Risk Transfer Insurance Alliance

Change Request

Please use this form to request minor changes to your medical malpractice insurance policy.
We will contact you if additional information is required.

*Policyholder Name (as listed on the declarations page of the policy):

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*Policy Number:

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*Request being made by (if other than policyholder)

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*Best way to contact:

____

☐ Please issue a certificate of insurance
(if you would like the certificate of insurance faxed to you, please provide a fax number in the Other section below)

☐ Please change the address on my policy
(change of address information should be typed into the Other section below)

Other:
Please use this section to address anything not referenced above.

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*Required Fields

Please return to: **Risk Transfer Insurance Alliance, LLC**
175 Federal Street, Suite 725
Boston, MA 02110-2202

Fax: 617-423-7541