CHANGE REQUEST FORM

Policy Upgrades, Coverage, Endorsements, AI's and Other

Print Name: _____

Make Change Effective: ❑ Immediately ❑ On Renewal ❑ Other date (not before current date): _____

**If are adding an additional insured within 60 days of your renewal period, please note that you will incur this fee now, as well as on the renewal.*

Professional Liability Update:

Primary Practice Address	City	State	Zip
Email	Office #	Cell #	Fax #
Mailing Address *(If different than primary)*	City	State	Zip

Entity: Your owned Entity/Corporation or Additional Insured (AI)

❑ Add Entity - Check here for entity, that you own (No additional charge) - List below
❑ Add AI - Check here for entity, that you *do not* own (Annual cost 5% of net premium per AI entity) – List below
❑ Add AI - Check here for Landlord (Annual cost 5% of net premium per AI entity) - List below
❑ Cancel - Existing Coverage for additional insured/entity (Non-refundable) ❑ Update for corrected spelling

EXACT name as registered with the state (Legal Entity/Corporation)

Name: _____ DBA _____

Owners Name _____ Relationship _____

Type of corporation ❑ LLC, ❑ PLLC, ❑ S Corp, ❑ C Corp, ❑ Other _____

Other: Misc. policy changes resulting in premium adjustments

❑ Malpractice Limit Change: ❑ 100K/300K ❑ 500/1.5M ❑ 1M/3M ❑ 2M/4M
❑ Update - To full-time status (Additional premium due)
❑ Add - Upgrade to Premier Coverage ($125 fee)
❑ Update - Downgrade coverage to AcuPlus Policy
❑ Order - Arb forms @ $25 per pack (100 sheets): _____
❑ Update - Switch policy from Elite Program to Preferred Program
❑ Add -Business Personal Property Coverage @ $110 for first $10,000 (Primary Practice Address listed above)

Payment Method (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: _____

❑ **Check to update Payment Method on File to the Above**

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 60 days of your policy will be effective upon your renewal, unless otherwise approved.

Signature: _____

Submit to: **Email:** info@acupuncturecouncil.com
AMERICAN ACUPUNCTURE COUNCIL
1100 W. Town & Country Road, Suite 1400
Orange, CA 92868
(800) 838-0383 **FAX: (714) 571-1863**