



Professional Liability Association, LLC

RISK RETENTION GROUP, INC.

Email to: teresa@care-ins.com

Agency: \_\_\_\_\_

Agent: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Designation/Title:  MD  DO  DDS/DMD  
 DC \_\_\_\_\_ (Other)

Primary Practice \_\_\_\_\_  
Street \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

County: \_\_\_\_\_

Requested EFFECTIVE Date: \_\_\_\_\_

Specialty: \_\_\_\_\_%

Requested RETRO Date: \_\_\_\_\_

Sub Specialty: \_\_\_\_\_%

Requested LIMITS: \_\_\_\_\_/\_\_\_\_\_

Surgery:  None  Minor  Major

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

States Requesting Coverage In:

Number of Claims in last 10 years: \_\_\_\_\_

State: \_\_\_\_\_ % of Practice: \_\_\_\_\_

Claim Status: # of \_\_\_\_\_ Open \_\_\_\_\_ Closed

State: \_\_\_\_\_ % of Practice: \_\_\_\_\_

Number of Board Actions in last 10 years: \_\_\_\_\_

Number of Procedures per week: \_\_\_\_\_

Number of Hours working per week: \_\_\_\_\_

Number of Deliveries (if applicable): \_\_\_\_\_

Number of Patients per week: \_\_\_\_\_

Number of Reads (if applicable): \_\_\_\_\_

Do you want coverage for your Entity or Allies:  Y  N

Current Carrier: \_\_\_\_\_

Entity/Allied Name: \_\_\_\_\_

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 purposes only, applicants are subject to full underwriting review.