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Authorization and Release Form for Proof of Coverage and Claims History

ProAssurance
Treated Fairly

Insured Name: _____

Policy Number: _____

ProAssurance is or was the carrier of my professional liability insurance; as such, it maintains certain information regarding my practice, including the history of any malpractice claims against me and the professional liability coverage history regarding policies in force or previously in force. I hereby authorize and request ProAssurance to release information relating to my professional liability coverage and/or claims and suits against me which is on record with any of its affiliates.

Certificate of Insurance (indicate on the following page)

ProAssurance agrees to provide Certificates of Insurance (proof of coverage) outlining the policy number, policy period, type of insurance, and limits of liability of the insured to any hospitals, other practice entities, insurance companies or third party credentialing services listed below. ProAssurance will automatically send Certificates to the specified organizations each year until otherwise notified. The Certificate of Insurance neither affirmatively nor negatively amends, alters, or extends the coverage afforded by the policy described on the Certificate of Insurance. In the event of material change in, or cancellation of, the herein described policy, ProAssurance has no obligation to notify the party to whom the Certificate was issued, and shall not be liable in any way for failure to give such notice.

Claims History (indicate on the following page)

ProAssurance will furnish a Claims History report showing all pending lawsuits, lawsuits closed within the last ten years, and all claims with an indemnity payment, regardless of date, upon my authorization of such action. I hereby request the release of this information relating to claims and suits against me on record with ProAssurance to the entities listed below. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. This authorization is in effect for those entities named below and considered approved for release upon request from these third parties until otherwise notified; no other verification will be required unless I notify ProAssurance otherwise regarding that information.

_____

Signature of Insured or Insured's Representative and Title

_____

Printed Name of Insured or Insured's Representative and Title

_____

Date

Please use the following page to furnish us with the names and addresses of desired hospitals, entities and third party credentialing services so we may send the requested documentation. Email the completed form to credentialing@proassurance.com or fax to 205.868.4073. Questions? Call 877.274.7007.

Insured Name: ______________________________

Policy Number: ______________________________

☐ **Certificate of Insurance** Name: NJ PURE

☒ **Claims History** Address Line 1: 214 Carnegie Center Suite 101

Address Line 2: ______________________________

City, State, ZIP: Princeton, NJ 08540

☐ **Certificate of Insurance** Name: ______________________________

☐ **Claims History** Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, ZIP: ______________________________

☐ **Certificate of Insurance** Name: ______________________________

☐ **Claims History** Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, ZIP: ______________________________

☐ **Certificate of Insurance** Name: ______________________________

☐ **Claims History** Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, ZIP: ______________________________

☐ **Certificate of Insurance** Name: ______________________________

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City, State, ZIP: ______________________________

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Address Line 2: ______________________________

City, State, ZIP: ______________________________