Hartford HealthCare

HHC PHYSICIAN INSURANCE PROGRAM

Application for Coverage for Physician Extenders

Please fully complete this form and return it to Sharon Daust, Marsh, Inc., One Towne Square, Suite 1100, Southfield, MI 48076 Email: Sharon.L.Daust-DeLeeuw@Marsh.com
Or Fax to (248) 945-5410

APPLICANT'S INFORMATION:

Name (please print):_____DOB_____

Degree/Title: _____

Professional Corporation: _____

Supervising Physician(s): _____

Affiliated Hospital: _____

Office address: _____

Phone No: _____ Email: _____

1. Do you have a permanent unrestricted license to practice your specialty in the State of Connecticut? _____Yes _____ No
   License No. _____
   NPI No. _____
2. Have you ever had a grievance filed against you with any licensing board or medical society? _____Yes _____ No
3. Have you ever had your defined hospital staff or similar privileges restricted, modified, suspended or revoked? _____Yes _____ No
4. Have you had a claim or been sued for medical professional liability within the last five years and/or do you have any outstanding claims or lawsuits? _____Yes _____ No

   If you answered yes to any of the above questions, please provide an explanation and details on a separate sheet of paper.

Requested Effective Date of Coverage: _____

I certify that all information provided above is true and correct. I understand that any material inaccuracy or omission on this form shall automatically void from inception any and all coverage which may have been issued.

_____ _____
Provider Applicant Date

_____ _____
Supervising Physician Date