KOMA Medical Professional Liability Insurance Participation Agreement

Date: _____

ISMIE Policy Number: _____

Dear (ISMIE Contact):

This letter serves as written confirmation that I wish to participate in the Kentucky Osteopathic Medical Association (KOMA) Medical Professional Liability Insurance Program established by Professionals' Insurance Agency, Inc. and sponsored by ISMIE Mutual Insurance Company (ISMIE).

I understand that to be eligible for this program, I must be a KOMA member in good standing and have no past due balances owed to KOMA. I choose to participate in this program and understand that I may terminate this arrangement at any time without jeopardizing my ability to remain insured with ISMIE as long as I continue to meet ISMIE's underwriting standards.

To participate, please check the appropriate box below. Any ISMIE policyholder or prospective policyholder who does not have a broker prior to joining the insurance program must select the second option designating the program's managing agent, Professionals' Insurance Agency, Inc., to act as his/her broker in order to participate.

☐ Effective immediately, I wish to participate in the KOMA Medical Professional Liability Insurance Program. **I currently have a designated broker as I indicate below, or I wish to assign a new broker as I designate below** to represent my policy with ISMIE. Note: Your selected broker must be an ISMIE appointed agency.

I understand, in order to participate and remain in the program, the broker I appoint below will continue to service and represent my interests with ISMIE. **On this basis, I hereby appoint the following broker:**

_____

☐ Effective immediately, I wish to participate in the KOMA Medical Professional Liability Insurance Program. **I currently do not have a designated broker** to represent my policy with ISMIE. Therefore, I understand that in order to participate and remain in the program, I hereby appoint Professionals' Insurance Agency, Inc. to service and represent my interests with ISMIE.

Sincerely,

_____	_____	_____
Physician or Group President Signature	Printed Name – Physician or Group President	Group Name (If Applicable)

If the individual signing the Participation Agreement is the Group President, please attach a list of the group's physicians.

PLEASE FAX or EMAIL THIS DOCUMENT TO:
Professionals' Insurance Agency, Inc.
Attention: John DeWeese, President and CEO
2904 Eastpoint Parkway, Louisville, KY 40223
jdeweese@professionalsagency.net
Office: 502-423-7201 Ext. 12