First Professionals Insurance Company

CHANGE REQUEST FORM

Date Submitted:	Effective Date of Change:
Request Made By:	Agency Name:
Named Insured:	
Policy Number: TP	Physician Name:

PLEASE INDICATE THE TYPE OF CHANGE YOU ARE REQUESTING (CHECK APPROPRIATE BOX). RETURN THIS FORM WITH REQUIRED INFORMATION

- ❑ **Class/Specialty Change**: Requires signed letter request from named insured
- ❑ **Limit Change**: Requires limit request change form (FPIC MPL-184-IL [01/08]) and letter from named insured
- ❑ **Primary/Mailing Address Change**: Requires signed letter from named insured
- ❑ **Employee Coverage Add:** (Specify designated, allied healthcare professional or vicarious) Vicarious coverage requires proof of employee coverage (a declarations page). Designated and allied healthcare employees require a completed application (FPIC-MPL-114-IL [01/08]) and a letter from the named insured.
- ❑ **Employee Coverage Delete**: Requires a signed letter from the named insured.
- ❑ **Convert an Individual to a Group Policy**: Requires completed application (FPIC MPL-113-IL [01/08]) and letter from named insured.
- ❑ **Convert Group Policy to Individual Policy**: Requires signed letter from named insured.
- ❑ **Retroactive Date Change**: Requires documentation (declarations page)
- ❑ **Addition of Corporate Affiliation**: Requires legal corporation paperwork.
- ❑ **Deletion of Corporate Affiliation**: Requires signed letter from named insured.

- **Policy Cancellation**: Requires completion of a lost policy release (ACORD) form and letter from named insured.

- **Reinstate Coverage**: Requires signed letter from named insured.

- **Add Physician Coverage**: Requires completed FPIC application (FPIC MPL-105 [01/08]), CV, loss history for immediate 10 years prior, evidence of prior coverage.

- **Delete Physician Coverage**: Requires signed letter from named insured.

- **Add Non-Insured Coverage**: Requires evidence of the non-insured's current coverage elsewhere.

- **Delete Non-Insured Coverage**: Requires signed letter from the named insured.

- **Full-time to Part-time Status Change**: Requires signed letter from named insured/physician, showing average hours worked per week.

- **Name Change**: Provide articles of incorporation.

- **Other/Miscellaneous**: Describe: ______________________________

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ALL RELATED SUPPORTING DOCUMENTATION MUST BE ATTACHED.

Please return this form and all supporting documentation to: AVRECO, 550 W. Van Buren, Suite 1200, Chicago, IL 60607 or fax: 312-416-7992.