

Request for Retroactive Coverage—Financial

Ref: Sections Ins 17.25 (10) (cm) and 17.28 (3s) (c), Wis. Adm. Code



State of Wisconsin
Office of the Commissioner of Insurance
Injured Patients and Families Compensation Fund
PO Box 7873
Madison, Wisconsin 53707-7873

This form will be valid for 120 days from date of signature.

Provider Name (please print or type)	License No. or Account No. (if applicable)
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I am requesting retroactive coverage for the period _____ through _____ from the Injured Patients and Families Compensation Fund.

Date lack of payment was discovered:

Name and position of person responsible for failure to pay for coverage:

Explain the circumstances involved in the failure to pay Fund fees on a timely basis (attach additional pages as necessary; attach any supporting documents):

I have no notice of any pending claim alleging malpractice or knowledge of a threatened claim or of any occurrence that might give rise to such a claim for the period of time for which retroactive coverage is being requested.

Provider Signature	Date	Phone
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Subscribed and sworn before me

This ____ day of _____, _____

Notary Public

County, State

My commission _____