

Medical Professional Liability Program

8198301

NOW THERE ARE 3 WAYS TO REQUEST A PREMIUM ESTIMATE!

Please print or type

- 1. By Fax!** For the fastest service, complete this form now and fax it to us at **1-515-365-0681**.
- 2. Postal Mail!** Complete this form and mail it to us today at:
Mercer Health & Benefits Administration LLC • Medical Professional Liability Insurance
PO Box 14438 • Des Moines, IA 50306-9803
- 3. On the Web!** Visit www.acpmedpl.com for more information about this program and to download an electronic version of this form. You can also submit your contact information through our secure online connection and one of our representatives will contact you right away!

SECTION 1 Member Information

First Name: _____ Last Name: _____
Practice Locations: _____ State Licensure: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
County: _____ Date of Birth: _____
Phone: (_____) _____ Fax: (_____) _____
Email: _____
I would prefer to be contacted: By Phone By Fax By Email
Office Contact Person: _____ Date you began practice: _____
NPI: _____ ACP Member Number: _____

SECTION 2 Professional Information

- a. Type of Practice: Group* Individual
*Please indicate number in group: _____ Group Name: _____
- b. Area of Specialty: _____ Specialty %: _____
- c. Subspecialty (if any): _____ Subspecialty %: _____
- d. Do you perform surgical procedures? Yes No
If "Yes," select type: Major _____ Minor _____
- e. Board Certified: Yes No
If "Yes," Name of Board: _____
- f. Do you practice part-time (20 hours per week or less)? Yes (10-20 hrs/wk) Yes (10 hrs or less/wk) No

SECTION 3 Insurance Information Check here if you are interested in changing carriers prior to your renewal date.

- a. Current Insurer: _____
- b. Limits of Liability: Each Claim _____ Aggregate _____
- c. Last Annual Premium: _____
- d. Requested Effective Date (mm/dd/yyyy): _____
- e. Current Coverage: Claims Made* Occurrence
*Claims Made Retroactive Date (mm/dd/yyyy): _____
- f. Have you ever been involved in a claim? Yes No
Number of Open Claims: _____ Number of Closed Claims: _____ Amount paid or settled: _____
- Mercer is authorized to approach the following carriers on my behalf:
 MedPro Group (available in All states except NY)
 Coverys (available AR, AZ, CA, CO, DC, GA, IA, ID, IL, IN, KY, MD, ME, MN, MS, MT, NC, NH, NV, OR, SC, TX, UT, VA, VT, WA, WI, WY)
- Signature: _____

Sponsored by:



We respect your right to privacy. All personal information will be protected.

Administered by:



MAKE TOMORROW, TODAY

PO Box 14438, Des Moines, IA 50306-9803 | Phone 1-888-643-0323 | Fax 1-515-365-0681 | LH.Admin@Mercer.com

Program Administered by Mercer Health & Benefits Administration LLC

AR Insurance License #100102691 • CA Insurance License #0G39709

In CA d/b/a Mercer Health & Benefits Insurance Services LLC

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