New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Malpractice Insurance Verification Form

_____ has applied for a medical license with the State of New
Insured's Name

of New Jersey. He/she held medical malpractice insurance issued by your company. Please complete this form, attach relevant supporting documentation concerning any medical malpractice cases in which this practitioner was named and the business card of the individual completing this form and return directly to:

State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625

Malpractice Insurance Company Name:_____

Address: _____
Street City State Zip Code Country

Dates of coverage: from:_____ to _____
Month / Dsy / Year Month / Dsy / Year

Dates should include entire period the insured was covered, not just the dates of the current policy.

List the name(s) and status of each case in which the doctor has been involved. Attach supporting documents concerning the status of the case.

Plaintiff's Name	**Status**
_____	_____
_____	_____
_____	_____
_____	_____

1. Was this doctor ever denied malpractice coverage? ☐ Yes ☐ No
2. Was this doctor's practice ever curtailed or limited? ☐ Yes ☐ No
3. Was this doctor ever assessed a surcharge based upon specific claims history? ☐ Yes ☐ No
4. Was office monitoring or special hospital monitoring ever required for this doctor? ☐ Yes ☐ No
5. Was this doctor ever subjected to underwriting review based upon specific claims history or for any other cause? ☐ Yes ☐ No

_____ _____
Print Name and Title of the person completing this form. Date

_____
Signature of the person completing this form.