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
	Medical Assistants
	Nurses
	Nurse Anesthetists*
	Nurse Midwives

	Nurse Practitioners*
	Physicians or Surgeons
	Physician Assistants*
	Surgical Assistants*
	Other (Please specify below)

**Please provide proof of insurance for these employees*

List <u>all</u> 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)

Details: _____

_____ _____

Physician's Signature Date