



Professional Liability Decreased Limits Application - Occurrence Plus

Name Insured: _____

Agency Name: _____ Policy Number: _____

1. Please check the limits you are requesting:

Chiropractors Only

_____ \$1,000,000/\$3,000,000

_____ \$100,000/\$300,000

_____ \$2,000,000/\$4,000,000

_____ \$200,000/\$600,000

_____ \$500,000/\$1,500,000

2. The requested effective date of change: _____

3. Please indicate your reason for requesting this decrease in limits: _____

4. Do you know of any circumstance, act, error or omission that could potentially result in a professional liability claim against you?

_____ Yes _____ No

If YES, please provide full details for each incident. Use a separate sheet if necessary. _____

5. I understand and agree that all claims reported on or after the effective date of this change will have the lower limits of liability.

All of the information above is true to the best of my knowledge and belief.

Signature of Applicant: _____ Date: _____

All changes are subject to final company approval.

All questions must be answered for change to be considered.