MDADVANTAGE®
A MAGMUTUAL® COMPANY

Request for Group Policy Physician Claim History Information
(Not to be used with Physicians Insured on Individual Practices)

*This application **must be completed in full** and signed by an authorized individual. Additional copies may also be obtained on our website at MDAdvantageonline.com. Please direct questions to Policyholder Services at 888-355-5551.*

There is a $35 fee for each physician or paraprofessional on your Group Policy subject to a maximum of $150. For active MDAdvantage groups, within limitations, the fee is waived. Mail the completed form or email the form to **claimsinfo@magmutual.com**. Your check made payable to "MDAdvantage" and/or your form may also be mailed to:

MDAdvantage
Claims Department
100 Franklin Corner Road
Lawrenceville, NJ 08648-2104

Note: Only Claim History information for active physicians and paraprofessionals on your Group Policy will be provided with this request.

Medical Professional Liability Claim History ☐ Supreme Advantage Claim History ☐ Both ☐

To whom should this information be released?

Company/Organization Name: _____

Attention: _____ Dept: _____

Email: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of Group/Practice: _____

Contact: _____

MDAdvantage Group (GRP) Policy Number: _____

Named Insured on Policy: _____

Current mailing address:

_____ / _____ / _____ / _____
Street/PO Box City State Zip Code

Phone number: _____ Email address: _____

By way of their signature, the named individual below represents that he or she has the authority to request and receive all claim history information relative to the physicians and/or paraprofessionals within the Group referenced above.

I, _____, authorize the release of the Group Policy Physician Claim History information.
(Name of authorized individual)

for each risk on the above-referenced Group Policy to the organization indicated above, its designated agent(s) or broker(s), employee(s) or representative(s). I agree to indemnify and hold MDAdvantage harmless for any and all liability, expense or claims arising out of the release of this information.

My signature below authorizes the release of this Group Policy Physician Claim History information. This authorization expires in 30 days from the date signed unless another date is specified here _____.

_____ _____
Signature of named individual (*NO STAMPED SIGNATURES ACCEPTED*) (Signature date **required**)

MDAdvantage and its representatives have taken reasonable steps to ensure the accuracy of the information in the Group Policy Physician Claim History Information or related report. Errors or omissions may occur due to the high number of requests and the volume of data involved. Independent verification with the healthcare professional is strongly recommended. The information provided in no way alters or supersedes any of the terms and conditions of the policy.