



OPTOMETRIST PROFESSIONAL LIABILITY QUICK-QUOTE FORM

www.RockwoodMedMal.com

4001 Miller Road, Wilmington, Delaware 19802 • Tel: 800-365-0816 • Fax: 302-764-9125

Name _____

Primary Office Address _____

City _____ County _____ State _____ ZIP _____

Email _____ Phone (____) _____ Fax (____) _____

Date of Birth _____ Date Practice Started _____

License No. _____ Do You Practice At Multiple Locations? Yes No *If "Yes", provide details on a separate sheet.*

Annual Revenue, Last 12 Months \$ _____ Number of Patient Visits, Last 12 Months _____

I practice as: Owner Employee Associate Independent Contractor

My practice is: Solo Practice Partnership Corporation LLC Association Multi-Optometrist

I employ other

Optometrists in my practice: Yes No *If "Yes", how many are employees?* _____ *Independent Contractors?* _____

EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From ___/___/___ To ___/___/___	_____
_____	From ___/___/___ To ___/___/___	_____
_____	From ___/___/___ To ___/___/___	_____

Please describe in detail the nature of your practice and types of services rendered: _____

Are any laser/lasik procedures performed by or on behalf of you? Yes No

Do you perform or assist in any surgical procedures? Yes No

Please list ALL surgical procedures performed (including minor surgery): _____

PLEASE PROVIDE the following information regarding your current Professional Liability coverage:

Current Policy Expiration Date ___/___/___ Retroactive Date ___/___/___

Current Policy Limits \$ _____ Current Policy Deductibles \$ _____

Insurance Company Name _____ Annual Premium Paid Last Year \$ _____

Do you require General Liability Insurance? Yes No

Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No

LOSS INFORMATION Has any professional liability claim or suit been made against you, your predecessors in business, or against any past or present partner? Yes No *If "Yes", please provide details on a separate sheet.*

Are you aware of any circumstances that might give rise to a claim under this policy? Yes No *If "Yes", please provide details on a separate sheet.*

Please return via fax to 302-764-9125.
Forms can also be sent via e-mail to: sales@rockwoodinsurance.com