Podiatrist Insurance Quote Sheet

Name of Podiatrist: _____ FEIN #: _____

Practice Name: _____ Requested Effective Date: _____

Location Address: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

How did you hear about us? _____

PROFESSIONAL LIABILITY

Liability Limit: ☐ $200,000 / $600,000 ☐ $500,000 / $1,500,000 ☐ $1,000,000 / $3,000,000 ☐ Other:_____

What type of policy do you have? ☐ Claims-made ☐ Occurrence

If claims-made, what is the retroactive date?_____

First date of practice:_____

What is your practice comprised of:

☐ Non-surgical procedures only

☐ Currently performing surgical procedures

☐ Previous surgical procedures

If yes, date surgery was stopped: _____

Are you performing procedures that require anesthetic or gaseous sedation, including post-op treatment? ☐ Yes ☐ No

How many hours per week do you practice?

☐ Less than 20 hours per week ☐ 21 hours or more per week

Current Carrier: _____ Exp. Date:_____

GENERAL LIABILITY

Type: ☐ Sole Proprietor ☐ Partnership ☐ Corp. ☐ LLC ☐ Other

Liability Limit: ☐ $1 mil / $2 mil ☐ $2 mil / $4 mil

Umbrella: ☐ $1 mil ☐ $2 mil ☐ $5 mil ☐ $10 mil ☐ None

BUSINESS PERSONAL PROPERTY

Amount of Business Personal Property? (furniture, medical and office equipment, etc.) $ _____

Deductible: ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000

Amount of Computer Equipment? (software, hardware, laptop, etc.) $_____

Current Carrier: _____ Exp. Date:_____

LOCATION INFORMATION

Do you own the Building or Commercial Condo? ☐ YES ☐ NO

Is a separate entity set up to own the building? ☐ YES ☐ NO

If Yes, Name:_____

If you are responsible for insuring the building, how much? $ _____

If you are responsible for cost of Tenant Improvements, how much? $ _____

Building Construction: ☐ Frame/Stucco ☐ Brick/Block ☐ Other:_____

Approx. Year Built:_____ Office sq.ft:_____ # of Stories:_____

Safety Features: ☐ Sprinklers ☐ Central Station Burglar Alarm ☐ Central Station Fire Alarm

Estimated Annual Gross Revenue: $_____

WORKERS COMPENSATION

Number of Full-time Employees:_____ Part-time:_____

Total Annual Payroll: $_____

Coverage for the Owner(s): ☐ Include ☐ Exclude

If Excluded, does your Health Insurance Policy cover you for work related injuries? ☐ YES ☐ NO

Employer's Liability Limit: ☐ $100,000 ☐ $500,000 ☐ $1,000,000

Current Carrier: _____ Exp. Date:_____

CLAIMS INFORMATION

Any Claim reported on your professional liability, property, general liability or workers compensation policy in the last 3 years? ☐ YES ☐ NO

If Yes, please describe:

_____

_____

May we email quotes, policies, and related coverage documents to you? ☐ YES ☐ NO

Date: _____ Signature: _____

WE CAN WRITE PROPERTY AND GENERAL LIABILITY WITH OR WITHOUT PROFESSIONAL LIABILITY.

Fax completed form to 866.467.3611 or save pdf and email to info@desertmountaininsurance.com

Submitting completed form works best from desktops. On mobile devices/tablets: **MUST OPEN** in Adobe Acrobat Reader App. (Download free Adobe Acrobat Reader from the App Store or Google Play Store.)

Submit Form

For questions, please call: 866.467.3627

Desert Mountain INSURANCE SERVICES, INC.

For more info, please visit: www.desertmountaininsurance.com