

Renewal Application For Policy Term: _____

Policyholder Name: _____ Contact Name: _____

Keane Producer: _____ Date: _____

Please provide the following phone numbers: Office(s): _____

Fax: _____ Direct Dial/Back Line: _____

Email: _____

- 1. Has your practice (group or individual) changed or made plans to change, since your last renewal?
If yes, please describe on **Notes** page that follows. Yes No
- 2. Have you added any medical related equipment to your practice, or, are you sharing any medical equipment with others since your last renewal?
If yes, please describe on **Notes** page that follows. Yes No
- 3. Have you started or stopped performing any procedures since your last renewal?
If yes, please describe on the **Notes** page that follows. Yes No
- 4. Are any physicians, NPs, advanced nurse practitioners (ANPs), or PAs working part time?
If yes, please complete the [Part-Time Form \(www.mpmains.com/parttimeform\)](http://www.mpmains.com/parttimeform). Yes No
- 5. Have you employed, or made plans to employ, any physicians, NPs, ANPs or PAs since your last renewal?
If yes, please complete the [Ancillary Personnel Form \(www.mpmains.com/apform\)](http://www.mpmains.com/apform). Yes No
- 6. Have any physicians, NPs, ANPs, or PAs left your employment?
If yes, please describe on the **Notes** page that follows. Yes No
- 7. Are there any incidents that have occurred that may lead to a claim that you have not previously reported?
If yes, please complete the [Incident Form \(www.mpmains.com/incidentform\)](http://www.mpmains.com/incidentform). Yes No
- 8. Has any claim been reported or resolved on your behalf by another carrier since your last renewal?
If yes, please complete the [Claim Form \(www.mpmains.com/claimform\)](http://www.mpmains.com/claimform). Yes No

Please note that MPM offers online Risk Management courses which may entitle you to a premium discount and CME credits.

Keane Producer Signature: _____ Date: _____

Insured/Authorized Representative: _____ Date: _____

PLEASE FAX THIS FORM ALONG WITH ANY NOTES AND/OR ADDITIONAL FORMS TO THE KEANE GROUP AT:
314-966-7797

NOTES

<p>IF YOU ANSWERED <u>YES</u> TO QUESTION #1: Has your practice (group or individual) changed or made plans to change, since your last renewal?</p>	<p>Please describe:</p>
<p>IF YOU ANSWERED <u>YES</u> TO QUESTION #2: Have you added any medical related equipment to your practice, or, are you sharing any medical equipment with others since your last renewal?</p>	<p>Please describe:</p>
<p>IF YOU ANSWERED <u>YES</u> TO QUESTION #3: Have you started or stopped performing any procedures since your last renewal?</p>	<p>Please describe:</p>
<p>IF YOU ANSWERED <u>YES</u> TO QUESTION #6: Have any physicians, ANPS, NPs, or PAs left your employment?</p>	<p>Please describe:</p>