Company Name
Professional Liability Premium Indicator Form

You may complete this form and send it to us using our secure server by clicking on the "Submit" button below or you may fill in the information, print the form from your browser window by clicking "Print Page" button above and mail or fax the form to:

Company Name
Company Address
City, State, Zip
Tel. (555) 555-5555
Fax (555) 555-5555
www.domain.com

* Denotes Required Field

General Information

***Business Name:**

***Contact Name:** **Position:**

***Address:**

***City:** ***State:** ***Zip Code:**

***Business Phone:** **Fax:** *Ex. 920-111-2222*

Business Status: **Other:**

Best Time to Call:

License Number:

***Contact E-Mail Address:**

***Confirm E-Mail Address:**

***Location Address:**
(type "same" if same as above)

City: **State:** **Zip Code:**

Current Professional Liability Coverage

Current Insurance Carrier:

Limits of Liability: $ **Per claim**

Limits of Liability: $ **aggregate**

Effective Date: *Ex. 01/15/2007*

Premium: $

Retroactive Date: *Ex. 01/15/2007*

Professional Information

Occupation:

Specialty:

Practice Operates:

Board Certified?:

Claims History

THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Claim #1

Claim Status:

Claimant Name:

Insurance Carrier:

Incident Location:

Date of Occurrence: *Ex. 01/15/2007*

Date of Claim: *Ex. 01/15/2007*

Please enter the type and/or description of the occurrence or claim below:

Amount Paid on Your Behalf: $

Amount Reserved on Your Behalf: $

Claim #2

Claim Status:

Claimant Name:

Insurance Carrier:

Incident Location:

Date of Occurrence: *Ex. 01/15/2007*

Date of Claim: *Ex. 01/15/2007*

Please enter the type and/or description of the occurrence or claim below:

Amount Paid on Your Behalf: $

Amount Reserved on Your Behalf: $

Additional Comments

Please provide any additional comments that you feel would be appropriate for this quotation. If you have additional information to provide, where there were not enough fields above, please enter it here:

*Acknowledgement and Consent

I hereby certify that the above information is complete and accurate to the best of my knowledge. The agency receiving this application will retain the application whether or not a policy is issued. The agency may rely on this application when determining the quotation and when deciding whether to issue a policy. False statements may subject me to criminal penalties.

If a policy is issued, I authorize the agency to give information about me to its affiliates. **Yes** **No**

Enter Your Initials Here: ***Today's Date:*** *EX: 01/12/2007*

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