



PROFESSIONAL LIABILITY INSURANCE PROGRAM

QUICK QUOTE FORM

FAX BACK TO: (770) 399-6647 ATTENTION: JENNIE HARP

To obtain a premium indication please complete for each physician in your practice.

- 1) Physician Name
2) Practice Name
3) # of MDs
4) Contact Name
5) Phone #
6) Mailing Address
7) Fax #
8) Current Insurance Carrier
9) Exp. Date
10) Physician Limits
11) Organization Limits
12) Does your current policy provide a separate limit of liability for your organization?
13. What is most important to you in choosing an insurance company?

14) Please tell us more about you...

Table with 4 columns: Medical Specialty, Retro Date, Medical License Number, Number of Years Practicing Without a Paid Claim

- 15) Was a residency completed?
16) Are you a Foreign Graduate?
17) Are you Board Certified in the specialty in which you practice?
18) Do you currently have hospital privileges?
19) Has any insurer ever canceled, declined to issue, or refused to renew your professional liability insurance...
20) Has any lawsuit ever been filed against you...
21) Have any judgments been made against you...
22) Have you ever been or are you currently under a State Board of Medical Examiner's Order?
23) Have you been treated for alcoholism or drug addiction within the last five years?
24) For any questions answered "Yes", please provide details on your letterhead.
25) Claims information
26) Please include copy of current policy "Declarations" page...
27) E-mail Address:

CLAIMS INFORMATION

Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?

No Yes – Complete the following. If you need more space, please outline additional claims information on your letterhead.

Patient's Name		Date of Occurrence
Patient's Name		Date of Occurrence
Allegations		

Additional Defendants		
Claim is closed or settled	Amount paid or reserved	If claim is closed, date closed or settled
Claim is still open and pending	\$	

Signature

Date

Patient's Name		Date of Occurrence
Patient's Name		Date of Occurrence
Allegations		

Additional Defendants		
Claim is closed or settled	Amount paid or reserved	If claim is closed, date closed or settled
Claim is still open and pending	\$	

Signature

Date

**For additional information call Potter-Holden & Company at:
(770) 399-6760 or Toll Free: (888) 528-0589**