LAMMICO

Louisiana Medical Mutual Insurance Company • www.lammico.com
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504/831-3756 • 800/452-2120 • FAX: 504/841-5300 or 504/841-5205

Application for Increased Limits

Agency Name: (If using Agent)	Agency Address: (City, State, Zip)	Producer

Named Insured: _____

Address: _____

Policy #: _____

Current Limits: $_____ each medical incident / $_____ annual aggregate

Please indicate amount of new limits being requested:

$_____ each medical incident / $_____ annual aggregate

Requested effective date of change: _____

Please indicate reason for requesting this increase: _____

_____

Please answer the following questions. They apply **only to events you have not already reported to LAMMICO or your previous insurer.** For all YES answers, attach an explanation on a separate sheet.

1) Is any claim or suit pending against you? ☐ Yes ☐ No

2) Has any attorney inquired about the care you rendered to a patient? ☐ Yes ☐ No

3) Has any patient, patient's family member or attorney asked you for copies of your medical records or, to your knowledge, the records of a hospital or laboratory? ☐ Yes ☐ No

4) Are you aware of any medical or surgical outcome or other circumstance that makes you believe or anticipate that a claim or suit is likely to arise from the care you gave a particular patient? ☐ Yes ☐ No

I CERTIFY THAT MY ANSWERS ARE TRUE AND CORRECT to the best of my knowledge. I understand that I have a duty under my policy to report events of the type listed above without undue delay. I further understand that submitting this application does not bind LAMMICO to increase my limits, but that this application will be the basis of such an increase if my request is approved.

_____ _____
Policyholder Signature Date

_____
Print Name

Supplemental Remarks Page

Question No.	Remarks (Attach additional sheets, if necessary)