6/5/2007

26255 American Drive Southfield, MI 48034-2438 · (800) 482-2726

Medical Professional Liability Quick Indication Questionnaire

1a). Applicant's Name: (First) _____ (Middle) ____ (Last) _____ ☐M.D. ☐D.O.

1b). Office Address: _____ _____ _____ _____ _____
(Street) (City) (State) (Zip Code) (County)

1c). Office Phone: (_____)_____-_____ Office Fax: (____)_____-_____

1d). Date of Birth: ____/____/____

1e). Contact Person: _____ Phone: (____)_____-_____

2a). Requested effective date: ____/____/____

2a). Years in Private Practice: _____

2a). Practicing Specialty: _____ Sub-specialty_____

2b). Do you perform? (Please check appropriate response)

☐No surgery (No invasive procedures) ☐Minor surgery (Invasive procedures) ☐Major surgery (Operation under general anesthesia)

2c). Are you Board Certified? _____

2d). How many hours do you work per week? _____

2e). What is your average weekly patient load?_____

3). In what county is your practice located? _____

4a). What type of coverage are you requesting?

☐ Occurrence ☐ Claims Made ☐ Pre-funded Tail

4b). What is your desired retroactive date? (Claims Made ONLY) ___/___/___

4c). What are your desired limits of liability? _____ Incident limit / _____ aggregate limit

5). Please complete and attach a Claim Supplemental Form for any medical malpractice suits within the last 10 years.

6). If there is any pertinent information (e.g. procedures performed that fall outside of your specialty, practice in multiple counties) not addressed by this application, please attach a separate page with this additional information.

7). Please provide a list of prior insurance carriers for the last ten years, if applicable. Please include dates of coverage:

_____ _____

_____ _____

The Applicant authorizes all former insurers to furnish the Company with all available information concerning the Applicant's prior underwriting and claims history. The Applicant agrees that the release of this information, even if erroneous or partial, shall not result in the liability of the insurers.

Signed; _____ Date _____

This is for an indication only. Coverage can not be bound based on an indication. Firm quotation is subject to receipt & approval of a complete, signed Star or Savers application. This information may affect availability of coverage and/or terms & conditions. Changes in exposure and/or changes in company rates may affect this indication.