

REINSTATEMENT REQUEST FORM
For Kentucky State Program Participants

Policy: **08 EO 0017KY**

Expiration Date of Previous Coverage: **April 1, 2008**
Or Requested Coverage Date: _____

Name: _____

Firm: _____

Firm Address: _____

Business Phone: () - - Home Phone: () - - Fax: () -

Social Security Number: - - License #: _____

Please state reason for requested reinstatement:

I, the undersigned, certify that as of the current date **I have no knowledge of any claims which have been made against the entity or individual for which insurance is requested since the date of expiration listed above.** I, the undersigned, also certify that as of the current date **I have no knowledge of any negligent acts, errors or omissions or related negligent acts, errors or omissions committed or alleged to have been committed prior to the current date,** that may reasonably be expected to become the basis of a claim against the entity or individual for which insurance is requested.

Signature of individual licensee applicant

Current date