



CORPORATION APPLICATION

PRACTICE ORGANIZATION

A. Coverage desired for: (check all that apply)

- Checkboxes for Solo Entity, Partnership/Group, and Other (i.e., implied partnership, corporation, etc.) with associated name fields.

Corp. IRS or Employer Number: \_\_\_\_\_ Date of Incorporation: \_\_\_\_\_

B. Give the full names of all other physicians affiliated with any organization(s) named above. All physician members or employees must complete a separate application if organization coverage is to be provided.

Table with 2 columns: NAME, CURRENT MEDICAL PROFESSIONAL LIABILITY INSURANCE CO. and 5 rows.

Signature \_\_\_\_\_

Date \_\_\_\_\_

