Professional Liability Association, LLC

RISK RETENTION GROUP, INC.

Agency: ______________________________________

Agent: _______________________________________

Name: ____

Primary Practice Address: ____
Street
____
City *State* *Zip*

Designation/Title: __MD __DO __DDS/DMD ___ DC _________(Other)

Date of Birth ___________________________________

County: ______________________________________

Requested EFFECTIVE Date: ___________________________

Requested RETRO Date: ______________________________

Requested LIMITS: _________________/_________________

Requested DEDUCTIBLE: _____ $0 _____$5,000 _____ $15,000

Specialty: _____________________________________%

Sub Specialty: _________________________________ %

Surgery: _____ None _____ Minor _____ Major

Number of Claims in last 10 years: _____________________

Claim Status: # of _________ Open _________ Closed

Number of Board Actions in last 10 years:_______________

States Requesting Coverage In:

State: ____________ % of Practice: __________

State: ____________ % of Practice: __________

Number of Procedures per week:__________________

Number of Hours working per week: ___________________

Number of Patients per week: ________________________

Number of Deliveries (if applicable): ______________

Number of Reads (if applicable): __________________

Do you want coverage for your Entity or Allieds: ____Y ____N

Entity/Allied Name: _________________________________

Current Carrier: _________________________________

Expiring Premium: $_____________________________

Do you perform Cosmetic Surgery: _____Y _____N ______%

________% Elective ________% Reconstructive

Aesthetics or Laser Procedures: ____Y ____N ______%

Describe: _______________________________________

Do you perform Bariatric Procedures: _____Y _____ N

Do you practice in Correction Facilities: ____Y _____N

Do you perform Telemedicine: _______Y _______N

In what States:_____ _____ _____ _____ _____ _____

Agent Notes: ____

Do you practice in Nursing Homes: ____Y ____ N________%

Do you want coverage for Medical Director: ___Y___N

** This is for indication puposes only, applicants are subject to full underwriting review.*