THE DOCTORS COMPANY

ADDRESS CHANGE REQUEST

In order for us to provide you with timely/accurate service and coverage, it is important that we have current information with regards to your practice locations. Please complete all questions shown on the form and then send your response to The Doctors Company. If you have any questions, please contact Member Services at (800) 421-2368.

This change of address request pertains to:

- ☐ An individual physician's information
- ☐ Group/entity information

Name of Physician: _____

Name of Group/Entity: _____

Policy Number: _____

Requested Effective Date of Change: _____

Please check the box(es) for the location type(s) for which we should correct or update an address:

- ☐ Practice Address (location where you practice medicine)
- ☐ Billing Address (location where bills and invoices should be sent)
- ☐ Mailing Address (where all policy documents should be mailed)
- ☐ Home Address (the insured's home address for our records)

Practice Address Change:

Is this a change (due to relocation) or correction to your current practice address, or are you expanding to include additional locations?

- ☐ Change or correction
- ☐ Expansion

Practice Address:

Street Address: _____

City, State, ZIP: _____

Percentage of practice at this location: _____

Practice Address:

Street Address: _____

City, State, ZIP: _____

Percentage of practice at this location: _____

Practice Address:

Street Address: _____

City, State, ZIP: _____

Percentage of practice at this location: _____

Practice Changes:

1. Do you employ new personnel or have you become employed with a new entity? ☐ No ☐ Yes

If Yes, please explain: _____

2. Have you established a new partnership or association, and are you requesting entity coverage be added to your policy? ☐ No ☐ Yes

If Yes, please explain: _____

3. Are you reducing the number of practice locations associated with your policy? ☐ No ☐ Yes

If Yes, please explain: _____

Billing Address:

Street Address: _____

City, State, ZIP: _____

Mailing Address:

Street Address: _____

City, State, ZIP: _____

Home Address:

Street Address: _____

City, State, ZIP: _____

Please provide your current contact information in order for us to provide you with the best possible service:

E-mail Address: _____

Office Telephone: _____

Office Fax: _____

Sign up for eDelivery by setting up an online account at our website www.thedoctors.com**. Contact Member Services at (800) 421-2368 if you have any questions regarding paperless document delivery.**

If you need other address related changes made to your account, please list your requested changes below:

_____

_____

_____ _____

Insured or Authorized Signature **Date**

By signing above, I certify that I am authorized to submit this information on behalf of the insured and that the information I have provided above is accurate to the best of my knowledge.

_____

Print Name