# Application for Medical Student Liability Insurance

Name (Please print) _____
Last First

Date of Birth (MM/DD/YY) _____

Permanent Address _____Ph:_____

_____
Zip

**Date of Enrollment: _____ Anticipated Date of Graduation_____**

Professional Licenses (if any) _____

Have you had liability insurance before? ___Yes ___No

If yes give details: _____

Have you ever had any claims? ___Yes ___No

If yes give details_____

Have you ever been denied insurance coverage before? ___Yes ___No

If yes give details_____
Has your insurance ever been cancelled? ___Yes ___No

If yes give details _____

***I certify that the above information is true and correct to the best of my knowledge. I understand that the fee paid by me includes the total cost of policy premium, administrative costs and applicable taxes, and that there shall be no refund whatsoever of monies paid for any reason whatsoever, once the application has been made and a certificate of insurance has been issued. I understand the coverage issued will be rescinded if any of the above information is not provided or inaccurate.***

***AGREED TO AND SIGNED THIS DAY OF :_____( Date)***
***MM/DD/YY***

***Signature*** _____***Place***_____

**Return Completed Form to: Saint James School of Medicine, C/o Human Resource Development Services Inc., 1480 Renaissance Dr. Suite 300, Park Ridge IL 60068**