

**Risk Management Service Plan Request**

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| **INSURED / REINSURED****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 PhoneInsured 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 |
| **Amount of Risk Grant Available:**  | **Policy Number:**  |
| **Cost of this Service Plan:**  |
| **Payment Instructions:** **[ ]  Pay Vendor Directly** **[ ]  Reimburse Insured / Reinsured** |
| **VENDOR****Name:****Address:****Contact:****Contact Phone:****Contact Email:****Tax ID:** | Vendor NameVendor Street Address 1Vendor Street Address 2Vendor 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 **greg.struhar@bhspecialty.com****.**

• In order for us to process payment, we will need a copy of the W-9 for the party to whom we are making a payment.

• Grant Requests must be made during the policy period for services that are rendered during the policy period.

**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, Food, beverages, non-coach travel, non-approved conferences, any off-shore activity

• Requests for office supplies or equipment

**PAYMENT PROCESSING**

**If we are reimbursing you for services:**

• We will require the Name, Address, Contact Information, and a copy of the W-9 for the insured / reinsured.

• If we are providing insurance; payments will be made to the First Named Insured as listed on the declarations
of the Insurance Policy. We can make payments to any other Named Insureds on the policy if we are directed
to do so in writing by the First Named Insured.

• If we are providing reinsurance; payments will be made to the Captive Insurance Company as listed on the
declarations of the Reinsurance Certificate. We can also make payment to Named Insureds listed in the captive policy if we are directed to do so in writing by the Captive Insurance Company.

• Prior to making any payment, we will require a copy of the invoice from the vendor for the services rendered.
This invoice must be clearly tied to;

* The services we approved, and
* The entity listed on this request form.

**If we are paying the vendor directly, we will require:**

• The Name, Address, Contact Information, and a copy of the W-9 for the vendor.

• A copy of the invoice from the vendor for the services rendered. This invoice must be clearly tied to;

* The services we approved, and
* The entity listed on this Service Request form.

*Payments may not exceed the approved amount. The Insured/Reinsured listed on this Service Request form
will be responsible for any amounts above what was approved.*