APPLICATION FORM FOR INDEPENDENT MEDICAL EVALUATORS

Insured Company:			
Contact name:			
Address:			
City:			
State:		ZIP code:	
Email address:		Website:	

Please state the number of years as a Physician performing IMEs.:

Please state the percentage of your overall practice that are IME's: %

Please state the estimated number of IME's performed per year:

CLAIMS INFORMATION

In regards to claims, are both of the below statements true? ☐Yes ☐No

1. After full inquiry, you are not aware of any circumstances, complaints, claims, loss, or penalties/fines levied against you in the last five years, in relation to the risks that this application relates to.
2. After full enquiry, you are not aware of any current or previous problems or errors in your work that may give rise to a liability claim against you, in relation to the risks that this application relates to.

DECLARATION

I declare that after proper inquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.

I agree that this application form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.

I undertake to inform underwriters of any material alteration to these facts occurring before completion of the contract.

Full name:		Date:	DD / MM / YYYY
Position:		Signature:	