

## GROUP QUICK QUOTE FORM

<b>CONTACT INFORMATION</b>			
Full Name*: _____	E-mail: _____		
Phone*: _____	Fax: _____		
Administrative Position: _____			
Preferred Contact Method: _____			
<b>PRACTICE INFORMATION</b>			
Corporation / DBA Name: _____			
Address 1: _____		Address 2: _____	
City: _____	State: _____	Zip: _____	
<b>COVERAGE INFORMATION</b>			
Group Specialty: _____			
Does the group practice Alternative, Integrative, and/or Holistic Medicine?			Yes    No
Number of Physicians: _____		Number of Allied Staff: _____	
Requested Limits: _____			
Effective Date: _____			
Current Carrier: _____			
Current Annual Group Premium: _____			
Do any physicians practice less than 20 hours per week?		Yes    No	
Do any physicians work as locum tenens?		Yes    No	
<b>ATTACHED INFORMATION</b>			
Please provide the following:			
1. A roster of physicians, allied staff and all medical personnel			
<i>*Note all locum and part-time physicians on the roster</i>			
2. A claims history for each physician and any other pertinent claims information			
3. The "Declarations of Coverage" page for the group and each physician			
<b>ADDITIONAL INFORMATION</b>			
How did you hear about Fairway Physicians Insurance Co.? _____			