Pennsylvania Osteopathic Medical Association

ALERAGROUP HPL DIVISION

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POMA QWIK QUOTE

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

Prospective Applicant Name: _____
Phone Number: _____ Email: _____

POMA Member? Yes ❑ No❑ Do you practice more than 50% of your practice time in PA? Yes ❑ No ❑
Do you participate in Mcare? 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

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
			Separate	

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 Alera Group HPL Division.

_____ _____

(Applicant signature) (Date)

How do I sign this Application?

PLEASE ATTACH CURRENT POLICY DECLARATIONS

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