



Pennsylvania Osteopathic
Medical Association



Processing Number: _____
For Internal Use

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

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 The Glatfelter Agency.

(Applicant signature)

(Date)

PLEASE ATTACH CURRENT POLICY DECLARATIONS

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