Name of Insured: ____________________

Address: ____________________

City: ____________ State: ____________ ZIP: ____________

Policy Number: ____________________

AFFIDAVIT OF RETIREMENT FORM, AND/OR CESSATION OF, THE PRACTICE OF MEDICINE

The undersigned, ____________________ hereby certifies as follows:

1. I am currently insured by ProAssurance under a Health Care Professional Insurance Policy as identified by the Policy Number above.

2. I have been insured continuously under the Policy since ____________.

3. I am currently ___ years of age.

4. I permanently and totally retired from the practice of medicine, or I intend to permanently and totally retire from the practice of medicine, on ____________________, 20___. My present intention is not to engage in the practice of medicine for monetary or financial compensation in any form at any location either full-time or part-time at any time in the future.

5. I have submitted this Affidavit in order to induce ProAssurance to issue a Reporting Endorsement to me under the Policy either without payment of any additional premium or at a premium discount. I request that ProAssurance waive or discount the normal premium charge for a Reporting Endorsement in reliance upon my representations contained in this Affidavit.

6. I agree that if either (a) any representation contained in this Affidavit should be inaccurate or (b) I should recommence the practice of medicine for monetary or financial compensation at any time within five (5) years after the date of this Affidavit, I will pay to ProAssurance such premium (or additional premium) as would have been payable if this Affidavit had not been delivered to ProAssurance.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the above numbered policy, other than as above stated.

Dated this ___ day of ____________, 20___.

____

Signature

____

Please Print Name

Sworn to and subscribed to before me this ___ day of ____________, 20___.

____

Notary Signature

My commission expires ______________.

____

Please Print Name