

## Professional Liability Quoting Information Sheet

This sheet is designed only to obtain basic information for quoting purposes.  
A completed company application must be submitted to determine the final premium.

### General Information

Name of group or physician name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Business address: \_\_\_\_\_ Number of physicians: \_\_\_\_\_  
 County: \_\_\_\_\_ Business phone: \_\_\_\_\_ Business fax: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_ Cell phone (optional): \_\_\_\_\_  
 Addresses of any additional practice locations: \_\_\_\_\_  
 How did you hear about MSVIA? \_\_\_\_\_

### Physician Information (For additional physicians, please use the attached sheet)

Physician's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Practicing specialty: \_\_\_\_\_ Board certified in which specialty \_\_\_\_\_  
 No surgery \_\_\_\_\_ Minor surgery \_\_\_\_\_ Major surgery \_\_\_\_\_ Number of practice hours per week: \_\_\_\_\_  
 List any invasive procedures performed or briefly explain the types of surgery you do: \_\_\_\_\_  
 \_\_\_\_\_  
 Date completed residency: \_\_\_\_\_ Medical license #: \_\_\_\_\_  
 Date joined this practice: \_\_\_\_\_ OB Physicians – Participating member of Birth Injury Fund?      Yes      No  
 Other states where you have practiced medicine (including Washington D.C.): \_\_\_\_\_  
 Have you been involved in a malpractice claim or suit?      Yes      No (If yes, please complete attached claim supplement)  
 Has your license to practice medicine or your license to prescribe narcotics ever been voluntarily limited, suspended, revoked or restricted?      Yes      No (If yes, attach an explanation – include date, state, reason for action, etc.)  
 Requested effective date: \_\_\_\_\_ Physician retroactive date: \_\_\_\_\_  
 Is prior acts coverage being requested?      Yes      No  
 Current insurance carrier: \_\_\_\_\_ Current agent/agency: \_\_\_\_\_  
 Current physician premium: \_\_\_\_\_ Limits: \_\_\_\_\_  
 Total premium for group: \_\_\_\_\_

Do you have any employees required by state law/regulation to maintain a professional license, certification or registration?

Name of ancillary employee:	Type:	Number of practice hours per week:	Separate coverage requested?

### If corporate coverage is needed:

Federal ID number (FEIN): \_\_\_\_\_ Corporate retro date: \_\_\_\_\_

### Please attach the following:

- A copy of your current insurance declaration page
- For claims – please complete the attached *Prior Claims Supplement* form
- A copy of your current CV – if available

## Additional Physicians

(Please complete information for each additional physician in the group)

### Physician Information

Physician's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Practicing specialty: \_\_\_\_\_ Board certified in which specialty \_\_\_\_\_

No surgery \_\_\_\_\_ Minor surgery \_\_\_\_\_ Major surgery \_\_\_\_\_ Number of practice hours per week: \_\_\_\_\_

List any invasive procedures performed or briefly explain the types of surgery you do: \_\_\_\_\_

Date completed residency: \_\_\_\_\_ Medical license #: \_\_\_\_\_

Date joined this practice: \_\_\_\_\_ OB Physicians – Participating member of Birth Injury Fund? Yes No

Other states where you have practiced medicine (including Washington D.C.): \_\_\_\_\_

Have you been involved in a malpractice claim or suit? Yes No (If yes, please complete attached claim supplement)

Has your license to practice medicine or your license to prescribe narcotics ever been voluntarily limited, suspended, revoked or restricted? Yes No (If yes, attach an explanation – include date, state, reason for action, etc.)

Retroactive date: \_\_\_\_\_ Current premium: \_\_\_\_\_

Is prior acts coverage being requested? \_\_\_\_\_ Yes No

### Please attach the following:

- A copy of your current insurance declaration page
- For claims – please complete the attached *Prior Claims Supplement* form
- A copy of your current CV – if available