Mike Haffar Insurance Services

Professional Medical Liability Proposal Request

Fax your completed form to 626.966.9882

Business/Group Information

Physician/ Entity Name _____

Address: _____City _____**CA**, Zip_____

Business Number: _____ Fax Number: _____ Cell Number: _____

Proposed Effective Date: _____ Proposed Premium: _____

Are you adding to your policy: □ **Additional Physicians** □ **Physician Assistants and Nurses** □ **Locum Tenens** □ **None**

If yes, how many of each? _____

Are you *also* interested in: □ **General Liability** □ **Health Insurance** □ **Workers Comp** □ **Directors & Officers**

Carrier Information

Current Carrier: _____ Current Premium: _____

Dates of Coverage: _____ Retroactive Date: _____

Previous Carriers, If any: _____

_____

Any Claims? □ Yes □ No (If yes, how many?) _____ Number of Open Claims: _____

Is carrier offering renewal? □ Yes □ No (If no, why?) _____

Please Provide the Following:

- □ Completed Application (attached)
- □ Completed Claim Supplement(s) (also attached)
- □ Currently valued claims history from previous carriers
- □ Current Curriculum Vitae
- □ Current Certificate of Insurance
- □ Estimated revenue and number of patient encounters for upcoming year (for surgery center only)
- □ Additional Applications, CVs, and Claims History for each additional insured, if any.
- □ Other: _____

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