

PROFESSIONAL LIABILITY QUOTE REQUEST

NAMED INSURED: _____

CONTACT PERSON: _____

MAILING ADDRESS: _____

PHONE #: _____

FAX #: _____

D.O.B.: _____

COUNTY: _____

SPECIALTY: _____

SURGERY: _____

** BOARD CERTIFIED: Yes / No

RESIDENCY: Yes / No

EFFECTIVE DATE: _____

RETRO DATE / PRIOR ACTS: _____

LIABILITY LIMITS: _____

DEDUCTIBLE: _____

ENTITY COVERAGE: _____

SHARED/SEPARATE LIMITS: _____

TYPE OF EXPOSURE: _____
(ER /Prison Facility/Medical Office/etc.)

CLAIMS HISTORY

TOTAL CLAIMS: _____ # of CLOSED CLAIMS: _____ #of OPEN CLAIMS: _____

TOTAL AMOUNT PAID OUT ON CLOSED CLAIMS: _____

TOTAL AMOUNT RESERVED BY CARRIER ON OPEN CLAIMS: _____

LICENSE RESTRICTIONS (Current & Prior): _____

CURRENT CARRIER: _____ EXP. _____

RETRO DATE: _____

PURCHASE TAIL COVERAGE: _____

CURRENT LIMITS: _____

PREMIUM: _____

AFFILIATED ASSOCIATIONS: _____

COMMENTS: _____

Please fax the completed questionnaire to 817.820.8928 for a proposal.