

**RATE INDICATION FORM— CONFIDENTIAL**

Please note: The response to this form will result in a preliminary rate indication which is not an offer of coverage. A completed application with required documents must be received prior to an underwriting review which will determine coverage eligibility.

**NOTE: If a copy of the current declaration page is included, only sections A and C below need to be completed.**

**SECTION (A) – CUSTOMER/CONTACT INFORMATION:**

Physician name: \_\_\_\_\_

Contact name: \_\_\_\_\_

Practice name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**SECTION (B) – COVERAGE INFORMATION:**

Renewal/effective date: \_\_\_\_\_ Current premium: \$ \_\_\_\_\_

Primary specialty: \_\_\_\_\_ Sub specialty: \_\_\_\_\_

No surgery  Minor surgery  Major surgery

**Coverage Requested:**  Claims-made  Modified claims-made Retroactive date: \_\_\_\_\_

**Requested Limits of Liability:**  \$100,000/\$300,000  \$200,000/\$600,000  \$300,000/\$900,000

\$500,000/\$1,500,000  \$1,000,000/\$3,000,000\*  Other \_\_\_\_\_

\*Patient Compensation Fund primary limits will apply in **Wisconsin** at \$1,000,000/\$3,000,000.

**SECTION (C) – OTHER:**

**Number of hours worked per week** in office & hospital:  20 hours or less  21–30 hours  31 hours or more

Hospital privileges: \_\_\_\_\_

If new to practice, date residency completed: \_\_\_\_\_ Start date of practice: \_\_\_\_\_

**Claims in the last 10 years?**  Yes  No - If **YES**, please list the year(s) and reserve or paid amount(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please fax form to (517) 327-2719.**

To discuss your rate indication form, please contact one of our insurance specialists today at **(800) 777-6428**.

Or you may e-mail your questions to [info@fincorsolutions.com](mailto:info@fincorsolutions.com).