Stanford Medicine Health Care & Stanford Medicine Children's Health
Certificate of Insurance and Claims History Request Form

Today's Date:	

Requestor – Person Completing the Form

Name:		**Department:**	
Email:		**Phone:**	

Request Type – Select all that apply

☐	**Claims History Letter**	A claim history is issued by an insurer and describes an insured's claims history, typically up to 10 years. **(Complete sections A and B)**
☐	**Certificate of Insurance**	A certificate of insurance is proof of insurance coverage and summarizes key coverage elements such as name of insurer, coverage dates, and policy limits. **(Malpractice Only: complete sections A, C and D) (All Other Coverages: Complete section C and D)**

Section A – Provider Details

Provider Name:		**Dates of Service/Employment**	
Employment Type:	Select Employment Type	Faculty SoM or Staff SHC/LPCH:	
Specialty:	Select Specialty	Dates of Fellowship(s):	
		Dates of Residency:	

Section B – Where to Send Claims History

Requesting Facility		**Email**	

A signed authorization is required to release claim data.
I authorize The Risk Authority to release my SUMIT Insurance Company malpractice claims history as outlined below.

☐	Release letter directly to requesting facility.	
☐	Release letter to:	
Provider's Signature:		**Date:**

Section C – Certificate of Insurance Request

Select the entity and purpose for insurance request: Select Entity		**Select All Coverages Required**	
◉	Working at 3rd party facility per contract	☐	General Liability
○	Residency / Fellowship Rotation	☐	Medical Malpractice / Professional Liability
○	Volunteer Activity	☐	Automobile
○	Lease – Property or Contract	☐	Workers' Compensation
○	Event - Blood Drive/Space Rental etc.	☐	Property
○	Other – Describe:	☐	Cyber

Activity will be performed on a repeat basis	◉ Yes ○ No	**Dates of Activity**	**Start:**	**End:**	
Is there a contract?	◉ Yes ○ No	**Does this activity generate income?**		◉ Yes ○ No	

Certificate Holder (requestor of insurance coverage and listed on the certificate of insurance)

Certificate Holder:		**Contact:**	
Mailing Address: (city/state/zip)			

Section D – Approvals for Certificates of Insurance

Malpractice requests without a contract require both Department Chair and Hospital Leadership to extend coverage.
Activities must be at the direction of Stanford Medicine, within your scope of practice and approved.

Department Chair:	**Title:**	**Signature:**	**Date:**
Hospital Leadership:	**Title:**	**Signature:**	**Date:**

Other Certificate Requests -*(Events, Leases, Blood Drives)*

Authorized Department or Hospital Leadership:	**Title:**	**Signature:**	**Date:**

Submit to: riskmanagement@stanfordhealthcare.org *Processing may take up to 10 business days.*