Medical Corporation Professional Liability Insurance Renewal Application

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ProAssurance
Treated Fairly

ProAssurance Casualty Company/ProAssurance Indemnity Company, Inc.
PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

Date:_____ Policy #:_____ Expiration Date:_____

Agent/Agency Name:_____ License No.:_____ Agent/Agency Phone:_____

Important: Please review, complete, and return this form with **a copy of your current business letterhead**. Please make any changes to the pre-filled information below. Your prompt, accurate reply will avoid delay of your policy's renewal. Thank you.

1. Organization Information

Organization Name:_____

Federal Tax ID:_____-_____

Primary Office Street Address:_____

City:_____ County:_____ State:_____ ZIP:_____

Office Phone:_____ Office Fax:_____ Website:_____

Mailing Address:_____

Preferred Billing Address:_____

Contact Name:_____ Title:_____

Phone:_____ Email:_____

Is the above contact the authorized representative for access to policy information at ProAssurance.com? Yes ☐ No ☐

If no, please provide the name of the policy's authorized representative:_____

A. Type of Corporation:

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership

☐ Multi-shareholder Corporation ☐ Limited Liability Corporation ☐ Other:_____

B. Does the Organization practice under a d/b/a (doing business as) name? Yes ☐ No ☐

If yes, please list all d/b/a names:_____

2. Claims Information

A. Since you became insured by a ProAssurance company, has any claim or suit for alleged malpractice been made against you and reported to **a prior insurance carrier or hospital self-insured trust**, or has any claim or suit resulted in payment by you or on your behalf? (Do not include claims reported to a ProAssurance company.) Yes ☐ No ☐

If yes, please explain in space provided at the end of the application.

3. Practice Information

A. Current **insured professionals** designated in the **Coverage Summary**:
Please cross off any professionals no longer with the practice and provide last date of practice in space provided.

[Prefill Names] Last date of practice (if applicable) _____

Name:_____ Policy #:_____ Expiration Date:_____

B. List all healthcare providers **not listed above**. You must provide proof of current professional liability for each physician insured elsewhere.

Name	Specialty	Start Date

C. Current **insured paramedical* employees** designated in the **Coverage Summary**:
Please cross off any employees no longer with the practice and provide last date of practice in space provided.

Last date of practice (if applicable)

[Prefill Names] _____

D. List all **insured paramedical* employees** not listed above. You must provide proof of current professional liability for each paramedical insured elsewhere.

Name	Specialty	Start Date

**Paramedicals include a person practicing as a psychologist, nurse midwife, nurse anesthetist, nurse practitioner, physician's assistant, surgeon's assistant, perfusionist, optometrist, cytotechnologist, emergency medical technician, anesthesiologist assistant, or any person licensed, certified or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician.*

E. Do physicians/individuals not affiliated with your organization use your facilities and/or equipment? Yes ☐ No ☐

F. Is the organization or any member physician whole or part owner in any medical professional joint venture outside of this practice? Yes ☐ No ☐

If "yes," please explain in space provided at the end of the application.

G. Please give us the name of any **newly formed**, **not previously reported or dissolved** solo or professional group practice entity (e.g., P.A., P.C., L.L.C., L.L.P., Inc., etc.) related to your practice:_____

_____

Do you desire coverage for this entity?_____ Yes ☐ No ☐

I agree to notify the Company of any of the following events within thirty (30) days of its occurrence, including but not limited to the following:

A. A change in location of practice.

B. Investigation of your Medicare/Medicaid billing procedures.

C. A claim or suit for alleged malpractice has been made against you and reported to **another insurance carrier or hospital self-insured trust,** or if any claim or suit resulted in payment by you or on your behalf, since you became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the **Coverage Summary** of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof:

Signature:_____ **Title:**_____

Date:_____

Additional Comments

Please attach additional sheets as necessary.

Current Certificate of Insurance Holders:
(Please cross out any Certificate holders no longer applicable and use the additional lines to add other Certificate holders to whom we should mail a Certificate.)

Include Name, Address, and Phone