



### Insurance Authorization & Verification Form

Applicant Name: \_\_\_\_\_

SI Registration#: \_\_\_\_\_

#### SecureInsight™™

#### PART I AUTHORIZATION (To be completed by Applicant)

I, \_\_\_\_\_ of \_\_\_\_\_

hereby authorize my insurance representative(s), to verify the existence of my insurance coverage with Secure Insight™. If for any reason you wish to contact me, please feel free to do so via the following contact information:

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: This authorization form is valid until rescinded by the Applicant named above.

#### PART II A VERIFICATION - PROFESSIONAL LIABILITY INSURANCE (To be completed by Insurance Representative ONLY)

N/A E&O Agency/Brokerage: \_\_\_\_\_ Insurance Representative: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Agency/Brokerage Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_

E&O Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Coverage Limit \$: \_\_\_\_\_

Policy is:  Paid in Full  Financed If financed, is the policy current?  Yes  No Next Payment due: \_\_\_\_\_

If financed, payments are due:  Monthly  Quarterly  Semi-Annually Deductible/Retention: \_\_\_\_\_

Does the above listed policy have any specific claim exclusion endorsements against an Individual or Entity:  Yes  No

If yes, please provide a brief explanation: \_\_\_\_\_

Insurance Representative verifies the above information is correct:

Name \_\_\_\_\_ Title: \_\_\_\_\_

(Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### PART II B VERIFICATION - FIDELITY INSURANCE (To be completed by Insurance Representative)

N/A Fidelity Agency/Brokerage: \_\_\_\_\_ Insurance Representative: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Agency/Brokerage Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_

Fidelity Bond Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Coverage Limit \$: \_\_\_\_\_

Policy is:  Paid in Full  Financed If financed, is the policy current?  Yes  No Next Payment due: \_\_\_\_\_

If financed, payments are due: Monthly:  Quarterly:  Semi-Annually:  Deductible/Retention: \_\_\_\_\_

Insurance Representative verifies the above information is correct:

Name \_\_\_\_\_ Title: \_\_\_\_\_

(Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For SI Office Use Only: \_\_\_\_\_

Please return ASAP to SI via fax to 888-908-6194 or email to sender  
Secure Insight™ 100 Lanidex Plaza, Suite 1201, Parsippany, NJ 07054

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