Send Completed Application to:

Physicians Standard Insurance Company
287 N. Lindbergh Boulevard
St. Louis, MO 63141

Ph.: 314-587-8050 or Toll Free 866-262-4030

Fax: 314-587-8001

www.physiciansstandardinsurance.com

Renewal Application

Policy Holder Name: ______________________________ **Effective Date:** ____________________

Contact Name: ______________________________ **Email:** ______________________________

Please provide the following numbers:

Office(s): ____________________ **Fax:** ____________________ **Direct Dial/Back Line:** ____________________

1. Has your practice (group or individual) changed or made plans to change, since your last renewal? ☐Yes ☐No

   If yes, please describe on **Notes** page that follows.

2. Have you added any medical related equipment to your practice, or, are you sharing any medical equipment with others since your last renewal? ☐Yes ☐No

   If yes, please describe on **Notes** page that follows.

3. Have you started or stopped performing any procedures since your last renewal? ☐Yes ☐No

   If yes, please describe on the **Notes** page that follows.

4. Are any physicians or advanced practice registered nurses (APRN: CNP, CRNA, CNS, CNM) working part time? ☐Yes ☐No

   *If yes, please complete **Form G**.*

5. Have you employed, or made plans to employ, any physicians, NPs or PAs since your last renewal? ☐Yes ☐No

   *If yes, please complete **Form F**.*

6. Have any physicians, APRNs or PAs left your employment? ☐Yes ☐No

   If yes, please describe on the **Notes** page that follows.

7. Has any claim been reported or resolved on your behalf by another carrier since your last renewal? ☐Yes ☐No

   *If yes, please complete **Form A**.*

All of our forms referenced are available on our website: www.physiciansstandardinsurance.com

Physicians Standard Insurance Company offers online Risk Management courses which may entitle you to a premium discount and CME credits. If interested, go to our website link: https://www.lawandmed.com/elearning/physiciansstandardinsurance.com

Insured/Authorized Representative ______________________________ Date ____________________

By my signature, I understand and agree that any policy issued to me will be issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand and agree that failure to provide true and complete responses to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

Please fax this form along with any notes and/or additional forms to Physicians Standard Insurance Company at: (314) 587-8001

NOTES

IF YOU ANSWERED YES TO QUESTION #1:	Please describe:
Has your practice (group or individual) changed or made plans to change, since your last renewal?	
IF YOU ANSWERED YES TO QUESTION #2: Have you added any medical related equipment to your practice, or, are you sharing any medical equipment with others since your last renewal?	**Please describe:**
IF YOU ANSWERED YES TO QUESTION #3: Have you started or stopped performing any procedures since your last renewal?	**Please describe:**
IF YOU ANSWERED YES TO QUESTION #6: Have any physicians, APRNs or PAs left your employment?	**Please describe:**

Physicians Standard Insurance Company

PHYSICIANS STANDARD CONTACT UPDATE FORM	
Physician Name	Today's Date
Preferred Contact Method □ Phone □ E-Mail □ Fax	Where to Send Written Correspondence □ Primary Office Address □ Home Address □ Other ________________
Primary Contact (relating to insurance policy and/or claims) □ Self □ Practice Administrator (please identify in next section) □ Other ____________________________________	

PRACTICE INFORMATION			
Practice Name			Office Hours
Practice Administrator			
Primary Office Address			
City	State	Zip	County
Office Phone	Office Fax	Office E-Mail	
Back Office Phone	Other Phone	Office Website	

PERSONAL INFORMATION			
Home Address			
City	State	Zip	County
Home Phone	Cell Phone	Physician's Preferred E-Mail	

ANCILLARY PERSONNEL The following ancillary personnel are part of this practice and require proof of coverage. (Attach separate page if necessary.)	
Full Name	Full Name
Full Name	Full Name
Full Name	Full Name

ADDITIONAL LOCATIONS			
Additional Location #1- Description			Office Hours
Address			
City	State	Zip	County
Phone	Fax	Contact Person at this Location	
Additional Location #2- Description			Office Hours
Address			
City	State	Zip	County
Phone	Fax	Contact Person at this Location	

NOTES