# Corporate Entity Renewal Application

Corporate Entity Name:
Policy Number:

Practice Administrator Name:_____

Practice Administrator Email Address:_____

Please indicate the number of people you employ at this practice:

***If n/a, put a "0" in the box. Do not leave any boxes blank***

| | | | |
|---|---|---|---|
| | Lab or X-Ray Technicians | | Nurse Practitioners* |
| | Medical Assistants | | Physicians or Surgeons |
| | Nurses | | Physician Assistants* |
| | Nurse Anesthetists* | | Surgical Assistants* |
| | Nurse Midwives | | Other (**Please specify below**) |

**Please provide proof of insurance for these employees*

Other: _____

List all physicians practicing within this entity:

| **Physician Name** | **Owner? Employee? Independent Contractor?** | **Email Address** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Does your practice have any DBA or trade names? YES ☐ NO ☐

If yes, please list: _____

_____

Have there been any new claims or activity on existing claims against this organization in the last 12 months? YES* ☐ NO ☐
(*if yes please provide details)

_____ _____
Physician's Signature Date