Submission Cover Sheet

Please completely fill out this form and attach it to all submissions. Complete submissions will be given highest priority. **Submissions will be cleared once minimum requirements (see checklist below) are met.**

ProAssurance
Treated Fairly

Email submissions to:
Submissions@ProAssurance.com

For assistance, call the Service Center:
800-282-6242

Submission Summary:

Agent Name:

Agency Name/Location:

Insured/Submitted Account Name:

Requested Effective Date:

Requested Limits of Liability:

Primary Practice State:

List Additional States with Exposure:

Expiring Premium:

Submission Type:

- ☐ Physician/Physician Group
- ☐ Hospital/Facility
- ☐ Senior Care
- ☐ Small Facility or Allied Healthcare Provider
- ☐ Other (please explain)

Line of Business or Program Option:

- ☐ Admitted
- ☐ Excess and Surplus
- ☐ OBRA
- ☐ Certitude
- ☐ MDVIP
- ☐ Other (please explain)

Minimum Requirements for Submissions:

Standard/Core Physician Policy

- ☐ Roster or Declarations Page
- ☐ Specialty/Risk Classifications
- ☐ Retro Date
- ☐ 10-year Loss Run

Note: *A completed application is not required for submissions to receive a rate indication, however it will be required prior to binding coverage.*

Specialty Underwriting Policy

- ☐ Completed Application or Equivalent Account Specifications
- ☐ Roster or Declarations Page
- ☐ Retro Date
- ☐ 10-year Loss Run
- ☐ Financial Statements
- ☐ Exposure History (at least five years)

Download/print the latest version of this form at **ProAssurance.com/SubmissionsCoverSheet**