Physicians Insurance
A Mutual Company

1301 Second Avenue, Suite 2700
PO Box 91220
Seattle, WA 98111

(206) 343-7300 (800) 962-1399
F (206) 343-7100

SUSPENSION REQUEST FORM

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers.

Name (as it appears on your policy/coverage):____
last first middle

Policy or Reference number (if known):____

New Address and Phone Information (if applicable – please write *same*, if no change)**:**

Effective date of address (and phone number) change:______________________________

Street:____

City:______________________________ State:__________ Zip:____________

Office phone:________________________ Home phone:________________________

Suspension Dates: Last day of practice:________________ Expected return to practice date:________________

Please Note: If you are a solo physician with Data Compromise Coverage, this will be cancelled effective the date of suspension.

Reason for Suspension:

Please check all that apply. If you check more than one, please discuss in the “Additional Remarks” section the length of time you will be spending on each activity.

- ☐ Maternity/Paternity leave
- ☐ Medical disability (please describe below. A letter from your treating physician will be required when returning to work, or as needed)
- ☐ Medical missionary work - please state location:________________________
- ☐ Professional sabbatical (please provide location and details in “Additional Remarks” section)
- ☐ Professional research or continuing education (Please provide dates and course schedule)
- ☐ Vacation (please discuss in “Additional Remarks” section)
- ☐ Other reasons for Suspension (please discuss in “Additional Remarks” section)

Additional Remarks (if applicable): ____

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Should I not return to practice, or reinstate my coverage with Physicians Insurance as planned, I agree to purchase the Extended Reporting Endorsement (“tail”) for my Physicians Insurance policy, unless I qualify for waiver of tail premium.

________________________________ ________________________
Insured’s Signature **Date**

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return to:

☐ Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

☐ Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821

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