

ProAssurance

CORPORATION APPLICATION

PRACTICE ORGANIZATION

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

- Solo Entity: Name _____
- _____ Member of a partnership or multi-shareholder corporation:
Partnership/Group Name _____
- Other (i.e., implied partnership, corporation, etc.):
Entity Name _____

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.

NAME	CURRENT MEDICAL PROFESSIONAL LIABILITY INSURANCE CO.

Castle Creek VI
 5975 Castle Creek Parkway North Drive, Suite 300
 Indianapolis, Indiana 46250
 (317) 558-2500 / (800) 284-7424