's Ohio license to practice, or acts or omissions performed without such licensure;
3. Acts or omissions manifestly outside of the Applicant's approved delineated privileges or in violation of the Medical Staff Bylaws of any of the hospitals where this coverage is effective;
4. Acts or omissions outside the scope of employment with UTP;
5. Non-payment of premium (contributions).

E. If coverage is provided, I agree to: Immediately report potential and actual claims to either UTP Risk Management or The University of Toledo Medical Center Risk Management; to cooperate in the investigation and litigation defense of any potential and actual claim; to participate in risk management programs; and to comply with practices and policies adopted by UT.

F. I understand that in order to underwrite professional liability insurance, UT must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, medical staff office or credentialing office, residency program, insurance company, risk retention group, professional liability, defense attorney, inter-indemnity arrangement, underwriters, insurance agent, or other person referenced in this application to furnish any information concerning me or my medical practice that UT may request. This authorization specifically includes, if applicable, my drug and alcohol treatment, HIV treatment, and/or mental illness treatment.

G. Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to UT pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, together with those UT persons appropriately seeking such information, will not be liable to me in any way for furnishing such information.

H. I UNDERSTAND AND AGREE THAT THE COMPLETION OF THIS APPLICATION TOGETHER WITH ANY PREMIUM OR FINANCING DOES NOT BIND THE UNIVERSITY OF TOLEDO TO ISSUE INSURANCE. IF I AM ISSUED INSURANCE BY THE UNIVERSITY OF TOLEDO, I UNDERSTAND AND AGREE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION BY ME IN THIS APPLICATION MAY ACT TO VOID SUCH CONTRACT OF INSURANCE AND MAY GIVE THE UNIVERSITY OF TOLEDO A RIGHT TO RESCIND SUCH INSURANCE. BY SIGNING THIS APPLICATION I AGREE TO BE BOUND BY THE TERMS OF THE UNIVERSITY OF TOLEDO INSURANCE PROGRAM INCLUDING THE TERMS OF THIS INSURANCE APPLICATION AND THE STATEMENT OF COVERAGE.

I have read and understand the above.

Actual Signature of Physician _____ Date _____

Print Form