



PHYSICIAN PROFESSIONAL LIABILITY  
BALLPARK QUOTE FORM



Your Name \_\_\_\_\_  
 Your Practice's Name \_\_\_\_\_  
 Type of Practice  Individual Practice  Group Practice, Number in Group \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 ➤ *Primary Practice Location:*  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Number of locations where you practice \_\_\_\_\_  
 Phone(\_\_\_\_\_) \_\_\_\_\_ Fax(\_\_\_\_\_) \_\_\_\_\_  
 Email Address \_\_\_\_\_ Practice website: www. \_\_\_\_\_  
 Hours Practiced Per Week \_\_\_\_\_ Years In Practice \_\_\_\_\_  
 Best Way to Contact  Phone  Email  Fax  
 Contact Person \_\_\_\_\_  Now  Closer to My Expiration/ Renewal Date  
 ➤ *Attach a copy of your last declarations page(s) including any retroactive dates or complete the following:*  
 Current Carrier \_\_\_\_\_ Current Premium \_\_\_\_\_  
 Current Limits \_\_\_\_\_ / \_\_\_\_\_ Current Deductible \_\_\_\_\_ Per Claim  Yes  No  
 Current Coverage  Occurrence  Claims-Made, Retroactive Date \_\_\_\_\_  
 Current Expiration Date \_\_\_\_\_

Are you associated with and/ or do you provide or perform any of the following? <i>Please check all that apply</i>			
<input type="checkbox"/>	Nursing Home	<input type="checkbox"/>	Chelation Therapy Services
<input type="checkbox"/>	Weight Loss Surgery	<input type="checkbox"/>	Hospital Emergency Room
<input type="checkbox"/>		<input type="checkbox"/>	Diagnostic or Therapeutic Radiology
<input type="checkbox"/>		<input type="checkbox"/>	Jail/ Correctional Facilities

Specialty	Details	% of Practice
Current Specialty		
Sub-Specialty		

Are you...	<input type="checkbox"/> Board Certified <input type="checkbox"/> Board Eligible <input type="checkbox"/> Neither
Do you perform surgical procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please select all that apply	<input type="checkbox"/> In office <input type="checkbox"/> Surgery Center <input type="checkbox"/> Hospital
Do you perform any procedures or provide any professional services considered to be unusual or not customary to your practice specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Do you practice outside of the state of Florida (other than incidental)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in a partnership, corporation or association with other physician(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in a space sharing arrangement with other physician(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain	
Has any claim for alleged malpractice ever been brought against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, was/ were payment(s) made on your behalf?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, any claim(s) still open?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Loss Information-** Tell us about any and all claims made against you in the past 10 years.  No known claim history

Date Reported	Details	Open/ Closed	Dollar Amount

**Professional Services Plans**  
 3101 W Martin Luther King Jr. Blvd, Ste 400, Tampa, FL 33607  
 Ph: (800) 467-8734 x 5150 Fax: (813) 222-4288