



CARE SUPPLEMENTAL APPLICATION
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE

This supplement application must be completed, signed and dated by any applicant who has suffered impairment as a result of substance abuse. Please complete this application in ink and answer all questions. An incomplete application cannot be processed. If a question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the questions, please attach a separate page. Where appropriate, also attach supporting documentation.

1). Print Name: _____.

2). Date of Birth: _____.

3). Please specify the addiction for which you have been treated: _____
_____.

4). Are you currently participating in a treatment program? _____ yes _____ no.

5). Does the program include random drug screening? _____ yes _____ no.

6). If you have completed the treatment program, please specify the completion date: _____.

7). Please provide the following information regarding your treatment program:

Name of Program: _____ Location: _____.

Monitoring Physician (Name, Business Phone): _____.

8). Which of the following describes your treatment program? (Circle one)

None or non-completion Outpatient Inpatient less than 1 month

Inpatient more than one month. Length of stay: _____.

9). Are you participating in a 12-step program? _____ yes _____ no.

If yes, Number of meetings attended weekly: _____.

10). If you have completed a treatment program, have you experienced any relapses? _____ yes _____ no.

If yes, please describe the number of times and the circumstances: _____.

11). Please describe any licensure, legal or criminal actions have been taken against you to date: _____
_____.

(Use addition sheet if necessary).

12). Please check, which describes your length of sobriety?

Less than six months Less than one year One to two years Two to three years

Three to four years Four to five years More than five years

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated.

The applicant understand and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations.

This applicant understands that incorrect information could void coverage.

Signature: _____

Date: _____