Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Deliver to:
Fax: 800-398-6726
Email: medproinduction2@medpro.com
Postal Mail: P.O. Box 15021 Fort Wayne, IN 46885-5021

Cancellation Request Form

Policy:

Insured Name:

Requested Date of Cancellation:

- *Medical Protective does not typically backdate cancellation requests.*
- *If cancel date falls after your renewal date, additional premium may be required.*
- *If changing groups or coverage state and desire continued coverage with MedPro, please complete a Group/Employer, Practice Location or State Change adjustment or contact 1-800-4MedPro for assistance.*

Please select the statement that best describes the reason for cancellation.

No Longer Require Coverage:

☐ Ceased Moonlighting ☐ Disability ☐ Dissolved my Corporation / Partnership
☐ Active Military Duty ☐ Leave of Absence ☐ Retirement ☐ Death
☐ Other, Please explain:

New Coverage Provided Due to:

☐ Secured a teaching position ☐ Coverage provided by employer
☐ Coverage provided by government body ☐ Locum Tenens position
☐ Change in MedPro line of business

Chose Another Malpractice Carrier Due to:

☐ Better Price for Similar Coverage: Premium amount that motivated you to switch Carriers: $

☐ Dissatisfied with service provided by Medical Protective:
☐ Claims Department ☐ Billing ☐ Customer Service
☐ General Policy Service ☐ Online Service ☐ Underwriting Decisions
☐ Lack of Response ☐ Turnaround Time

☐ MedPro Coverage did not Meet my needs:
☐ Unable to obtain desired limits ☐ Unable to obtain coverage for my Specialty / Procedures
☐ Unable to obtain other policy detail requests.

- **New Insurance Carrier:**

Please provide additional details regarding cancellation:

If the correspondence address or contact information has changed please update below:

Address: Phone:
City, State, Zip: Fax:
Email:

I authorize the above policy to be cancelled by Medical Protective:

Signature: Date Signed:
Title (if not Insured):

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