CAPITAL INSURANCE SERVICES

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Corporate Medical Malpractice Quote Sheet

Organization Name: ______________________________ FEIN #: ________________

Phone: ____________________________ Website: ______________________________

Location Address: _____________________ City: __________ State: _____ Zip: __________

Contact Person: ______________________ Title: ____________________

Phone: __________________ Ext: ______ E-Mail: ______________________________

Please list additional practice locations: *(If additional practice locations are needed please attach a separate sheet)*

Street Address: ______________________ City: __________ State: _____ Zip: __________

Street Address: ______________________ City: __________ State: _____ Zip: __________

Type of Corporation

☐ Corporation – Not for Profit ☐ Solo Corporation ☐ Partnership
☐ Multi-shareholder Corporation ☐ Limited Liability Company ☐ Other ________________

Does the Organization practice under a dba (doing business as) name? ☐ Yes ☐ No

If yes, please list all dba names: ____

____

List other separate entities for which coverage is requested not listed above: ________________

____

Limits Requested			
	$100,000 each claim / $300,000 aggregate		$300,000 each claim / $900,000 aggregate
	$200,000 each claim / $600,000 aggregate		$500,000 each claim / $1,000,000 aggregate
	$250,000 each claim / $750,000 aggregate		$1,000,000 each claim / $3,000,000 aggregate

1. Specialty: ____________________ Retro Date *(if claims-made)*: ______________
2. Desired type of coverage: ☐ Claims-Made ☐ Occurrence
3. Is the organization requesting Prior Acts Coverage? ☐ Yes ☐ No Requested Retro Date: __________
4. Deductible Amount: __________ ☐ Indemnity Only ☐ Indemnity & Expense ☐ None
5. Do you need Excess Coverage Limits? ☐ Yes ☐ No Requested Amount: ____________________
6. Were your prior limits: ☐ Shared ☐ Separate
7. Did you purchase / receive a reporting endorsement *(tail coverage)*? ☐ Yes ☐ No

Continue to page 2….

Practice Information

1. List all Physicians who will be insured elsewhere and provide proof of coverage.

Name	Specialty	Current Insurer

2. List all Paramedicals who will be insured elsewhere and provide proof of coverage.

Name	Specialty	Current Insurer

Loss Information

Have you ever been involved in a malpractice claim or suit? ☐ Yes ☐ No
(If yes, provide a narrative and disposition)

Do you have knowledge of any pending claims or situations which may give rise to claims? ☐ Yes ☐ No
If yes, have you notified your current insurer? ☐ Yes ☐ No

(If no, you must notify present insurer of all pending claims/incidents)

Has any company refused, declined, cancelled, or imposed special conditions/limitations on your professional liability coverage? ☐ Yes ☐ No If yes, please explain: ____

____

____

Current Insurance Information

Company Name: ______________________________ Annual Premium: ____________________

Prior Limits: ___________________________________ Expiration Date: _____________________

Please complete the Individual Medical Malpractice Quote Sheet for each individual to be covered under the corporation.