

## DIALYSIS CENTER QUICK QUOTE FORM

<b>CONTACT INFORMATION</b>	
Legal Entity Name*: _____	
Phone*: _____	Fax: _____
Email: _____	
Contact Person: _____	Preferred Contact Method: _____
Address 1: _____	Address 2: _____
City: _____	State: _____ Zip: _____
<b>COVERAGE INFORMATION</b>	
Physician's Name: _____	
Medical License #: _____	Date of Birth: _____
Requested Limits: _____	
Effective Date: _____	Retroactive Date: _____
Current Carrier: _____	
Current Annual Premium: _____	
*Please attach a copy of center's current "Declarations of Coverage" page.	
# Of Patients/Treatments: _____	
Have you had a claim in the last 10 years?      Yes      No	
If "Yes," how many? _____	
*Please attach a copy of the physician's claims history or any pertinent claims information.	
<b>ADDITIONAL INFORMATION</b>	
How did you hear about Fairway Physicians Insurance Co.? _____	