

CONTACT INFORMATION UPDATE

Physician: _____
Main Contact: _____
Current Mailing Address: _____
Email Address: _____

Do you practice under an entity name (corporation, PC, LLC, etc.)? _____

If so please provide the entity information below (ie. Name, Tax ID #, etc.):

Please indicate whether you would like to include this entity on a shared limit basis or with separate limits.
(Typically if an entity is covered on a “shared limits” basis, no additional premium charge applies.)
_____ (If available, please attach a copy of the Articles of Incorporation as well)

Please provide Certificates of Insurance to the following institutions:

(Attach separate page if necessary)

The following ancillary personnel are part of this practice and require proof of coverage:

(Attach separate page if necessary)

Yes, I am interested in:

- Life & Health/Asset Protection
- Hartford Business Owner’s Policy/Workman’s Compensation Insurance
- Keane Advantage Purchasing Program (KAP)
- NextGen Electronic Medical Records (EMR)