FPIC Arbitration Program Order Form

Name ____

Address ____

City ____________________ State __________ Zip Code __________

Phone ____________________ Fax ____________________

Email ____________________ FPIC Policy Number

Name(s) of Corporate Entity Insured by FPIC ____________________

Name(s) Physicians Insured by FPIC ____________________

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Signed ____________________ Date ____________________

Return the completed order form and signed participation agreement to:
FPIC • 1000 Riverside Avenue, Suite 800 • Jacksonville, FL 32204
Fax: 904-358-6728