PROASSURANCE
Treated Fairly

LawyerCare

Loss Run Confidentiality Agreement, Authorization and Release Form

Insured or Policyholder: _____ **Policy #(s):** _____

Firm Name: _____

Social Security or Tax Identification #: _____

Insured's Current Information:
(Street, City, State, ZIP, Phone, Fax #, E-mail)

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ProAssurance Corporation and its affiliates, ProAssurance Indemnity Company, Inc. and ProAssurance Casualty Company are hereinafter referred to collectively as "The Company".

The Company is or was the carrier of my professional liability insurance, and as such The Company maintains certain information regarding my practice, including the history of any claims against me. I understand that this information is extremely sensitive and confidential and may be protected by attorney-client privilege.

I hereby request the release of certain information concerning my claims history. I authorize The Company to release information relating to claims and suits against me which is on record with The Company. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant.

My representatives and I agree to maintain this information as confidential. I represent and warrant that the information will be disclosed to third parties only in the course of procuring insurance coverage. Prior to any such disclosure, I will cause any such entities to agree not to disclose the information to any other party. If requested or required to disclose the information in a legal proceeding, my representatives and I will immediately notify The Company in writing so that The Company may determine the appropriateness of contesting such disclosure.

I understand that neither The Company nor its representatives makes any representation or warranty as to the accuracy or completeness of the information and agree that they shall have no liability with respect to the information or its use.

I agree that money damages alone will not be sufficient remedy for any breach of the confidentiality of this information other than as stated herein either by me or my representatives, and, in addition to all other remedies, The Company shall be entitled to specific performance and injunctive or other equitable relief, including reasonable attorney fees incurred by The Company in enforcing its rights under this agreement.

_____ Date: _____

SIGNATURE of Insured or Policyholder Representative (must be signed and dated within 365 days of request)

_____

PRINTED NAME of Insured or Policyholder Representative and Title

ProAssurance
ATTN: Jean Eggleston
Direct Dial: (517) 347-6257
Fax #: (517) 349-8978
jeggleston@proassurance.com

Form updated 09/15/09