



### Short Form Application for FPIC Insured transferring from Clinic to Group/Individual Coverage

- If my application is approved, make coverage effective at 12:01 a.m. on \_\_\_\_\_ with a retroactive date of \_\_\_\_\_. I prefer to tail out on the previous policy YES NO
- Name: \_\_\_\_\_ MD DO (Check One)  

First	Middle	Last
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- Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Male Female
- Specialty: \_\_\_\_\_ Agent Name (if applicable): \_\_\_\_\_
- State: \_\_\_\_\_ Medical License #: \_\_\_\_\_ Status: \_\_\_\_\_
- Primary Address for which coverage is desired:

Number	Street	City	State	Zip	Phone Number
	Fax Number	E-mail Address			

- List all hospitals where you currently *have* or *have applied* for staff privileges (include courtesy staff privileges) and percentage of your hospital practice.

**Policy information, including cancellation, will be released to these facilities.**

Hospital	City/State	% of Practice
Hospital	City/State	% of Practice

- Limits of Liability (Please check the desired limits of liability)  
\$ 250,000.00 per Claim / \$ 750,000.00 Aggregate per single policy year  
\$ 500,000.00 per Claim / \$1,500,000.00 Aggregate per single policy year  
\$1,000,000.00 per Claim / \$3,000,000.00 Aggregate per single policy year  
Other: \_\_\_\_\_  
**\*Please Note:** A decreased limits form will be needed if lowering limits and an increased limits form is needed if increasing limits
- Are there any changes in the medical practice other than the change in offices? (ie: No longer performing certain procedures)  
\_\_\_\_\_  
\_\_\_\_\_

- Are there any staffing changes? (ie: Will you be supervising new employees or should any employees currently on your policy be transferred to the new policy?)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. If joining a new group or corporation, please specify:

\_\_\_\_\_  
Name(s) of Entity(s)

\_\_\_\_\_  
Name(s) of Entity(s)

12. Do you wish coverage for any of the above listed entities?    YES    NO If YES, please provide copy of corporate papers.

13. Are there other non-FPIC insureds in the new practice setting? If so, please explain:

\_\_\_\_\_  
\_\_\_\_\_

14. Are you leaving on good terms?    YES    NO If NO, please explain:

\_\_\_\_\_  
\_\_\_\_\_

I understand that, if I am insured by FPIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FPIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FPIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FPIC.

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

M.D./D.O.



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