



QUICK QUOTE — CONFIDENTIAL

Please note: This rate indication will not be an acknowledgment of acceptance of coverage or a binding quote until completed applications and full loss information are received and approved.

Physician name: _____

Contact name: _____

Practice name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Year residency completed: _____

Phone number: _____ Fax number: _____

E-mail: _____

Specialty: _____

No surgery

Minor surgery

Major surgery

Coverage Requested

Claims-made (retroactive date: _____)

Modified claims-made

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 _____

*Renewal/effective date: _____

Number of hours worked per week in office and hospital

20 hours or less

21-30 hours

31 hours or more

Claims in the last 10 years? Yes No If yes, please list the year(s) and amount(s):

*If you have recently renewed but would like us to contact you 90 days prior to your next renewal, check this box and fill in your renewal date.

Please fax form to (517) 327-2719.

To discuss your quick quote, please contact one of our insurance specialists today at (800) 777-6428.