

AUTHORIZATION TO RELEASE LOSS HISTORY

Physician's Name or Group Name: _____

Policy Number: _____

I hereby authorize American Physicians Assurance Corporation to release a copy of my claims history as follows:

Fax a copy to the following individual:

(Name) (Title)

Company: _____

Fax Number: _____

- OR -

Mail a copy to the following individual:

(Name) (Title)

Company: _____

Address: _____

Insured's Signature Title Date

Mail, fax, or e-mail this form to: American Physicians
Customer Assistance Center
P.O. Box 1471
East Lansing, MI 48826-1471

Fax Number: (517) 351-5565
E-mail: assistance@apassurance.com

ATTENTION AGENTS:

A completed loss history request form is required if: the policy is active and the requesting agent is not the agent of record; or the policy has been cancelled – even if the requesting agent was previously the agent of record.