

**Renewal Application For Policy Term:** \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Contact Name: \_\_\_\_\_

MPM Representative: \_\_\_\_\_ 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 or advanced nurse practitioners (ANPs) 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 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, ANPS, NPs, 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.

MPM Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insured/Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE FAX THIS FORM ALONG WITH ANY NOTES AND/OR ADDITIONAL FORMS TO THE MPM AT:  
**314-587-8001**

## NOTES

**IF YOU  
ANSWERED YES  
TO  
QUESTION #1:**

Has your practice (group or individual) changed or made plans to change, since your last renewal?

Please describe:

**IF YOU  
ANSWERED YES  
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?

Please describe:

**IF YOU  
ANSWERED YES  
TO  
QUESTION #3:**

Have you started or stopped performing any procedures since your last renewal?

Please describe:

**IF YOU  
ANSWERED YES  
TO  
QUESTION #6:**

Have any physicians, ANPS, NPs, or PAs left your employment?

Please describe: