REQUEST TO CANCEL POLICY

(Please complete Sections I through VIII)

I. Cancellation Request

I, _____________________________ am hereby voluntarily requesting Physicians Indemnity Risk Retention Group ("PIRRG") insurance policy numbered ____________________ be cancelled effective 12:01 am on the _____ day of _______________, 20____.

II. Reason for Cancellation (*Please check* ***all that apply to*** *your request for policy cancellation*):

☐ Switched to another insurance company; please indicate name: _____________________________

☐ Competitive premium; please include new annual premium: ________________________________

☐ New employer; please indicate new employer: ____

☐ Moving out of state; please list state: ____

☐ Practice acquired; please indicate acquiring entity's name: _________________________________

☐ Utilizing same broker after cancellation ☐ Broker not applicable

☐ Utilizing a different broker with new carrier; if so please provide agency name: _________________

III. Extended Reporting Period Endorsement Options (Tail Coverage)

Option 1 – Purchase Declination

☐ No, I do not wish to purchase the Extended Reporting Period Endorsement (tail coverage). Please indicate the reason for your decision:

☐ Prior Acts obtained (nose coverage)

☐ Purchased free-standing tail coverage from another carrier

☐ Obtained Occurrence Coverage

☐ Other ______________________________

I understand my right to purchase an Extended Reporting Period Endorsement must be exercised within thirty (30) days from date of cancellation provided in Section I above.

Option 2 – Agreement to Purchase

☐ Yes, I will purchase the Extended Reporting Period Endorsement to be issued on my behalf.

☐ One Year Extended Reporting Period Endorsement

☐ Two Year Extended Reporting Period Endorsement

☐ Unlimited Extended Reporting Period Endorsement

Option 3 – FREE Extended Reporting Period Endorsement Benefit Statement of Eligibility

☐ I request the FREE Extended Reporting Period Endorsement based on the following declaration:

_______ **Permanent disability preventing the practice of medicine.** (NOTE: Permanent disability shall be defined by the Social Security Administration and/or Medicare)

______ **Retirement from the practice of medicine.** (NOTE: must be 55 years or older and been insured with PIRRG for more than one year at a mature premium rate immediately before retirement)

Retirement Date ___________________________

______ **Death.** (Please provide a copy of the death certificate)

It is understood that should the Policyholder return to the practice of medicine, PIRRG must be immediately notified in writing.

It is further understood that should a claim be reported to PIRRG and it is discovered that the Policyholder has been practicing medicine, no coverage will apply to the claim(s).

____
Signature (*Required)*

Printed: _______________________________

IV. Please provide any additional information you would like known about your cancellation request:

____

____

V. Please send all future correspondence to the following address:

Mailing Address:

Address Line 1: ____

Address Line 2: ____

City: ________________ State: ____ Zip: _______ Phone #: ________________

Billing Address: *(if different from above)* ☐ *Please bill my employer*

Address Line 1: ____

Address Line 2: ____

City: ________________ State: ____ Zip: _______

VI. Policyholder's Name: ____________________ **Policy Number:** ____________

VII. Policyholder's Signature: ________________________ **Date:** __________

VIII. OR Insurance Producer:

____________________________ **Date:** __________

Signature

____

Printed

Please return to PIRRG by facsimile (888-608-6327) or email (info@pirrg.com)