

Express Quote Form

Practice Information

Practice Name: _____

Practice Address: _____

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

Specialties represented in your practice: _____

Please provide a description of the services offered by your practice, your website and/or a copy of brochures describing the services provided. _____

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 complete a claims supplement form for each claim (or provide 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:

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