Request for Professional Liability Insurance Premium Indication

Physician Name: ____

Medical Specialty: ____

Number of Years in Practice: ____________

Please check all that apply:

☐ No Surgery ☐ Minor Surgery ☐ Major Surgery

☐ Full Time ☐ Part Time # of hours per week: ________

Desired coverage: ☐ Claims Made ☐ Occurrence

Limits of liability: ☐ $1M/$3M ☐ $2M/$4M

Number of claim free years beginning with current: ____________

Number of open claims: ____________

Number of closed claims with indemnity payment in last 10 years: ________

Please contact me by:

☐ Phone: ____

☐ Email: ____

☐ Fax: ____