COREWELL HEALTH PHYSICIANS INSURANCE COMPANY
ESTIMATE REQUEST FORM *

To obtain a CHPIC estimate, we require a copy of your current insurance policy "face sheet" (Certificate or Advice of Insurance) with this fully completed form to: Email: CHPIC@CorewellHealth.org or Fax: 947-522-1041
Questions? Call: 947-522-1040

PHYSICIAN NAME: _____M.D./D.O./OTHER_____
(Please Print) **Last,** **First**

Your P.C. Name	_____ **Practice: ☐ Solo or ☐ Group** **If Group, indicate number of physicians in your group _____**		
Physician Contact	Phone	Fax	Email
U.S. Mail Address			
Office Contact	Name		Email: Phone:

YOUR CURRENT COREWELL HEALTH AFFILIATION

1. **Are you on Corewell Health's Active Staff? ☐ Yes ☐ No If not, please explain: _____**

2. **Your Specialty: _____ _**
   ☐ No Surgery
   ☐ Minor Surgery
   ☐ Major Surgery

   Are you employed by Corewell Health?
   ☐ Yes ☐ No
   ☐ Full Time ☐ Part Time

3. **At which Corewell Health hospital(s) do you currently have privileges?**

Place a check mark next to each hospital where you have staff privileges							
	Big Rapids		Greenville		Pennock		Watervliet
	Blodgett		Grosse Pointe		Reed City		Wayne
	Butterworth		Helen Devos		Royal Oak		Zeeland
	Dearborn		Lakeland		Taylor		
	Farmington Hills		Ludington		Trenton		
	Gerber		Niles		Troy		

What is your level of Medical Staff Membership?

	Active		Ambulatory
	Attending		Courtesy Staff with Privileges
	Associate		Other?

YOUR CURRENT INSURANCE

1. **We require a copy of your current insurance "face sheet" (Declarations Page/Advice of Insurance).**
   Did you include a copy with your submission? ☐ Yes ☐ No

2. **Current Policy Retroactive Date: _____**

3. **Current Policy Form:** ☐ Modified Claims Made ☐ Claims Made

4. **Current Limit of Liability:**
   ☐ $100,000 per claim/$300,000 annual aggregate
   ☐ $200,000 per claim/$600,000 annual aggregate
   ☐ $300,000 per claim/$900,000 annual aggregate
   ☐ $1,000,000 per claim/$3,000,000 annual aggregate
   ☐ Other: _____

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**Note: this form is for a premium indication only. An application must be completed and submitted before any coverage may be bound.*

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YOUR CHPIC ESTIMATE
For a most accurate estimate, please answer all questions and include a copy of your current insurance face sheet and recent loss run/claims history.

1. **Desired CHPIC Effective Date:** _____ *(Note: The Program runs on a common renewal date from January 1 to January 1. Any physician that joins the Program after January 1 will have his/her premium prorated based on the policy inception date.)*

2. **For the coverage needed from CHPIC, on average, what are your total hours worked per week?_____**
(Including, but not limited to: hospital, office, home visits, nursing homes, etc.)

3. **Choose Policy Form:** ☐ Modified Claims Made ☐ Claims Made (See Program Summary for further explanation)

4. **Choose Limit of Liability:**
☐ $100,000 per claim/$300,000 annual aggregate *
☐ $200,000 per claim/$600,000 annual aggregate
☐ $300,000 per claim/$900,000 annual aggregate
☐ $1,000,000 per claim/$3,000,000 annual aggregate

5. **Have you been involved in a claim in the last 5 years? ☐ Yes ☐ No**
If yes, please include a loss run/claims history from your current insurer dated within the most recent 30 days.

Comments: _____

6. **Year you graduated medical school (if within the last 3 years) _____**

7. **Is the coverage you need from CHPIC to cover your activities for a Hospital Professional Services Agreement (PSA)?**
☐ Yes ☐ No

8. **Do you have any questions?**

_____

*Limits of $100,000 per claim/$300,000 annual aggregate will be discontinued effective January 1, 2026.

**Note: this form is for a premium indication only. An application must be completed and submitted before any coverage may be bound.*
2025 – 9/16/2024