Quick Quote Form – Group Information

Practice Name: _____

Requested Practice Retroactive Date: _____

Shared or Separate limit entity coverage: ☐ Shared ☐ Separate

Mid-level(s) (APRNs, PAs): Name, Retroactive date, sharing limits or separate limits coverage

_____

_____

_____

_____

_____

_____

_____

***Please complete information on the attached page for each provider in the group.**

Quick Quote Form – Provider Information

Physician Name: _____

Practice Name: _____

Primary Practice Address: _____

Requested Effective Date (MM/DD/YYYY): _____

Requested Retroactive Date (MM/DD/YYYY): _____

Degree: _____

Specialty: _____

Requested Policy Limits

- ☐ $250,000 per incident/$750,000 annual aggregate
- ☐ $500,000 per incident /$1,500,000 annual aggregate
- ☐ $1,000,000 per incident /$3,000,000 annual aggregate

Please Provide Loss Runs (5-10 Years) ☐

*Minimum of 5 years, 10 years will provide best Loss Free Discount.

Any claims from start of practice through today: ☐ Yes ☐ No

Average hours per week: _____

Latest Residency Fellowship Ending Date (MM/DD/YYYY): _____

Initial Start Date in Practice (MM/DD/YYYY): _____