

**BEAUMONT PHYSICIANS INSURANCE COMPANY**  
**QUOTE REQUEST FORM\***  
**Medical Professional Liability Insurance**

**FAX or EMAIL QUOTE REQUEST FORM AND CURRENT POLICY "FACE SHEET" TO:**  
**FAX (248) 423-3106 or EMAIL [BPIC@beaumont.edu](mailto:BPIC@beaumont.edu)**  
**QUESTIONS? CALL (248) 423-2511**

**PHYSICIAN NAME:** \_\_\_\_\_

**P.C. NAME:** \_\_\_\_\_

**OFFICE MANAGER / CONTACT NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **FAX NUMBER:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**ARE YOU A SOLO PRACTITIONER? \_\_\_\_\_ OR BELONG TO A GROUP? \_\_\_\_\_**

1) PLEASE ATTACH A COPY OF YOUR POLICY DECLARATIONS PAGE OR "FACE SHEET"

2) SPECIALTY: \_\_\_\_\_

- No Surgery
- Minor Surgery
- Major Surgery

3) CURRENT POLICY FORM:      Modified Claims Made  
                                           Claims Made

4) CURRENT POLICY RETROACTIVE DATE: \_\_\_\_\_

5) CURRENT COVERAGE TYPE:      Broad Location/24 Hour  
                                           Limited Location (Limited to the Insured's office and Beaumont scheduled facilities)

6) CURRENT LIMIT OF LIABILITY:    \$100,000 per claim/\$300,000 annual aggregate  
                                           \$200,000 per claim/\$600,000 annual aggregate  
                                           Other: \_\_\_\_\_

7) DESIRED EFFECTIVE DATE: \_\_\_\_\_

(Note: The Program runs on a common renewal date from January 1 to January 1. Any physician that joins the Program after January 1 will have his/her premium prorated based on the policy inception date.)

8) On average, what are your total hours worked including, but not limited to, hospital, office, home visits, nursing homes, etc. per week?: \_\_\_\_\_

9) Does your office utilize Electronic Health Record (EHR) technology?    YES    NO

If Yes, please provide the name of the EHR Company: \_\_\_\_\_