Processing Number: ______________
For Internal Use

Attention: Underwriting Division

20 N. Michigan Avenue, Suite 700
Chicago, IL 60602
Toll-free 1-800-782-4767
Telephone: 312-782-2749
E-mail: underwriting@ismie.com
www.ismie.com

ISMIE QWIK QUOTE

Type of quote requested: Individual ❑ Group/Clinic ❑ Requested Effective Date: ______________

Prospective Applicant Name: ____

Primary Practice Address: ____
(Street) (City) (State) (County)

Primary Hospital Affiliation: ____
(Name) (City) (State) (County)

Physician Medical License Number: ______________ **or** Corp/Clinic Federal Tax ID: ______________

Name of Current Insurance Company: ____________________ Policy Expiration Date: __________________

Current Policy Type: ❑ Claims-Made or ❑ Occurrence Expiring Premium: $______________

Requested Policy Type: ❑ Claims-Made or ❑ Occurrence or ❑ Transfer-to-Occurrence™

Requested Limits of Liability: ____________________

Any Claims in Past 10 years? ❑ No ❑ Yes

Any Claims in Past 5 years? ❑ No ❑ Yes

If yes: Complete the following or attach a claim history report
Number of claims closed without indemnity: __________
Number of claims closed with indemnity: __________
Amount(s) paid: $ __________ Date(s): __________
Number of open claims: _______

I. Individual Physician Applicant: Please complete below.

Primary Specialty/Sub-Specialty	Retro Date (if applicable)	Residency/Fellow Completion Date	Years in Practice	Board Certification yes or no

II. Please complete below for any employed Allied Health Professional (AHP).

Allied Health Professional Name (attach census for multiple AHPs)	Professional Designation	Retro Date (if applicable)	Separate or Shared Limit	Years in Practice

III. Group/Clinic Applicant: Please attach a census of each physician affiliate including: Physician Name, Specialty, Retro Date (if applicable), Residency/Fellow Completion Date, and Years in Practice.

I am requesting a premium indication based on the above underwriting information. I understand that the actual premium and eligibility will be determined by ISMIE Mutual after I submit a fully completed insurance application. By signing below you are agreeing to ISMIE sharing your information with an ISMIE agency partner, if you do not indicate an agency below.

______________________ ______________________ ______________________
(Applicant signature) (Date) (Email address)

Agency Name: ______________ ______________________ ______________________
(Agent Signature) (Date)

PLEASE ATTACH CURRENT POLICY DECLARATIONS PAGE
Please send completed form to underwriting@ismie.com or fax to (312) 782-2023