South Carolina Medical Malpractice Association
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SC MMA
INSURED ADDRESS CHANGE REQUEST FORM

Instructions:

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
2. If you need more space for responses, continue on a separate sheet with the question noted.
3. The change request form must be signed and dated by the insured
4. Please submit the completed form to the SCMMA via fax or regular mail.

A. CURRENT POLICY INFORMATION:

1. The precise name of the insured individual or practice entity requesting a change:

   Name: _____

2. Policy Information: Policy#: _____ 2a. Expiration Date: _____ / _____ / _____

B. CURRENT ADDRESS AND CONTACT INFORMATION:

3. Current Billing Address: (Your invoice is mailed to this address.)

   P.O. Box: _____

   Street Address: _____

   City: _____ State: _____ Zip: _____

4. Current Practice Address: (If different from billing address)

   Street Address: _____

   City: _____ State: _____ Zip: _____

5. Current Practice Telephone: _____ 5a. Current Practice Fax: _____

6. Current Insured Email Address: _____

C. NEW ADDRESS AND CONTACT INFORMATION:

7. Please Check all that apply: NEW: ☐ Billing Address ☐ Practice Address ☐ Phone/Fax Number ☐ Email Address

8. New Billing Address: (Your invoice is mailed to this address.)

   P.O. Box: _____

   Street Address: _____

   City: _____ State: _____ Zip: _____

9. New Practice Address: (If different from Billing Address)

   Street Address: _____

   City: _____ State: _____ Zip: _____

10. New Practice Telephone: _____ 10a. New Practice Fax: _____

11. New Insured Email Address: _____

D. REASON FOR CHANGE:

12. Please check all that apply: ☐ Location Change ☐ Billing Address Change ☐ Employment Change
13. Effective Date of Change: _____ / _____ / _____
14. Please provide details of new employment, if applicable, including any changes in scope of practice:

_____

_____

_____

E. AUTHORIZATION:

Signing this address change request form does not commit the JUA to bind insurance. I hereby warrant that the information contained in this change request form is accurate and complete to the best of my knowledge.

_____ _____ / _____ / _____

Signature of Insured (Authorized Representative) Date

_____

Title