

Darwin National Assurance Company  
 Platte River Insurance Company  
 Darwin Select Insurance Company  
**c/o American Professional Agency, Inc.**  
**95 Broadway**  
**Amityville, NY 11701**

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

Account #: \_\_\_\_\_

To Whom it May Concern:

I wish to increase my Limits of Liability on my Psychiatrist Professional Liability policy

# \_\_\_\_\_ from \$ \_\_\_\_\_ to

\$ \_\_\_\_\_.

For your underwriting purposes:

"I HEREBY WARRANT THAT I AM NOT AWARE OF ANY ACT, ERROR OR OMISSION, WHICH MIGHT REASONABLY BE EXPECTED TO GIVE RISE TO A CLAIM UNDER THIS POLICY.

"I UNDERSTAND THAT THIS LETTER WILL BE ATTACHED TO AND BECOME PART OF THE SAID POLICY."

\_\_\_\_\_  
Signature of Named Insured

\_\_\_\_\_  
Date

**Please make check payable to:**

**American Professional Agency, Inc.**

**Mail to:**

**American Professional Agency, Inc.  
95 Broadway  
Amityville, NY 11701**