

QUICK QUOTE

All information disclosed on this form is 100% confidential and will only be used for the purpose of obtaining a quotation. Please complete all questions below, being as specific as possible. This form does not constitute a formal application for insurance. Any premium indication on this request is not binding.

Once you have completed this form, please use the E-Mail or Print & Fax buttons below to submit to MPM.

Physician/Group Name _____

Group _____

Contact Person _____

Address _____

Phone No. _____ Fax No. _____

E-Mail _____ May we contact you via e-mail in the future? Yes ___ No ___

Specialty or Sub-Specialty _____

How many years have you been in practice? _____ Are you board certified? Yes ___ No ___

Do you perform invasive surgery? Yes ___ No ___ Liability Limits _____

Are you an owner at a surgery center? Yes ___ No ___

Current Carrier _____

(Please attach a copy of your current declarations page)

Expiration Date _____ Expiring Premium \$ _____ Retroactive Date _____

Claims-Made ___ Occurrence ___ Full-time ___ Part-time ___

Corporate Coverage? Yes ___ No ___ Separate ___ Shared ___

Have you ever had a claim filed against you? Yes ___ No ___ If yes, how many? # _____

| Date of Loss | Date Claim Filed | Claim Status | Settlement Amount |
|--------------|------------------|--------------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Additional Physicians/Specialty: _____ Retro Date _____

Additional Physicians/Specialty: _____ Retro Date _____

Where do you reside? MO ___ KS ___ IL ___ TN ___ KY ___ AR ___ OK ___ NE ___ IA ___

What percent of your practice is in each state? MO ___ KS ___ IL ___ TN ___ KY ___ AR ___ OK ___ NE ___ IA ___

Do you participate in the Kansas Stabilization Fund? Yes ___ No ___