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PRIOR ACTS COVERAGE APPLICATION

NO COVERAGE FOR PRIOR ACTS WILL BE PROVIDED BY UMIA UNLESS APPROVED BY THE UNDERWRITING COMMITTEE. NO PRIOR ACTS COVERAGE IS AVAILABLE FOR MEDICINE PRACTICED OUTSIDE OF A STATE IN WHICH UMIA IS LICENSED TO WRITE BUSINESS.

1. Requested Retroactive Date_____ (MO/DAY/YR)
2. State(s) for which Prior Acts coverage is being requested:

   ☐ UTAH ☐ MONTANA ☐ IDAHO ☐ OTHER
3. Did you practice obstetrics or neonatology at any time subsequent to the requested Retroactive Date? ☐ Yes ☐ No
4. Provide name(s) and policy date(s) of all Professional Liability Insurers who have insured you in the past five (5) years.

NAME OF INSURER	POLICY DATES	
	FROM	TO
	FROM	TO
	FROM	TO

CLAIM INFORMATION:

1. Have you been involved in an incident or medical sequence of events that you reasonably might anticipate will result in a claim being made against you? ☐ Yes ☐ No
   Please describe in complete details on a separate sheet of paper.
2. Have you submitted a written report of this incident to your current Professional Liability Insurer? ☐ Yes ☐ No
3. If a written report has been made, has or will your current Professional Liability Insurer commit to providing coverage should a formal claim or suit arise in the future? ☐ Yes ☐ No

IT IS NOT THE INTENT OF THE UMIA POLICY TO COVER KNOWN PATIENT INJURIES. Your current Professional Liability Insurer should cover claims arising out of these injuries. Since you are requesting Prior Acts coverage for your professional liability exposure, we must have confirmation that you have informed your current Professional Liability Insurer of any incident or circumstance that COULD lead to a claim that may be made against you.

We therefore ask that you inform your current Professional Liability Insurer of all incidents known to you that might reasonably be expected to lead to a claim being brought against you.

Please sign and return this form to UMIA along with a copy of any written correspondence to your current Professional Liability Insurer informing them of any incidents or circumstances that could lead to a claim.

SIGNED BY _____ DATE _____

PLEASE NOTE:
YOUR COMPLIANCE WITH THIS REPORTING PROCEDURE IS OF THE UTMOST IMPORTANCE.

ATTACHMENT TO PRIOR ACTS APPLICATION

1. Have you prescribed the drugs Fenfluramine, Dexfenfluramine or Phentermine, either alone or in combination with other drugs, during the last five years? ☐ Yes ☐ No

If yes, please answer the following questions:

2. How many patients were prescribed the drugs?_____

3. Over what period of time were you prescribing the drugs?_____

4. Were the risks of primary pulmonary hypertension discussed with the patient? ☐ Yes ☐ No

5. Were these discussions charted in the patient's record? ☐ Yes ☐ No

6. Was a consent form used when prescribing the drug? ☐ Yes ☐ No
(If yes, please attach a copy of the form used to your application)

7. What type of history and physical examination was conducted prior to prescription of the medication?

_____

8. Was the patient questioned or instructed relative to diet and exercise to be used in conjunction with the medication? ☐ Yes ☐ No

9. Were the drugs prescribed to any patients who did not meet the criterion for exogenous obesity? ☐ Yes ☐ No

_____

Signature Date