

CHANGE REQUEST FORM

POLICY UPGRADES, COVERAGE, ENDORSEMENTS, AI'S AND OTHER

Print Name: _____ Effective Date of Change: _____

AcuProperty Plus: (Business Personal Property Insurance)

- Add - (List address below) \$103.20 for first \$10K Cancel - Existing Business Personal Property
 Add - Additional \$10K x _____ (\$67.08 Per \$10K; cannot exceed \$100K) Update - The address of my current BPP (List address below)

Street Address (Include Ste./Apt. #): _____

City / State / Zip Code: _____

Additional Insured (AI) / PC: (i.e. Landlord, Individual renting space from, or your owned Entity/Corporation)

- Add AI - Check here for Landlord, Entity, or Individual (Annual cost 5% of net premium per AI)
 Add PC - Check here for Professional Corporation (PC), that you fully own (No additional charge)
 Cancel - Existing Coverage for additional insured (Non-refundable) Update for corrected spelling or address

Name of Additional Insured: _____

Street Address (Include Ste./Apt. #): _____

City / State / Zip Code: _____

Other: (See cover letter for explanation of options listed below)

- Malpractice Limit Change: 100/300K 500/500K 1M/1M 1M/3M 2M/4M 10K/30K (Florida ONLY)
 Update - To full-time status (Additional premium due) Add - Upgrade to Premier Coverage for an additional \$125
 Update - Downgrade coverage to AcuPlus Policy Order - Arb forms @ \$25 per pack (100 sheets): How many? _____
 Update - Switch policy from Elite to Preferred Program

Credit Card or ACH (Complete applicable section and sign)

Credit Card Payments:

Name on Card: _____

Card Type: Visa MasterCard American Express

Card #: _____

Expires: _____

ACH Payments from Bank Account:

Account Type: Personal Business

Account #: _____

Bank Name: _____

Bank Routing #: _____

Branch City: _____

You are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing. Please make the changes requested effective the date indicated. I declare that I signed/typed my name below, and that the statements made in this document are true, and I have not misstated or suppressed any facts. Any requested change within the last 90 days of your policy will be effective upon your renewal, unless otherwise approved.

Signature: _____

Submit to: Email: info@acupuncturecouncil.com

Fax: 714-571-1863



American Acupuncture Council

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