



IOPA QWIK QUOTE

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

Prospective Applicant Name: _____

Phone Number: _____ Email: _____

IOPA Member? Yes No Do you practice more than 50% of your practice time in Idaho? Yes No

Do you practice Part-time Yes No

If Part-time, indicate number of weekly practice hours: 8 hours or fewer , 16 hours or fewer , 24 hours or fewer

Are you a Newly Practicing Physician? Yes No , if yes indicate: Year 1 Year 2 , or Year 3

Are you a Moonlighting Resident? Yes No , if yes indicate total moonlighting practice hours per year _____

Primary Practice Address: _____

(Street) (City) (State) (Primary Practice County-for rating)

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

If yes: Complete the following or attach a claim history report

Any Claims in Past 5 years? No Yes

Number of claims closed with indemnity: _____

Amount(s) paid: \$ _____ Date(s): _____

Number of open claims: _____

Number of claims closed without indemnity: _____

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 |
|---------------------------------|-------------------------------|-------------------------------------|----------------------|-------------------------------------|
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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 |
|--|-----------------------------|-------------------------------|-----------------------------|----------------------|
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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 acknowledge that the actual premium and eligibility will be determined by ISMIE Mutual after I submit a fully completed insurance application. By signing, I acknowledge that I agree to ISMIE sharing my information with SYRINGA Risk Mangers Plus LLC.

(Applicant signature)

(Date)

PLEASE ATTACH CURRENT POLICY DECLARATIONS

PLEASE SEND COMPLETED FORM TO IOPA@ismie.com or fax to (312) 782-2023