FAIRWAY PHYSICIANS INSURANCE COMPANY, A RISK RETENTION GROUP

PHYSICIAN'S *QUICK QUOTE* FORM

Please fill out this form in its entirety to receive a premium estimate for medical malpractice insurance through Fairway Physicians. DO NOT CANCEL your current coverage prior to receiving Confirmation of Coverage with FPIC. Fairway is pleased to provide $1/$3 Million Limits of Liability on a "Claims-Made" basis only.

A Risk Retention Group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a Risk Retention Group.

CONTACT INFORMATION

Physician's Name (Please Print)**:** _____
LAST FIRST MIDDLE

Practice Address*: _____
STREET ADDRESS CITY STATE ZIP

**If less than 10 years at this location, please list prior addresses on a separate sheet of paper.*

Business Phone: ( ) _____ **Business Fax:** ( ) _____

Cell Phone: ( ) _____ **E-Mail:** _____

Person to Contact: _____ **Best Time to Reach:** _____ Am / Pm

PROFESSIONAL INFORMATION

Medical Specialty Requiring Coverage: _____ **Date of Birth:** __/__/__

CA Medical License #: _____ **Do you want coverage for a part-time practice?** ❑ **YES** ❑ **NO**

Describe Your Practice: ❑ **Solo Practice** ❑ **Employed by a Medical Group:** ❑ **Office Sharing Arrangement**
Name (DBA): _____

COVERAGE INFORMATION

Requested Effective Date of Coverage: __/__/__ **Retroactive Coverage Date:** __/__/__

Name of your Current Professional Liability Carrier*: _____

**Please attach a copy of your current carrier's Declaration of Coverage indicating the retroactive coverage date and premium.*

CLAIMS INFORMATION

Have you been named in any claims (including incidents or arbitrations) in the past 10 yrs? ❑ **YES** ❑ **NO**

If **Yes**, please indicate number of claims: _____

ADDITIONAL INFORMATION

How did you hear about Fairway Physicians Insurance Company? _____

Thank you for your interest!

We will do our best to have a premium estimate out to you within 48 hours of receipt.

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