

**Pennsylvania Physicians' Reciprocal Insurers (Pennsylvania PRI)
Medical Malpractice Premium Indication Form**

Applicant's Name: _____ [] M.D. [] D.O.

Mailing Address: _____

Phone # _____ Fax # _____

Primary Office Location (County and State only): _____
(If more than one location, please indicate where you practice more than 50% of time)

Total hours per week? *(For all locations to be covered)* _____ Years in practice? _____

Specialty: _____
Check one: [] No Surgery [] Minor Surgery [] Major Surgery

Type of Policy Requested: [] Claims-Made [] Occurrence

If claims-made, is Prior Acts (Retroactive) Coverage requested? [] Yes [] No

If yes, what is the requested retroactive date? _____

Do you currently have a relationship with an insurance broker? [] Yes [] No
(Pennsylvania PRI would like to work with your broker to ensure that all your specific needs are met.)

If yes, agency name? _____

If yes, broker name? _____

Currently Insured? [] Yes [] No Current Policy Period: _____
(Example: 01/01/2006 – 01/01/2007)

Current Insurance Carrier: _____

Why are you looking to leave your current carrier? _____

For a 5% discount, is applicant willing to give Pennsylvania PRI authorization to settle claims on their behalf? [] Yes [] No

How many claims have been paid on behalf of the applicant in the past 5 years? [] 0 [] 1 [] 2+
10 years? [] 0 [] 1 [] 2+

Signature _____ Date _____

***Please Note: Premium Indications will be provided based on the above information. This form does not guarantee coverage. An application must still be completed and all required materials must be submitted for a policy to be issued. All premiums are subject to underwriting review of a completed application.**