



Connecticut Medical Insurance Company

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Application for Corporate/Partnership Coverage - Claims Made (Please type or print in ink)

A. PROFESSIONAL CORPORATION/PARTNERSHIP INFORMATION

- 1. Corporation/Partnership Name
2. Business Mailing Address (Street, City, State, Zip)
3. Office Telephone No. 4. Office Fax No. 5. Office Manager
6. President/Partner 7. This Practice is a 1. Professional Corporation 2. Partnership
8. Names of any other practices for which you require professional liability insurance.
9. Medical Specialty of Group
10. Please attach a copy of the incorporation papers for the practice.

B. COVERAGE INFORMATION

- 1. Desired Effective Date
2. Desired Retroactive Date
3. Desired Limits of Liability* (circle one choice)
\$1,000,000/\$4,000,000 [7] \$3,000,000/\$6,000,000 [9]
\$2,000,000/\$5,000,000 [8] \$5,000,000/\$8,000,000 [C]

*Coverage will be issued for the lowest limits issued to a physician member of your group.

- 4. List below the names of all shareholders, partners or physician employees. If any individual physician is not and/or does not intend to be insured by CMIC, please refer to question #5.

Table with 6 columns: Shareholder/Partner's Name, CMIC Policy #, Physician Employee's Name, CMIC Policy #. Rows a, b, c.

- 5. List below the names of physician members (including those with whom you contract for services) who do not intend to be insured through CMIC. For physicians not insured through CMIC, please attach a copy of his/her current professional liability Declarations Page (facesheet).

Table with 4 columns: Physician Name, Medical Specialty, Independent Contractor? Yes/No. Rows a, b, c.

