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| **RISK MANAGEMENT SERVICE PLAN REQUEST** |
| **Insured** |
| *Name:**Address:**Contact:**Contact Phone:* *Contact Email:**Tax ID:* | First Named Insured NameFirst Named Insured Street Address 1First Named Insured Street Address 2First Named Insured City, State, ZipInsured ContactInsured Contact Phone Insured Contact eMailTax ID (We need the tax ID to reimburse you for approved expenses) |
| **Policy Period Effective From:**       **to:**      ;Both days at 12:01 am local standard time at the mailing address of the Named Insured |

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| **Amount of Risk Grant Available:**      | **Policy Number:**       |
| **Cost of this Service Plan:**       |
| **Vendor:** |
| *Name:**Address:**Contact:**Contact Phone:* *Contact Email:**Tax ID* | Vendor NameVendor Street Address 1Vendor Street Address 2Venor City, State, ZipVendor ContactVendor Contact PhoneVendor Contact EmailTax ID (We need the tax ID to pay vendors directly for approved charges) |
| **Description of Service Plan:**      |
| *Alternatively, you can provide a copy of the service plan provided by the vendor including cost of services.* |
|  | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_****Approved By Date** | **$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Approved Amount** |

**Application Instructions.**

Please complete the attached application and forward to greg.hamlin@bhspecialty.com.
We will review and respond within 3 working days.

Examples of approved services:

* Risk Management Education: in-house programs, speakers, CE Credits
* Service Area Assessments: OB, ER, Surgical, Physician Office Practice
* Team Building & Communication within your RM, Patient Safety and Claim team
* Project Management with a risk management focus or objective
* Expert Consultation
* On-Line Subscriptions for Risk Management, Benchmarking Services

Examples of requests that would be denied:

* Entertainment, alcohol, non-coach travel, non-approved conferences, any off-shore activity
* Requests for office supplies or equipment