



SUPPLEMENT **6**

AUTHORIZATION FOR RELEASE OF PRIOR CARRIER'S LOSS EXPERIENCE

1. Full name of Applicant _____

2. Mailing Address: _____

3. Please provide the following information regarding the Applicant's professional liability insurance for the past five (5) years.

a) Name of Carrier: _____

Policy number: _____

Policy Term / Limits and Deductible: _____

b) Name of Carrier: _____

Policy Number: _____

Policy Term / Limits and Deductible: _____

c) Name of Carrier: _____

Policy Number: _____

Policy Term / Limits and Deductible: _____

d) Name of Carrier:

Policy Number: _____

Policy Term / Limits and Deductible: _____

e) Name of Carrier:

Policy Number: _____

Policy Term / Limits and Deductible: _____

I hereby authorize the release of claims information from any prior carrier for the firm(s) named in question 1 above to:

Authorized Signature

Title

Date