MedChoice Renewal Application

Policy Number TBD

As of: Date

PLEASE UPDATE ANY INFORMATION THAT IS INCORRECT ON THE REVERSE PAGE OR LEFT BLANK

Corporation Name

Entity Address | City | State | Zip

Phone | Fax | Office E-mail

Current Limits | Effective Date | Retro. Date | Office Manager or Contact

Additional Insured : Yes ☐ No ☐ ☐ check if changes are on the reversed page

PLEASE EXPLAIN ANY "YES" RESPONSE, OR PROVIDE ANY REQUIRED EXPLANATION OR DETAILS ON SUPPLEMENTARY PAGES AND ATTACH TO THIS RENEWAL APPLICATION.

1. Are any owners non-physicians? ☐ Yes ☐ No If "Yes," list names and percentage of ownership below:

2. Are you or any of your entities affiliated with or do you anticipate forming alliances with any other clinics, practice associations or hospitals? ☐ Yes ☐ No If "Yes," please list the association(s) below:

3. Do you employ, subcontract with, supervise, or sponsor any physicians, nurse anesthetists, nurse midwives, nurse practitioners, or physician assistants? ☐ Yes ☐ No If "Yes," list names, describe their specialties, attach copies of their credentials, indicate whether or not they have their own professional liability insurance coverage, and describe the nature of your professional relationship. Attach an extra page if necessary. Do you employ (file a W2 for) any other non-physician personnel such as a receptionist, billing specialist, office manager, RN, medical assistant, etc.? ☐ Yes ☐ No

Name	Title	Insured by	Policy No.	Limits

We hereby represent and warrant the truth of all statements and reasons mentioned herein and that we have not withheld any information that is likely to influence the judgment of MedChoice Risk Retention Group in considering this application for professional liability insurance. We agree to notify MedChoice Risk Retention Group promptly of any change in the information contained in this application. We further agree to be bound by the underwriting guidelines of MedChoice Risk Retention Group.

Signature: _____ Date: _____