CARE

Professional Liability Association, LLC

RISK RETENTION GROUP, INC.

Email to: teresa@care-ins.com

Agency: _____

Agent: _____

Name: _____

Primary Practice _____ *Street*

Address: _____ *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: _____

Number of Hours working per week: _____

Number of Patients per week: _____

Do you want coverage for your Entity or Allieds: ☐ Y ☐ N

Entity/Allied Name: _____

Do you perform Cosmetic Surgery: ☐ Y ☐ N _____%

_____% **Elective** _____% **Reconstructive**

Do you perform Bariatric Procedures: ☐ ☐ N

Do you perform Telemedicine: ☐ Y ☐ N

States Requesting Coverage In:

State: _____ **% of Practice:** _____

State: _____ **% of Practice:** _____

Number of Procedures per week: _____

Number of Deliveries (if applicable): _____

Number of Reads (if applicable): _____

Current Carrier: _____

Expiring Premium: $_____

Aesthetics or Laser Procedures: ☐ Y ☐ N _____%

Describe: _____

Do you practice in Correction Facilities: ☐ 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.*