



Malpractice Indication Worksheet

Business Name:		Business Address:			
Contact Name:		Contact Phone #		Contact Email	
Requested Effective Date:		Retro Date (if applicable)		Requested Limits:	\$250,000/\$750,000
					\$1,000,000/\$3,000,000
					Other
Number of Physicians:		Number of Midlevels		Number of Locations:	

Physician Roster			
Physician Member	Employment Date	Estimated Hours Per Week	Primary Location Worked (if applicable)

If additional space is needed, please complete and attached a separate roster (page 3)

For a pricing indication send a completed worksheet to ucac@assuranceagency.com

Location Information

If you have multiple locations, please complete estimated visits breakdown for each location.

Center Address:	
Type of Service Provided	Estimated Number of Visits for the Next 12 Months
Preventative/Diagnostic: <i>This includes corporate health, physicals, immunizations, allergy shots, alcohol/drug testing and blood pressure screenings</i>	
Non-Emergent: <i>This includes abrasions, animal and insect bites, minor burns, coughs, earaches, flu, minor fractures, minor lacerations, sore throat and sprains</i>	
Emergent Care: <i>This includes moderate/severe burns, fractures, allergic reactions, breathing difficulties, chest pains or pressure.</i>	
Occupational Medicine: <i>Dealing with workers compensation claimants</i>	

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