University Hospitals

UH SPONSORED PHYSICIAN PROGRAM

July 1, 2016

Subject:	Medical Professional Liability Information for UHCMC Residents &/or Fellows Graduating in Summer, 2015
Insurance Carrier:	Western Reserve Assurance Co., Ltd., SPC
Policy Number	WRUHPHPL
Limits of Liability:	$1,000,000 per occurrence/ $3,000,000 annual aggregate
Policy Term:	7/1/2016 through 06/30/2017

Dear Physician:

Residents and Fellows of University Hospitals Case Medical Center are afforded medical professional liability coverage under University Hospitals General Liability insurance policy under the policy number listed above. This CLAIMS MADE coverage is currently underwritten by The Western Reserve Assurance Co., Ltd., SPC. Coverage under this policy goes back to July 1, 2002 and extends to all UH employees, including residents and fellows, while acting within the course and scope of their employment at University Hospitals. Because the limits of this coverage are shared with the hospital, residents and fellows are not required to purchase an Extended Reporting Period Endorsement ("Tail" coverage) upon their graduation.

Prior to July 1, 2002, University Hospitals of Cleveland (UHC) was self-insured. All residents and fellows during this time were covered under the Hospital's self-insured program for activities within the scope of their residency and/or fellowship.

If you require additional verification of your coverage and claims history information, please contact the UH Sponsored Physician Program's Physician HOTLINE at 216-767-8282. Please note that our office requires your signed authorization to release details relating to your residency or fellowship at UHCMC. For your convenience, a release of information form is attached to this memo. Please fax the completed requests to 216-201-4402. All inquiries about insurance coverage provided by Western Reserve Assurance Co., Ltd., SPC should be sent to the UH Corporate Risk Management Department at the address listed below.

UH Corporate Risk Management Department
3605 Warrensville Center Road
Mail Stop: MSC 9120
Shaker Heights, OH 44122

Thank you in advance for you cooperation, and congratulations and good luck with your medical career!

Sincerely,

UH Corporate Risk Management Department

University Hospitals

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REQUEST FOR CLAIM HISTORY &/OR LOSS DATA

Authorization to Release Information

To request your claim history, please legibly complete as much of the information below as possible. Please FAX this signed form to 216-201-4402. If you have any questions, you may call the University Hospitals Insurance and Risk Management PHYSICIAN INSURANCE HOTLINE at 216-767-8282.

Coverage Status: ☐ **a Resident** ☐ **a Fellow** ☐ **Employed by UH *Allied Health Professional*** ☐ **Employed Physician Participant *(UHMG/UHMP)***

Provider Full Name: ______________________________

Dates of Coverage *or Employment*: ______________________________

Location / Facility / Entity: ______________________________

Policy Number: ______________________________

Social Security #: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

UH may use this email address to respond to this request only. It will not be used for any other purpose.

Forward information to: ☐ Email address as above, ***&/or:***

Name: ______________________________

Address: ______________________________

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Fax #: ______________________________

Phone #: ______________________________

Email Address: ______________________________

I request and therefore authorize the release of information and documents concerning my claims &/or loss history, as it pertains to my employment, Residency or Fellowship at **University Hospitals**, **UH Case Medical Center**, or to my participation in the **UH Sponsored Physician Program**. These programs are currently insured through the Western Reserve Assurance Co., Ltd, SPC.

I release all persons and entities from any liability for supplying information and documents in response to such a request. I authorize the use of a copy of this authorization in place of the original.

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Printed Name: Date:

______________________________ ☐ MD ☐ DO ☐ ____

Signature: Degree: