PLICO

PHYSICIANS PROFESSIONAL LIABILITY INSURANCE
Request for Change

THIS FORM APPLIES TO CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

Insured Name:
Policy Number:
Effective Date of Change:
Briefly explain the requested change and complete all applicable sections below: _____ _____

SECTION 1 - STATUS CHANGE

Average number of hours you will be working per week (under this policy): _____

Has your practice been reduced because of any of the following? (Check all that apply)

☐ Retirement ☐ Semi-retirement ☐ Disability ☐ Pregnancy or dependent care

☐ Teaching or ☐ Majority of practice is conducted in a teaching role which is insured elsewhere

☐ Majority of practice is insured through another entity such as an employer

☐ Maintenance of another practice in bordering state that is insured elsewhere

☐ Other, (please state reason) _____

SECTION 2 - SPECIALTY / CLASSIFICATION/ PROCEDURES CHANGE

1. What is your new Specialty? _____

2. What is your new Subspecialty? _____

3. Have you begun performing any new invasive procedures or discontinued any invasive procedures? _____
   If yes, please attach a list of changes/procedures.

Please check which ONE of the following best describes your practice:

☐ **No Invasive Procedures-** Applies to both general practitioners and specialists who do not perform obstetrical procedures or surgery. Minor procedures encountered in a family-type practice do not constitute invasive procedures. Assisting in surgical procedures constitutes surgery.

☐ **Invasive Procedures**- Applies to general practitioners and specialists who perform invasive procedures or assist in major surgery.

☐ **Major Surgery** - Applies to general practitioners and/or specialists who perform major surgery.

SECTION 3 - LIMITS OF LIABILITY CHANGE

Requested limits of liability:

- ☐ $1 million / $3 million
- ☐ $2 million / $4 million
- ☐ $1 million /$1 million
- ☐ $2 million / $2 million
- ☐ $500,000 / $1 million
- ☐ $100,000 / $300,000
- ☐ $125,000 / $1 million

SECTION 4 - OTHER CHANGES (INCLUDING CONTACT INFORMATION)

Indicate any other changes we should make to your policy:_____

_____

WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to previous carrier(s) or risk transfer entities (self-insured retention), or to PLICO. I have no knowledge of:

1. Any incident that could result in a medical negligence claim or suit, and/or
2. No knowledge of any pending medical negligence claim or suit, that may be, or has been made or filed against me in the last 10 years that has not been reported to the applicable insurance company, risk transfer entity (SIR), or to PLICO.

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

Signature_____ Date_____

APPLICABLE IN ARKANSAS

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

APPLICABLE IN OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.