Medical Professional Liability Program

8558501

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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