SUPPLEMENT 6

AUTHORIZATION FOR RELEASE OF PRIOR CARRIER'S LOSS EXPERIENCE

1. Full name of Applicant____

   ____

2. Mailing Address:

   ____
   ____
   ____

3. Please provide the following information regarding the Applicant's professional liability insurance for the past five (5) years.

   a) Name of Carrier:

      ____

      Policy number: ____

      Policy Term / Limits and Deductible: ____

   b) Name of Carrier:

      ____

      Policy Number: ____

      Policy Term / Limits and Deductible: ____

   c) Name of Carrier:

      ____

      Policy Number: ____

      Policy Term / Limits and Deductible: ____

d) Name of Carrier: ______________________________

Policy Number: ______________________________

Policy Term / Limits and Deductible: ______________________________

e) Name of Carrier: ______________________________

Policy Number: ______________________________

Policy Term / Limits and Deductible: ______________________________

I hereby authorize the release of claims information from any prior carrier for the firm(s) named in question 1 above to:

______________________________ ______________________________
Authorized Signature Title

____
Date