Claims History Release Authorization

This letter will serve as written authorization to release claim information regarding any professional liability coverage while insured with Curi/Medical Mutual Insurance Company of North Carolina ("the Company"). My signature below authorizes the release of my claim history to the organization indicated, its designated agents, employees, or representatives. I agree to indemnify and hold the Company harmless for any liability, expense, or claims arising out of the release of this information.

_____ _____

Signature of Named Insured/Individual **Date**

Insured First Name:_____

Insured Middle Name: _____

Insured Last Name: _____

Insured Previous Last Name (if applicable):_____

Date of Birth:_____ Social Security Number: XXX-XX-_____

Did the insured work as a locum tenen? _____

Insured's Policy #: _____ Insured's Client #: _____

Name/Company of Requester:

_____

Phone Number of Requester: 1-(____) _____ Ext._____

Release Information to:

_____

Email to: _____

This completed and signed form may be emailed to CVO@curi.com.