

Date: [Insert Date]

[Physician Name]

[Facility Name]

[Address Line 1]

[City, State, Zip Code]

Re: Delivery of Medical Malpractice Specialty Coverage Policy

Policy Number: [Insert Policy Number]

Effective Date: [Insert Date]

Dear Dr. [Insert Last Name],

Enclosed please find your Medical Malpractice Specialty Coverage insurance policy. We recommend that you review this document thoroughly to understand your coverage limits, requirements, and conditions.

Please be advised that this policy contains a specific **Off-Label Procedure Exclusion**. This means that any professional services involving the use of drugs, devices, or procedures not approved by the FDA for the specific condition or application being treated are excluded from coverage, unless specifically endorsed in writing by the carrier.

To finalize your coverage, please sign the acknowledgment below and return a copy to our office.

Sincerely,

[Agent Name]

[Agency/Company Name]

ACKNOWLEDGMENT OF OFF-LABEL PROCEDURE EXCLUSION

I, Dr. [Insert Physician Name], hereby acknowledge receipt of Policy #[Insert Policy Number].

I explicitly acknowledge that I have read and understand the Off-Label Procedure Exclusion contained within this policy. I understand that medical malpractice claims arising from or related to off-label uses of drugs, medical devices, or procedures are not covered under this policy unless prior written approval has been granted by the insurer.

Signature: _____ Date: _____