

Hospital Insurance Forum

Sharing Experience, Information and Ideas

Application for Membership

Name of Applicant Company:

Address:

City: State: Zip Code:

Country:

State the nature of operation of Applicant Company, by whom it was formed, and by whom it is owned:

What is the makeup of Board of Applicant Company (hospital administrators, doctors, etc.)

Is the Applicant Company engaged in lines of business, other than hospital professional and general liability? Yes No

If yes, list:

Annualized HPL and GL premium is:

Survey Completed by:

Name: Date:

Company:

Please e-mail completed applications to: Meredith Dismukes at mdismukes@inspirien.net