



CPG DELETE HEALTH CARE PROVIDER FORM

Name of Clinic/Organization (please print)

Policy Number

Directions: Please complete this form to request the deletion of a health care provider from the clinic's/organization's NORCAL policy. Please ensure that you sign and date the form.

1. Please complete the following for those health care providers who are to be deleted:

Name of Health Care Provider (Last, First, Middle, Designation)	Deletion Effective Date (mm/dd/yy) 12:01 a.m. Local Time

2. Will the deletion of the health care provider(s) change the clinic's/organization's annual number of procedures or surgeries performed or services provided? Yes No

If yes, please complete and submit a CPG Procedures and Services Supplemental Form.

3. Please provide any additional information material to the risk that has not otherwise been addressed in this form:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Arizona or New Mexico clinics/organizations. By statute, Arizona or New Mexico clinics/organizations are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my clinic's/organization's or the applicable health care provider's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the practice changes in any way and of any change in the information contained in this form.

Signature of Clinic's/Organization's Authorized Representative

Date

Print Name