COREWELL HEALTH PHYSICIANS INSURANCE COMPANY
ESTIMATE REQUEST FORM*
Medical Professional Liability Insurance

To obtain a CHPIC estimate, please return a copy of your current insurance policy "face sheet" (Certificate or Advice of Insurance) with this fully completed form to: Email: CHPIC@CorewellHealth.org or Fax: 947-522-1041
Questions? Call: 947-522-1040

PHYSICIAN NAME: _____M.D./D.O./OTHER_____
(Please Print) **Last,** **First**

Your P.C. Name	_____ **Practice: ☐ Solo or ☐ Group** **If Group, indicate number of physicians in your group** _____		
Physician Contact	Phone	Fax	Email
U.S. Mail Address			
Office Contact	Name		Email: Phone:

YOUR CURRENT COREWELL HEALTH AFFILIATION

1. **Are you on Corewell Health's Active Staff? ☐ Yes ☐ No If not, please explain:** _____
2. **Your Specialty:** _____ _ ☐ No Surgery ☐ Minor Surgery ☐ Major Surgery

Are you employed by Corewell Health?
☐ Yes ☐ No
☐ Full Time ☐ Part Time

3. **At which Corewell Health hospital(s) do you currently have privileges?**
☐ Dearborn ☐ Farmington Hills ☐ Grosse Pointe ☐ Royal Oak
☐ Taylor ☐ Trenton ☐ Troy ☐ Wayne

YOUR CURRENT INSURANCE

1. **Did you attach your current insurance policy "face sheet" (Declarations Page/Advice of Insurance)? ☐ Yes ☐ No**
2. **Current Policy Retroactive Date:** _____
3. **Current Policy Form:** ☐ Modified Claims Made ☐ Claims Made
4. **Current Limit of Liability:**
☐ $100,000 per claim/$300,000 annual aggregate
☐ $200,000 per claim/$600,000 annual aggregate
☐ $300,000 per claim/$900,000 annual aggregate
☐ Other: _____

YOUR CHPIC ESTIMATE

1. **Desired CHPIC Effective Date:** _____ ***(Note: The Program runs on a common renewal date from January 1 to January 1. Any physician that joins the Program after January 1 will have his/her premium prorated based on the policy inception date.)***
2. **For the coverage needed from CHPIC, on average, what are your total hours worked per week?**_____
(Including, but not limited to: hospital, office, home visits, nursing homes, etc.)
3. **Choose Policy Form:** ☐ Modified Claims Made ☐ Claims Made (See Program Summary for further explanation)
4. **Choose Limit of Liability:**
☐ $100,000 per claim/$300,000 annual aggregate
☐ $200,000 per claim/$600,000 annual aggregate
☐ $300,000 per claim/$900,000 annual aggregate (highest available CHPIC limits)
5. **Have you been involved in a claim in the last 5 years? ☐ Yes ☐ No Comments:** _____
6. **Year you graduated medical school (if within the last 3 years)** _____
7. **Is the coverage you need from CHPIC to cover your activities for a Hospital Professional Services Agreement (PSA)? ☐ Yes ☐ No**
8. **Do you have any questions?**

Note: this form is for a premium indication only. An application must be completed and submitted before any coverage may be bound.
2024 – 8.28.2023