ddi Doctors Direct Insurance
1140 W Lake St ● Suite 500 ● Oak Park, IL 60301
Phone: 630-574-9800 ● Fax: 866-422-2300
www.DoctorsDirectInsurance.com

# Express Quote Form – Ear Nose & Throat

**Practice Information**

Practice Name: ____________________

Practice Address: ____________________

Hospital and/or Surgery Center Affiliations and % of your practice at each:

____________________

% of your practice: Otology/Neurotology ________ Pediatric Otolaryngology ________ Allergy ________

Head & Neck ________ Facial Plastic/Reconstructive ________ Rhinology ________ Laryngology ________

Please describe any unusual or experimental procedures or services you offer:

____________________

Have any claims been brought against you or your group in the past ten years? ____________

If yes, please provide a copy of your claims history

Contact Person / Phone Number and Email address: ____________________

Please provide information on any practice activities, changes in your practice, processes/procedures you have implemented, etc. that may help us understand your risk, or steps you have taken to mitigate risk:

____________________

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**Fax this form to 866-422-2300** with the following information**:**

- Copy of most recent professional liability application, or hospital credentialing application
- Curriculum Vitae for each physician applying for coverage
- Claims History, if applicable

**Or forward applications you already completed for another insurance company.**

The above information is accurate to the best of my knowledge. I understand that this information is confidential and being submitted to Doctors Direct Insurance solely for the purpose of receiving a preliminary premium indication.

____________________ ____________________

Authorized Representative Signature / Date Print Name