ISMIE Mutual Insurance Company
The Physician-First Service Insurer

Twenty North Michigan Avenue
Suite 700 Chicago, Illinois 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
Web www.ismie.com

Change Request Form

Policyholder Name: ______________________________ ISMIE Mutual Policy Number ____________
Type or print name

I request the following change(s) to be made to my policy and/or underwriting record: **BE CERTAIN TO INDICATE EFFECTIVE DATE BASED ON 12:01 A.M. STANDARD TIME.** (If additional space is required to complete any of the following, attach an additional sheet. Submit this form to ISMIE Mutual by mail, fax to (312)782-2023 or e-mail to uwtg@ismie.com).

☐ 1. Change my billing address to: ______________________ effective ___/___/___
Number & Street City State zip Mo Day Yr
Phone Number Fax Number E-Mail

☐ 2. Change my mailing address to: ______________________ effective ___/___/___
Number & Street City State zip Mo Day Yr
Phone Number Fax Number E-Mail

☐ 3. Change the name of my medical corporation, of which I am the sole shareholder, to
____
(Please attach state issued organizational documents)

☐ 4. Add ☐ or delete ☐ coverage for the following medical corporation, of which I am the sole shareholder
____
(Please attach amended state issued organizational documents)

☐ 5. Change my approximate **total WEEKLY** office and hospital practice time for which ISMIE Mutual insurance is desired to:
__________ effective ___/___/___
Hours Mo Day Yr

NOTE: If you are not requesting insurance to cover all your practice activities, check here ☐ and indicate where and how you spend the balance of your practice time ______________________
Number & Street City State Zip
Description and approximate weekly hours of practice not to be covered by ISMIE

☐ 6. Please place my policy on Suspended Coverage for the following period: From: __________ To: __________
Reason for absence ______________________

☐ 7. Change my limits of liability effective ___/___/___ to: (check one) ☐ $500,000/$1,500,000
Mo Day Yr
☐ $1 MIL/$3 MIL
☐ $2 MIL/$4 MIL

A voluntary increase may be subject to a six month waiting period, unless mandated by a hospital or managed care entity.

☐ 8. **Change my practice location(s) as follows:**

Facility Codes (Please indicate all that apply)
- 01- Physician Office
- 02- Hospital
- 03- Extended Hour Walk-In Clinic
- 04- Surgicenter
- 05- Day Spa / Medi-Spa
- 06- Nursing Home/Extended Care Facility
- 07-HMO, IPA, PPO
- 08-Urgent Care Center
- 09-Clinic with overnight stays
- 10-Industrial Clinic
- 11- Government Location
- 12-Weight Reduction Clinic
- 13-Pharmacy
- 14-Abortion Clinic
- 15-Drug Control Clinic
- 16-Commercial Laboratory
- 17-Other

ADD PRACTICE LOCATIONS

A. Location Name: ____________________

Facility Code: ____________________

Address: ____________________

Suite/Room Number: ____________________

City, State, Zip: ____________________

County: __________ **Telephone:** ____________________

Is this your primary office location? Yes ☐ No ☐

Distance from Home: Miles ________ Minutes ______

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "No," describe activity not to be covered and state by whom insured:

____

____

Average number of patients per week: ________

***Average weekly practice time at this location:** ________

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

B. Location Name: ____________________

Facility Code: ____________________

Address: ____________________

Suite/Room Number: ____________________

City, State, Zip: ____________________

County: __________ **Telephone:** ____________________

Is this your primary office location? Yes ☐ No ☐

Distance from Home: Miles ________ Minutes ______

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "No," describe activity not to be covered and state by whom insured:

____

____

Average number of patients per week: ________

***Average weekly practice time at this location:** ________

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

DELETE PRACTICE LOCATIONS

A. ______________________________________ Effective ___/___/___
Number & Street City State Zip — Mo Day Yr

B. ______________________________________ Effective ___/___/___
Number & Street City State Zip — Mo Day Yr

☐ 9. Change the number of professional personnel I currently **employ**:

ADD:

Physician Name	ISMIE Policy No. (if available)	ISMIE Policy Limits (if available)	Employment Effective Date

DELETE:

Physician Name	ISMIE Policy No. (if available)	ISMIE Policy Limits (if available)	Employment Effective Date

☐ 10. Change the number of Allied Health Professionals I currently employ. Coverage is limited to the scope of employment. Limits of liability are available on a shared or separate basis for an additional charge. Separate limits, if desired, must be equal to those of the employer. A separate application is required. (Please submit licensure or certification)

		Total
A .	Certified Registered Nurse Anesthetist	____
B.	Certified Clinical Nurse Specialist	____
C.	Certified Nurse-Midwife	____
D.	Certified Nurse Practitioner	____
E.	Dialysis Technician	____
F.	Obstetrical Nurse (other than Nurse Midwife)	____
G.	Orthopaedic Technician/Nurse	____
H.	Physician Assistant	____
I.	Psychologist / Psychotherapist	____
J.	Social Worker	____
K.	Physical Therapist	____
L.	Other (Specify Below)	
	______________________________	____
	______________________________	____

New Employee Name(s)	Designation	Terminated Employee Name(s)	Designation

☐ 11. Cancel my policy effective ____/____/____ 12:01 A.M. STANDARD TIME.
Mo Day Yr

Please complete and submit the Policy Cancellation Form (available at www.ismie.com).

☐ 12. Other Changes

____

____

____

____

13. Signature Required

____ ____________________

Signature Date

ACR (07/08)