

South Carolina Medical Malpractice Association
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www.scmma.net

SC MMA
AUTHORIZATION TO RELEASE POLICY INFORMATION FORM

Instructions:

1. Please complete, sign and date this authorization, and return via email/fax to Teresa Anderson at the SCMMA:
Prefer Email: Teresa.Anderson@marsh.com Alternate Fax: 864-240-2750

A. INSURED INFORMATION:

1. Insured name: _____
2. SCMMA/JUA policy #: _____ 2a. Effective dates: ____ / ____ / ____ - ____ / ____ / ____
SCPCF policy #: _____ 2a. Effective dates: ____ / ____ / ____ - ____ / ____ / ____
3. Practice/Entity name: _____
4. Please accept this as my request and authorization to release the following:
- 4a. Claims History & Coverage Verification / Loss Runs (Please allow 2 weeks for this request to be processed.)
- 4b. Copy of my Declarations Page
5. Please forward this information to:
- 5a. Company name: _____
- 5b. Attention: _____
- 5c. E-mail address: _____
- 5d. Fax #: _____

B. AUTHORIZATION:

Signature of Insured

_____/_____/_____
Date

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