Positive Physicians Insurance Company
HEALTHCARE PROFESSIONAL INSURANCE
Additional Insured Supplement

Applicant/Insured Name: _____ Policy #:_____

A. Do you have a business entity or third party that you want to extend coverage to as an Additional Insured*? __ Yes __ No

If yes, complete the following information for the Additional Insured:

1. Name: _____
2. Address: _____
3. Effective Date**:** _____ /_____ /_____
4. Relationship to Applicant/Insured:
   __ Employer
   __ Landlord
   __ Physician
   __ Sole Proprietorship – With Employees
   __ Sole Proprietorship – No Employees
   __ Staffing Company
   __ Other – Please explain: _____

_____ _____
Applicant/Insured Signature Date Signed

_____
Print Name

**Coverage is limited to the Additional Insured's vicarious liability based solely on professional services rendered, or which should have been rendered, by the affiliated Named Insured.*

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