



# Health Care Facilities Policy APPLICATION

For Claims Made Professional Liability  
Insurance and Prior Acts Coverage

 **NORCAL**  
Mutual Insurance Company

# COVERAGE HIGHLIGHTS

Feature	Benefit
Physicians Administrative Defense Reimbursement Coverage	Provides defense cost reimbursement and practice interruption expense reimbursement for administrative proceedings and employment-related civil actions
Limited Professional Office Premises Liability Coverage	Provides limited coverage for slips and falls and property damage
Optional Health Care General Liability Insurance for Qualified Groups/Organizations (additional charge applies)	Replaces and provides broader coverage than Limited Professional Office Premises Liability Coverage and includes coverage for personal injury and advertising injury
Prior Acts/Nose Coverage (Over Current Retroactive Date)	Conveniently provides coverage from one insurer
Right to Consent to Settle	Places the Insured in control of whether to settle a claim

**The following benefits are provided in addition to the Limits of Liability of the policy:**

- Defense Costs
- Attendance at Trial: *\$500 maximum per half day per Insured*
- Fire and Water Damage Legal Liability: *\$500,000/\$500,000 for the Named Insured*
- Medical Payments: *\$10,000 per person*
- Pre-judgment and Post-judgment Interest on that part of any judgment we pay

**Additional Highlights**

Aggressive Claims Handling	Represents the Insured's interests and helps protect the Insured's reputation
On-Site Clinical and Administrative Assessment	Helps the group/organization to identify risks and evaluate and improve its practice systems
Award-winning CME Material	Assists the group/organization in enhancing patient safety and improving communication
Monthly <i>Claims Rx</i> Newsletter	Helps the group/organization stay on top of current administrative and clinical issues
Risk Management 24/7 Phone Consultations	Offers peace of mind and allows an Insured to call NORCAL 24/7 for Risk Management advice

The above information is intended only to highlight the NORCAL policy features and benefits. The conditions of coverage are specifically explained in the NORCAL policy. Please read the policy for complete coverage information.

If you have questions regarding this application or would like a copy of the NORCAL policy, please contact your broker or NORCAL's Policyholder Services Unit at (877) 443-7232.

# IMPORTANT INFORMATION

This is an application for coverage under NORCAL's Health Care Facilities Policy. Emergency Medicine Groups and Urgent Care Centers have various coverage options available and should contact their broker or NORCAL before completing this application.

The coverage of any policy, if issued, is limited to the liability of the Named Insured and any Insured. The Named Insured and all Insureds share a single limit of liability. Coverage for an Insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

The coverage of any policy, if issued, is generally limited to liability only for those claims that are first made against an Insured and reported to NORCAL while the policy is in force. The coverage provided under the optional Health Care General Liability Insurance, if purchased, is limited to bodily injury, property damage, fire damage, personal injury or advertising injury that occurred during the policy period.

Please review the policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker. Please note that no coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in the group's/organization's name.

The application asks that you provide information regarding affiliations, practice associations, etc. This information is requested to provide us with an understanding of the group's/organization's practice but does not mean that a policy, if issued, would cover such entities and persons.

## APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- If you wish to explain any of your answers, please use the Remarks section on page 10. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 11 for California and Rhode Island applicants or page 12 for Alaska applicants.
- In addition to a completed application, please provide the following items:
  - A current audited financial statement.
  - For emergency medicine groups, a completed location application for each location at which the group is providing services, a completed endorsed physician application for each physician and a completed application for each health care extender.
  - For urgent care centers, a completed location application for each facility, a completed endorsed physician application for each physician and a completed application for each health care extender.
  - For those other than emergency medicine groups and urgent care centers, a completed location application for each facility and a completed endorsed physician's application for each facility's medical director and/or laboratory director.
  - A copy of the group's/organization's letterhead(s).
  - Loss runs for the previous ten years. The loss runs must include paid and reserved amounts and be less than 90 days old.
  - A copy of the Declarations Page and any endorsements from the group's/organization's most recent insurance policy, if applicable. If each physician was issued a Declarations Page, please provide each Declarations Page. If each physician was not issued a Declarations Page, please provide the endorsement to the policy that identifies all Insureds and their Retroactive Dates.
- If the group engages in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, the group/organization is considered a *Covered Entity* under HIPAA and is thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at [www.norcalmutual.com](http://www.norcalmutual.com).
- Please make a copy of the completed application and supporting documentation for your records.

## SECTION I IDENTIFYING INFORMATION

Group/Organization Name					Tax ID Number	
Primary Address	City	County	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Mailing Address (Location where all mailings except invoices will be sent)		City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -
Billing Address (Location where invoices will be sent)		City	State	Zip Code	Telephone # ( ) -	Fax # ( ) -

### Authorized Representative

The Authorized Representative is the person responsible for providing consent decisions on behalf of the Named Insured and the person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to the policy. One person may be designated for both purposes or a separate person may be designated for each purpose.

Please provide the name and title of the person authorized to provide consent decisions on behalf of the Named Insured:

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

Please provide the name and title of the person authorized to act on behalf of the Named Insured and all other Insureds for all other (nonconsent) purposes relating to the policy:

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

## SECTION II COVERAGE/INSURANCE INFORMATION

### Requested Effective Date (the date you wish coverage to begin)

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

**NOTE:** NORCAL should receive the application at least thirty days before the Requested Effective Date.

### Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. **This coverage does not apply to the optional Health Care General Liability Insurance. NORCAL does not automatically provide Prior Acts Coverage.**

- The group/organization wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 9):
- The group/organization does not wish to apply for Prior Acts Coverage. It is understood that if the group/organization does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the Effective Date of the NORCAL policy, if issued.

### Requested Retroactive Date

\_\_\_\_\_ 12:01 a.m. Local Time  
Month Day Year

**NOTE:** The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

### Health Care General Liability Insurance – Occurrence

**NOTE:** This coverage is available only to qualified groups/organizations. Please discuss with your broker or contact NORCAL before completing the remaining questions.

Health Care General Liability Insurance is an optional, occurrence-based coverage. Additional premium will be charged if this coverage is approved. NORCAL does not automatically provide Health Care General Liability Insurance coverage.

Does the group/organization wish to apply for Health Care General Liability Insurance coverage?  Yes  No

If yes, please contact NORCAL or your broker for an application in order to apply for such coverage.

### Requested Limits of Liability

Please indicate the desired limits of liability for the group/organization. All Insureds will have the same limits of liability.

\$ \_\_\_\_\_ each claim/\$ \_\_\_\_\_ annual aggregate

## Deductible

NOTE: NORCAL offers deductibles in specified amounts and only to qualified groups/organizations. Please discuss with your broker or contact NORCAL before completing the remaining questions if you are interested in a deductible. Deductibles apply to both Professional Liability Insurance and Health Care General Liability Insurance, if applicable.

Does the group/organization wish to have a deductible on the policy?  Yes  No

If yes, please complete the following:

Type:  Indemnity only  Indemnity and Expense

Per Claim Amount: \$ \_\_\_\_\_

## Professional Liability Insurance History

1. Has any professional liability insurance company ever canceled, nonrenewed, modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) the group's/organization's insurance, declined to offer the group/organization coverage or notified the group/organization of its intent to pursue such action?  Yes  No

If yes, please provide a detailed, written narrative in the Remarks section on page 10 and copies of all pertinent documentation (e.g., a copy of the nonrenewal or declination notice). At a minimum, the narrative must include the name of the insurance company, the date(s) of the action(s) and a detailed description of the reason(s) for the action(s).

2. Please complete the following regarding all Professional Liability Insurance maintained by the group/organization during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (month/day/year)	Deductible or Self-insured Retention?	Policy Type	If Claims Made, Check One
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

3. If any one of the insurance coverages identified above was Claims Made Coverage, and the group/organization did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 10.

## SECTION III LEGAL STRUCTURE

1. Please complete the following regarding the primary legal entity applying for coverage and provide a copy of the entity's partnership agreement, articles of incorporation, etc:

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Other: _____	

2. Does the entity identified in question 1 own, operate or manage any other organization or entity?  Yes  No

**If yes,** please complete the following for each organization or entity and provide a copy of each entity's partnership agreement, articles of incorporation, etc. Please photocopy this page if additional space is needed.

Name of Entity	Legal Structure	Name(s) of Owner(s) and the Percentage of Ownership Interest	Is NORCAL Coverage Desired for the Organization/Entity?*
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Partnership <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If NORCAL coverage is not desired for the organization or entity, please explain in the Remarks section on page 10.

3. Does the group/organization desire coverage for any entity(ies) not already identified in question 1 or 2?  Yes  No

**If yes,** please identify each entity and its owner(s) and explain:

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4. Is the group/organization owned, operated or managed by another organization or entity not already specified above?  Yes  No

**If yes,** please explain and provide the name(s) of the organization(s):

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5. Is the group/organization involved in any joint ventures or partnerships?  Yes  No

If yes, please explain:

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6. If you answered yes to question 2, 3, 4 or 5, please provide a chart of the organizational structure on a separate sheet of paper.

7. Does the group/organization use any fictitious name(s) or dba(s)?  Yes  No

If yes, please identify each fictitious name or dba and explain:

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## SECTION IV PRACTICE LOCATIONS

1. Please complete the following regarding the current practice locations. Please photocopy this page if additional space is needed:

- For emergency medicine groups, please identify all locations at which group members provide services.
- For those other than emergency medicine groups, please identify all locations owned or operated by the organization.

Location (name and address)	Type of Location (e.g., surgery center, urgent care center)	Is NORCAL Coverage Desired for the Services Rendered at This Location?*
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If NORCAL coverage is not desired for the services rendered at any location, please explain in the Remarks section on page 10.

## SECTION V GENERAL PRACTICE INFORMATION

1. Within the next 12 months, are there any planned material changes for the group/organization (e.g., the addition of a new location(s), establishment of another entity)?  Yes  No

If yes, please explain:

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2. Does the group/organization advertise in any way other than listing the name, address and telephone number in the telephone book?  Yes  No

If yes, please submit copies of all of the advertisements (excluding those that appear on the website, if applicable) and/or the script of any voice, film or TV media.

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3. Is there a website related to the group's/organization's practice?  Yes  No

If yes, what is the website address (if more than one, please identify each):

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4. Has the group/organization entered into any contracts to provide professional health care services (excluding those with managed care organizations)?  Yes  No

If yes, please explain and provide a copy of the contract(s):

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## SECTION VI RISK MANAGEMENT

**NOTE: Please complete this section only if you are applying for coverage as an emergency medicine group.**

1. Does the group have a formal risk management program?  Yes  No

a. **If yes**, who (name and title) is responsible for the risk management program?

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b. **If no**, please explain:

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### Credentialing

1. Does the group have a formal process to credential its health care providers?  Yes  No

a. **If yes**, please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

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b. **If no**, please explain:

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2. Does the group evaluate the following when credentialing its health care providers?

Claim History	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, source(s) used: _____
Hospital Privileges	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment History	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, source(s) used: _____
Education History	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, source(s) used: _____
Felony/Misdemeanor History	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, source(s) used: _____
Medical/Dental/Nursing and Narcotic Licenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, source(s) used: _____

If you answered no to any one of the above, please explain:

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3. Does the group use the same credentialing procedures to credential independent contractors and locum tenens health care providers?  Yes  No

**If no**, please describe the credentialing process used:

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4. How often are the group's health care providers recredentialed?

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## SECTION VII SUPPLEMENTAL QUESTIONS

**NOTE: Please complete this section only if you are applying for coverage as an emergency medicine group.**

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the group?  Yes  No
2. Have the group's clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending?  Yes  No
3. Has the group **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  Yes  No
4. Has the group or any group member **ever** been accused of sexual misconduct?  Yes  No
5. Do you know if any individual who works on the group's behalf has a prior history or propensity for sexual misconduct?  Yes  No

## SECTION VIII CLAIMS HISTORY

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the group's/organization's entity(ies), or has a group/organization entity been notified of its involvement in a malpractice claim or suit, either directly or indirectly?  Yes  No
2. Is the group/organization aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against a group/organization entity, directly or indirectly, even if you believe the claim or suit would be without merit?  Yes  No

**If you answered yes to question 1 or 2, please complete a Claim Information Form on page 13 for each applicable claim, suit, incident, conduct, etc.**

## SECTION IX PRIOR ACTS COVERAGE

**NOTE:** If the group/organization is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the group's/organization's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date has there been a change in the legal structure of the group/organization (e.g., change in owners or type of entity)?  **Yes**  **No**

If **yes**, please explain and identify the appropriate dates:

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2. Since the Requested Retroactive Date, please identify the following:

- For emergency medicine groups, all locations (other than current practice locations) at which group members provided services.
- For those other than emergency medicine groups, please identify all locations (other than current practice locations) that were owned or operated by the organization.

Location (name and address)	Type of Location (e.g., surgery center, urgent care center)	Dates Services Provided For Owned/Operated

3. Since the Requested Retroactive Date, have there been any other material changes in the group/organization?  **Yes**  **No**

If **yes**, please explain and identify the appropriate dates:

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## FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

### Warranties and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my group's/organization's behalf is incorporated into and made a part of any policy of insurance that may be issued to my group/organization by NORCAL ("the Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the group/organization and NORCAL, the dispute will be submitted to binding arbitration.

I understand that this policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event this coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the group's/organization's behalf, including changes in its partners or associates, medical licenses, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by my group/organization or others trading under my group's/organization's name.

*I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where any members presently hold, are applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my group's/organization's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about my group/organization and its members that is done in good faith and without malice.*

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

If you are completing this application with a broker and/or brokerage firm, please state the name(s) and Broker License Number(s).

Name	Broker License Number
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

If you are completing this application with a NORCAL Account Executive, please state the name:

If you were referred to NORCAL by someone, please state the name:



# CLAIM INFORMATION FORM

Name of Patient: \_\_\_\_\_ Gender:  Male  Female

Age of Patient (at time of treatment): \_\_\_\_\_

Name of Claimant (if different than patient): \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Allegation Against the Group/Organization/Entity: \_\_\_\_\_

Group/Organization Member Defendants: \_\_\_\_\_

Non-Group/Organization Member Defendants: \_\_\_\_\_

Date Incident or Claim Was Reported to the Insurance Company: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Disposition or Current Status of the Incident, Claim or Suit Against the Group/Organization/Entity:

**Open**

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

**Closed** Date Closed (month/day/year): \_\_\_\_\_

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the entity's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): \_\_\_\_\_

Amount paid on the group's/organization's/entity's behalf: \_\_\_\_\_

Total verdict amount (if different than total loss payment amount): \_\_\_\_\_





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