



PART I - GENERAL INFORMATION

Dear Physician:

Thank you for renewing your medical professional liability policy with ProMutual Group®. Enclosed you will find your renewal declarations outlining your coverage for the coming policy year. Please take a moment to carefully review the information outlined in the declarations to verify that it is correct. If you have any changes, please indicate them in the spaces provided below and return this notice to your ProMutual Group® agent. **If there are no changes, you do not need to return this notice.**

A condition of your coverage with ProMutual Group® is notifying your agent when there is a change in your specialty or practice. By doing so, you are assured the most appropriate professional liability coverage for your needs. We appreciate your prompt notification of any changes to your practice.

While you are reviewing your professional liability coverage, you may also be interested in additional coverages we offer, such as:

- ◆ Billing Errors & Omissions Coverage
- ◆ Professional Liability coverage for your solo corporation or medical employees
- ◆ Commercial General Liability

Contact your ProMutual Group® agent for more information on these products.

We at ProMutual Group® thank you for allowing us to meet your insurance needs!

Physician Name	Physician Policy Number
Physician Telephone	Physician Mailing Address

PART II - CHANGES TO YOUR PRACTICE

In the last year, have you changed your practice by:

Finishing residency training and starting private practice? Yes No

If "Yes", indicate date ___/___/____.

Achieving board certification in your current specialty? Yes No

Changing your specialty? Yes No

New Specialty: _____

Performing additional surgical or other procedures? Yes No

Indicate any additional procedures: _____

Staffing an emergency room for more than three shifts per month? Yes No

Becoming a stockholder in a multiple doctor professional corporation? Yes No

Corporation: _____

Forming a solo professional corporation? Yes No

Joining or forming a partnership? Yes No

Partnership: _____

Do you wish to purchase a separate limit of coverage for your medical employees (non physician, nondentist employees only)?

Yes No

PART II - CHANGES TO YOUR PRACTICE (continued)

Do you practice less than 21 hours per week in direct patient care services?

Yes No

Indicate the states in which you conduct out of state practice and the percentage of practice in each.

State(s)	% of Practice

Date

Signature of Member