PLICO, Inc.
Application Guideline

Thank you for your consideration of PLICO for your professional liability insurance needs. Since 1979, PLICO has been the leading choice by Oklahoma physicians for protecting themselves and their practices.

Please note the following instructions for the included application. If you have any questions, please do not hesitate to call PLICO Underwriting at 405.815.4800.

- All questions must be answered. If a question does not apply, enter "N/A" for that question.
- Section 2 – Coverage Information (page 1): Previous Insurance Company information for the preceding 5 years must be provided. Proof of insurance from each carrier should accompany the application. If there are previous exclusions of specific procedures or restrictions on the professional liability insurance, please explain on the Additional Information Section, or on a separate sheet of paper.
- *Entity coverage* - **for associations, partnerships, corporations, or companies**, on shared or separate limits basis, please provide the following documents/information:

  1. Copy of the W-9 and 1099 (IRS) forms for the entity,

  2. Copy of the Employers Quarterly Contribution Report with a notation of employee's position for the entity,

  3. Copy of the Articles of Incorporation or Formation for the entity,

  4. Provide a current Certificate of Insurance for each employed or contracted physicians not insured by PLICO.
- *License restrictions or investigations*– explain any restrictions or investigation in the Additional Information Section, or on a separate sheet of paper.
- *Physicians' Section 9 and Ancillaries' Section 5* – Explain any "Yes" answers in the Additional Information Section, or on a separate sheet of paper.
- *Medical and Surgical Procedures* (Physicians' Section 8) - indicate the procedures that you will perform under this policy/coverage.
- ***CLAIMS HISTORY* – issued by all previous insurance carriers must be submitted with every application if you have had past claims. If no past claims, please complete the attached No Known Loss Affidavit.**

PHYSICIANS PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

☐ **Individual Policy** **or** **Add to a Group Policy** ☐ ***Group's policy #___________________________***
Name of Group ___________________________

SECTION 1 - GENERAL INFORMATION			
1. Name of Applicant:			2. SSN:
3. Indicate other names by which you have been known. Specify the dates during which the name was used:			
4. M. D. ☐ D. O. ☐	5. Sex:	6. Place of Birth:	7. Date of Birth:
8. Office Address:			
City:	State:		Zip Code:
9. Contact Person:			
10. Billing address (***if different than Office Address***) :			
City:	State:		Zip Code:
11. Home Phone:	12. Office Phone:		13. Fax:
14. E-mail:		15. Web Site:	
16. Home Address:			
City:	State:		Zip Code:
17. I hereby name as my insurance agent: ___________________________			

SECTION 2 - COVERAGE INFORMATION

1. Requested Effective Date: ____________________ 2. Requested Retroactive Date: ____________

3. Requested Limits of Liability:

☐ $100,000 / $300,000 ☐ $200,000 / $600,000 ☐ $500,000 / $1 million
☐ $1 million / $1 million ☐ $1 million / $3 million ☐ $2 million / $2 million
☐ $2 million / $4 million

4. Insurance history

Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current:				
Prior:				
Prior:				
Prior:				
Prior:				
Prior:				

5. Has your present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? If "Yes", provide details on Section 15. Yes☐ No☐

6. Have you ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 15. Yes☐ No☐

SECTION 3 - PROFESSIONAL EDUCATION AND TRAINING				
SCHOOL OR FACILITY	**NAME AND LOCATION OF SCHOOL AND/OR HOSPITAL**	**DEGREE OR SPECIALTY**	**START DATE**	**COMPLETION DATE**
Medical School:				
Internship:				
Residency:				
Residency:				
Fellowship:				
How many continuing education credits (CME's) have you completed during the past 3 years?				

SECTION 4 – LICENSURE – CERTIFICATION - ASSOCIATION

1. State Medical License #: — 2. Expiration Date:
3. Are you licensed in other states? Yes☐ No☐ — State: ______ License #:__________________ — State: _______ License #:__________________
4. Are you Board Certified? Yes☐ No☐
   If yes, name of specialty board:
5. Second Specialty Board: — Date Certified:
6. Third Specialty Board: — Date Certified:
7. Has your medical license in any state ever been suspended, revoked, denied, or limited? Yes☐ No☐
   If "Yes", provide details on Section 15.
8. Are you currently under investigation by any state licensing board or agency? Yes☐ No☐
   If "Yes", please explain on Section 15.
9. Medicare#: — 10. Medicaid#: — 11. State Bureau of Narcotics#:
12. Are you an active member of a state medical association? Yes☐ No☐
13. If you are a Doctor of Osteopathy: are you an active member of an osteopathic association? Yes☐ No☐
    If yes, please list association in the space provided below:
14. Please list any Medical Society Affiliations:

SECTION 5 – INSTITUTIONAL PRACTICE

1. Indicate the name and location (city and state) of each hospital where you currently hold staff privileges:

	NAME	LOCATION
a.	______________________________	______________________________
b.	______________________________	______________________________
c.	______________________________	______________________________

2. Has any hospital ever taken action to deny, suspend, revoke, or restrict your medical staff privileges, or your application or reapplication for medical staff privileges? Yes☐ No☐
   If "Yes", identify hospital, date, and reasons on Section 15.
3. Have you ever resigned from a hospital staff while under investigation, or to avoid possible disciplinary action? If "Yes", identify hospital, date, and give reasons on Section 15. Yes☐ No☐

SECTION 5 – INSTITUTIONAL PRACTICE (continued)

4. Has any of the following ever been denied, revoked, suspended, reduced, limited, canceled, sanctioned, placed on probation, not renewed, or relinquished for disciplinary reasons? Yes☐ No☐

   a. State narcotics registration Yes☐ No☐
   b. Academic appointment Yes☐ No☐
   c. Membership on any hospital or healthcare facility medical staff Yes☐ No☐
   d. Clinical privileges, prerogatives, or rights on any medical staff Yes☐ No☐
   e. Membership in other healthcare organizations or facilities Yes☐ No☐
   f. Professional society membership or fellowship Yes☐ No☐
   g. Any other type of professional reprimand or sanction Yes☐ No☐
   h. Educational Commission for Foreign Medical Graduates (ECFMG) certification Yes☐ No☐
   i. Participation in the Medicare/Medicaid program or other government health benefits program Yes☐ No☐

SECTION 6 – CLASSIFICATION – PRACTICE

1. Check the box(es) that best describe your practice

☐ No Surgery - Applies to both general practitioners and specialists who do not perform obstetrical procedures or surgery. Minor procedures encountered in a family-type practice do not constitute surgery. Assisting in surgical procedures constitutes surgery.

☐ Minor Surgery - Applies to general practitioners and specialists who perform minor surgery or assist in major surgery.

☐ Major Surgery – Applies to general practitioners and/or specialists who perform major surgery.

2. Has there been any change in your practice in the last five (5) years? Yes☐ No☐
   If "Yes",please describe below.

3. Do you plan to take additional residencies or change specialties? Yes☐ No☐
   If "Yes", please describe below.

4. Do you participate in clinical trials? Yes☐ No☐
   If "Yes", indicate what percentage of *your practice* is dedicated to clinical trials: ___________
   Indicate the percentage that clinical trials represent of your *total gross receipts*: ____________

5. Does your practice include locations outside the state of primary practice? Yes☐ No☐
   If "Yes", indicate locations: ____
   ____

SECTION 7 – MEDICAL SPECIALTY

1. What is your present Specialty?	2. Sub-specialty?

3. Please check the box that best describes your practice:

	Addiction Medicine		Nuclear Medicine		**MAJOR SURGERY (continued):**
	Aerospace Medicine		Nutrition		**Endocrinology**
	Allergy		Occupational Medicine		**Gastroenterology**
	Anesthesiology		Oncology		**GP/FP not primarily engaged in major surgery**
	Broncho-Esophagology		Ophthalmology		**General**
	Cardiovascular Disease		Otology		**Geriatrics**
	Dermatology		Otorhinolaryngology		**Gynecology**
	Diabetes		Pain Management		**Hand**
	Emergency Medicine		Pathology		**Head and Neck**
	Endocrinology		Pediatrics		**Laryngology**
	Family Practice (FP)		Pharmacology-clinical		**Neoplastic**
	Forensic Medicine		Physiatry		**Nephrology**
	Gastroenterology		Physical Medicine and Rehabilitation		**Neurology**
	General Practice (GP)		Psychiatry		**Obstetrics**
	General Preventive Medicine		Psychoanalysis		**OB/GYN**
	Geriatrics		Psychosomatic Medicine		**Ophthalmology**
	Gynecology		Public Health		**Orthopedic –including back**
	Hematology		Pulmonary Diseases		**Orthopedic – no back**
	Hospitalist		Radiology – Interventional* (list procedures in Section 15)		**Otology**
	Hypnosis		Radiology - Diagnostic		**Otorhinolaryngology**
	Immunology		Retired		**Plastic**
	Infectious Disease		Rheumatology		**Rhinology**
	Intensive Care Medicine		Rhinology		**Thoracic**
	Internal Medicine				**Traumatic**
	Laryngology		**MAJOR SURGERY:**		**Urological**
	Legal Medicine		**Abdominal**		**Vascular**
	Neoplastic Diseases		**Cardiac**		
	Nephrology		**Cardiovascular**		
	Neurology		**Colon and Rectal**		
	Other (please identify):				

SECTION 8 – MEDICAL and SURGICAL PROCEDURES

Please check off "Yes" or "No" for each procedure or activity that you performed in the past year or will perform in the coming year. Indicate the number of procedures performed in the past year, and also indicate if you anticipate any significant changes for the coming year.

1. Minor surgery (on a regularly scheduled basis).	Yes	No	# in past year	Changes?
2. Minor surgery (on an emergency basis only).	Yes	No	# in past year	Changes?
3. Assisting in major surgical procedures on your own patients.	Yes	No	# in past year	Changes?
4. Major Surgery includes but not limited to: Tonsillectomies, adenoidectomies, cesarean sections, dilation and curettage, abortions, vasectomies and other procedures performed under general anesthesia.	Yes	No	# in past year	Changes?
5. Assisting in major surgical procedures on other than your own patients.	Yes	No	# in past year	Changes?
6. Normal obstetrical procedures	Yes	No	# in past year	Changes?
7. Obstetrical procedures, which are considered to be major surgery: C-Sections, D&C, etc.	Yes	No	# in past year	Changes?

SECTION 8 - MEDICAL and SURGICAL PROCEDURES (continued)				
8. Plastic surgery-reconstructive? (Medically necessary following surgery or trauma).	Yes	No	# in past year	Changes?
9. Plastic/Cosmetic surgery - elective? (not medically necessary)	Yes	No	# in past year	Changes?
10. Non-surgical cosmetic procedures (Dermabrasion, Botox injections, permanent micro-pigmentation, thread lifts, mesotherapy, etc.)	Yes	No	# in past year	Changes?
11. Administering general anesthesia?	Yes	No	# in past year	Changes?
12. Acupuncture	Yes	No	# in past year	Changes?
13. Angiography – venous	Yes	No	# in past year	Changes?
14. Angiography – arterial	Yes	No	# in past year	Changes?
15. Colonoscopy	Yes	No	# in past year	Changes?
16. Cryosurgery – other than use on benign or non-malignant dermatological lesions or cervix	Yes	No	# in past year	Changes?
17. Discograms	Yes	No	# in past year	Changes?
18. Endoscopic retrograde cholangiopancreatography	Yes	No	# in past year	Changes?
19. Heart Catheterization - with or without coronary angiography	Yes	No	# in past year	Changes?
20. Occasional emergency insertion of central venous recording catheters and temporary pacemakers (Swan Ganz)	Yes	No	# in past year	Changes?
21. Laparoscopy (Peritoneoscopy)	Yes	No	# in past year	Changes?
22. Laser- used in surgery	Yes	No	# in past year	Changes?
23. Lymphangiography	Yes	No	# in past year	Changes?
24. Myelography	Yes	No	# in past year	Changes?
25. Needle biopsy - including lung and prostate	Yes	No	# in past year	Changes?
26. Needle biopsy - including liver, kidney, or bone marrow biopsy	Yes	No	# in past year	Changes?
27. Phlebography	Yes	No	# in past year	Changes?
28. Pneumatic or mechanical esophageal dilation (not with bougle or olive)	Yes	No	# in past year	Changes?
29. Pneumoencephalography	Yes	No	# in past year	Changes?
30. Radiation therapy	Yes	No	# in past year	Changes?
31. Radiopaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae	Yes	No	# in past year	Changes?
32. Electro-Convulsive Shock Therapy (ECT)	Yes	No	# in past year	Changes?
33. Vascular embolization	Yes	No	# in past year	Changes?
34. Chelation therapy	Yes	No	# in past year	Changes?

SECTION 8 - MEDICAL AND SURGICAL PROCEDURES (continued)				
35. Micro or blepharopigmentation (permanent eyelash enhancement)	Yes	No	# in past year	Changes?
36. Bariatric surgery, indicate procedures:	Yes	No	# in past year	Changes?
37. Liposuction	Yes	No	# in past year	Changes?
38. Hair Transplants	Yes	No	# in past year	Changes?
39. Angioplasty	Yes	No	# in past year	Changes?
40. Circumcisions	Yes	No	# in past year	Changes?
41. Breast augmentation	Yes	No	# in past year	Changes?
42. Deliver babies	Yes	No	# in past year	Changes?
43. Surgery on the spine	Yes	No	# in past year	Changes?
44. Does your practice include *non-invasive* pain management? If "Yes", list the number of pain management prescriptions per week.	Yes	No	# in past year	Changes?
45. Does your practice include *invasive* pain management? If "Yes", list procedures in Section 15.	Yes	No	# in past year	Changes?
46. Do you practice at an emergency department of a hospital or healthcare facility?	Yes	No	# in past year	Changes?
47. Are you employed in an Urgicare or Emergicare Center?	Yes	No	# in past year	Changes?
48. Do you perform office-based surgery in your professional office?	Yes	No	# in past year	Changes?
49. Are you using anesthesia including conscious sedation in your office?	Yes	No	# in past year	Changes?

SECTION 9 - Underwriting	
1. Have you ever been treated for, or do you currently have any medical and/or psychiatric problem including alcohol and/or drug dependence?	Yes☐ No☐
2. Have you been institutionalized during the past five years, or do you have a continuing health condition that requires therapy? If "Yes", provide details on Section 15	Yes☐ No☐
3. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation according to accepted standards of professional performance and without posing a direct threat to patients?	Yes☐ No☐
4. Are you currently engaged in the illegal use of drugs, or the misuse of legal drugs? (If you are making application to a government entity, you have the right to elect not to answer this question, if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution).	Yes☐ No☐
5. Is your physical or mental health such that it may impair your ability to practice within the scope of the privileges for which you have applied?	Yes☐ No☐

SECTION 9 - UNDERWRITING (continued)

6. Date of the most recent physical exam: ________________
7. Significant Findings:

8. Have you ever been charged of a crime other than a minor traffic offense? Yes☐ No☐

9. Are there any felony charges pending against you? Yes☐ No☐

10. Have you ever withdrawn your application for appointment, reappointment, and/or clinical privileges, resigned from the medical staff, or surrendered your clinical privileges while under investigation or before a recommendation or decision was rendered by a hospital or health care facility's medical executive or governing board? Yes☐ No☐

11. Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)? Yes☐ No☐

12. Has your employment at a health care organization ever been terminated? Yes☐ No☐

13. Have you ever been terminated, rejected, limited, or been excluded or refused membership in a managed care organization (HMO, PPO, PHO, etc.) for a stated reason? Yes☐ No☐

14. Are you employed by the state, any of its counties or local government office? Yes☐ No☐
    If "Yes", indicate percent of time involved in private practice:

15. Are you employed by the Indian Health Services or similar organization? Yes☐ No☐
    If "Yes", indicate percent of time involved in private practice:

16. Are you employed by the United States Military Service? Yes☐ No☐

17. Do you treat prisoners or jail inmates? Yes☐ No☐
    If "Yes", indicate name of penal/correctional facility:

18. Has your practice been reduced because of any of the following: (Check all that may apply)
    Semi-retirement ☐ Disability ☐ Pregnancy or dependent care ☐
    Majority of practice conducted in a teaching role which is insured elsewhere ☐
    Majority of practice insured through another entity such as an employer ☐
    Maintenance of another practice insured elsewhere ☐

19. List all locations where you will practice and for which practice coverage is being applied for under this application.
    Name/Address:
    Hours worked per week: ________ Medical specialty:_________________
    Refer to Section 15 for additional space.

20. List all other locations where you will practice and for which practice coverage is NOT being applied for under this application.
    Name/Address:
    Hours worked per week: ________ Medical specialty:_________________
    Insurance carrier providing coverage at the above location:
    Refer to Section 15 for additional space

21. Do you participate in telemedicine? Yes☐ No☐

If "Yes" indicate in Section 15, in which states and what percentage of your practice is dedicated to telemedicine. For the purpose of this question, telemedicine is defined as the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient as a result of transmission of the patient's data by electronic means. Telemedicine does not include an informal consultation provided without the expectation of, or compensation, not does it include services described above which are rendered in a bona fide emergency.

22. Do you prescribe narcotics using pre-printed pads? Yes☐ No☐
    If you answer "Yes", please provide a sample/specimen copy of the prescription.

23. If you are a radiologist or pathologist: do you or will you read, interpret, or diagnose films, slides, or specimens taken of patients who reside outside the state of of policy issuance? Yes☐ No☐

    If "Yes", please indicate the state or foreign country where the patient resides:

SECTION 10 - PROFESSIONAL PARTNERSHIP, CORPORATION, or ASSOCIATION

1. Do you operate as a Professional : Partnership ☐ Corporation ☐ Association ☐
2. Does the professional partnership, corporation, or association with which you are currently affiliated carry separate professional liability coverage? Yes☐ No☐
3. Do you want your professional partnership/corporation/association covered under your policy, sharing the limits of liability, at no additional charge? Yes☐ No☐
4. Do you want separate limits of liability for your partnership/corporation/association, for an additional premium?. Yes☐ No☐
5. Do you own or have ownership interest in a health care facility? Yes☐ No☐
   If "Yes", provide details on Section 15.

If you are requesting coverage for your professional partnership, corporation or association, please include the organization's information. Refer to Section 15 for a list of the information required.

SECTION 11 - EMPLOYEES

1. Do you, or your partnership/corporation/association employ any of the following?

Physicians	☐	Surgeons	☐	Physician Assistants	☐
CRNA's	☐	Nurse Practitioners	☐	Certified Nurse Midwives	☐
RN's	☐	LPN's	☐	Podiatrist	☐

Technicians:

Athletic Trainer	☐	EEG/EKG	☐	Laboratory	☐
Operating Room	☐	Physicial therapist	☐	Perfusionist	☐
Phlebotomist	☐	Radiation	☐	Radiology	☐
Respiratory	☐	X-ray	☐		

2. Complete a separate PLICO application (Physicians or Ancillary Medical Personnel) for each of the above professionals for whom individual limits of liability are desired.
3. Approximately what percent of the time do you use: Anesthesiologists: __________ CRNA's: _________
4. Do you regularly supervise more than one CRNA at the same time? Yes☐ No☐
   If "Yes", how many:
5. Do you regularly supervise physicians assistants or nurse practitioners? Yes☐ No☐
   If "Yes", how many:

SECTION 12 – CLAIMS HISTORY/ REPORT

1. Have you been involved in a professional liability claim/suit in the past ten (10) years? Yes☐ No☐

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes☐ No☐
   If "No", please explain on Section 15.

___

3. Complete the following questionnaire for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report from your current insurer with a recent valuation date if you have had any claims/suits.

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to your involvement: $____________________ *Paid by All Parties $ ________________

What is/was your status in the case?

☐Primary Defendant ☐Co-defendant ☐Other (explain)___________________

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? __________________

What is/was the alleged harm to the patient? ____

____

____

____

What were the allegations made against you? ____

____

____

____

Describe the patient's illness and related effects of the alleged harm ______________________________

____

____

Describe any other details you believe are pertinent to the case ______________________________

____

____

____

Name of other parties named in the suit: ____

____

____

SECTION 13 - WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I UNDERSTAND that the statements and answers herein will be relied upon by PLICO and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to PLICO, or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to my previous or current carrier(s), and that I have no knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and no knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last 10 years that have not been reported to the applicable insurance company or risk transfer entity (self-insured retention plan).

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

Signature____ Date_____________________

APPLICABLE IN ARKANSAS

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

APPLICABLE IN OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SECTION 14 - COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following documents with this application.

Attach	Documentation
	Individual Applicants: attach a copy of your current policy, including the Declarations Page and all endorsements. Group Applicants: attach a copy of your Certificate of Insurance.
	Current Federal DEA Registration Certificate
	Curriculum Vitae (C.V.)
	Ten (10) years claims history/report, recently prepared, from all previous insurance companies other than PLICO (even if you have not had any claims).
	For partnership, corporate, or association coverage include: ☐ Copy of the Articles of Incorporation ☐ List of Principals or Shareholders ☐ List of all ancillary medical personnel, indicate duties and medical license ☐ Brief description of operations, if other than those consistent with your medical practice or specialty ☐ Copy of the latest Employers Security Commission report ☐ W-9 form (IRS) ☐ 1099 (IRS)

SECTION 15 – ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please, make as many copies of this page as it may be required to fully answer all questions. As appropriate, note Section number and question number being addressed:

Section/
Question #

AFFIDAVIT

NO KNOWN INCIDENTS, CLAIMS, OR SUITS

I, ________________________, declare that to the best of my knowledge and belief, I have:

1. No knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and

2. No knowledge of any pending medical negligence claims or suits that may be or have been made or filed against me in the last ten (10) years.

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

______________________	______________________
Applicant's Signature	Date
______________________	______________________
Witness' Signature	Date

P.O. Box 1838 Oklahoma City, OK 73101-1838 • Accounting (405) 815-4824 • Claims (405) 815-4802 • Marketing (405) 815-4880
Risk Mgt. (405) 815-4803 • Underwriting (405) 815-4801 • Toll Free (866) 867-4566 • Fax (405) 815-4900