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Premium Indication Information **For Medical Professional Liability Insurance Program**

Complete one form for each physician

Name (First, Last, Professional Degree) / Practice Name

Requested Effective Date of Policy: _____

Requested Retroactive Date of Policy: _____

Requested Limits: _____

Current Policy Information (Please attach copy of current declarations page)

Current Carrier: _____

Current policy expiration date: _____

Physician Information

Specialty: _____

Board Certified (circle one) YES NO PENDING

PLEASE CIRCLE ONE

No Surgery Minor Surgery Major Surgery

Do you have hospital privileges? YES NO

Medical Director Responsibilities YES NO

If yes, where? (hospital, nursing home) _____

Do you treat patients in a nursing home? YES NO

If yes, what percentage of your practice? _____

Do you treat patients in jail / prison? YES NO

If yes, what percentage of your practice? _____

Claim Information

Have you been involved in a malpractice claim or suit? YES NO

If yes, please answer the following:

How many claims / incidents? _____

When were the alleged incidents? _____

What were the allegations? _____

Was the case(s): Settled? _____ Tried? _____ Dismissed? _____

If settled, what was the payment? _____

Practice Information

Practice Name:

Mailing Address:

City / State: _____ County: _____ Zip: _____

physicians in Group: _____ # ancillary personnel (NP, PA, CNM, RN)? _____

Would you like separate limits for corporation? _____ for ancillary personnel? _____

Avg. # patients seen per week: _____ Hours worked per week: _____

Contact Name: _____ Office phone: _____