

QUICK-QUOTE APPLICATION FOR MEDICAL GROUPS



Group Name:	Contact:
Phone:	E-Mail:
Address:	
Liability Limits:	
Current Insurer:	
Current Premium:	
Renewal Date:	Agent:

PO BOX 948399 | Maitland, FL 32794-8399 | toll free 1-866-596-3859

**For a no obligation premium indication,
please FAX to OROS RISK SOLUTIONS
at 407-838-3442 attn: Web Response**

Physician Name	Specialty	Retro Date	Invasive Procedures	Questions:					
				1	2	3	4	5	
Separate Limits for Organization? Yes / No	Organization		N/A		N/A	N/A	N/A	N/A	N/A

Please list the number of employees who are ARNP, PA-C, CRNA, or mid-wives:

Questions:
Please respond "Y" (yes) or "N" (no) in the spaces allowed above. Attach any explanation for any "yes" answer (except #5).

1. Has this physician (or organization) had any previous claims, or current open claims or demands? If so, please attach brief narrative of each (including status)
2. Did the physician attended foreign medical school? If so, give date of ECFMG or Fifth Pathway Certification. (If not applicable, respond N/A).
3. Is this physician practicing part-time (20 hours per week or less)?
4. Is this physician new to practice (right out of training)? If "yes" please provide first date entering private practice.
5. Is this physician Board Certified?

For separate limits for the employed medical staff, please list the name, professional occupation and retro date above.
If possible, please attach copy of current Policy declarations page, physician CV's, and loss runs (claims summaries).