

The Medical Protective Company
Medical Condition Supplement

Please make additional copies if needed.

If answered "Yes" in Section IV to question E please complete the following:

If you have a medical condition, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of such an impairment, **a statement from your treating physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of condition: _____

Date(s) of treatment(s): From: ___/___/___ To: ___/___/___ ___ Currently in treatment
 MM YYYY MM YYYY

Names of treating physician(s): _____

Address(es): _____

MANDATORY: ALL DISTRICT OF COLUMBIA APPLICANTS must read the following:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

MANDATORY: ALL FLORIDA APPLICANTS must read the following:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

MANDATORY: ALL MAINE APPLICANTS must read the following:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.