



INTEGRATIVE PHYSICIAN QUICK QUOTE FORM

CONTACT INFORMATION			
Full Name*:	_____	E-mail:	_____
Phone*:	_____	Fax:	_____
Contact Person:	_____	Preferred Contact Method:	_____
PRACTICE INFORMATION			
Corporation / DBA Name:	_____		
Address 1:	_____	Address 2:	_____
City:	_____	State:	_____ Zip: _____
COVERAGE INFORMATION			
Specialty:	_____		
Medical License #:	_____	Date of Birth:	_____
Requested Limits:	_____		
Effective Date:	_____	Retroactive Date:	_____
Current Carrier:	_____		
Current Annual Premium:	_____		
*Please attach a copy of the physician's current "Declarations of Coverage" page.			
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.			
Are you a member of a group?	Yes	No	
Group Name:	_____	Number of physicians in group:	_____
Do you work more than 20 hours per week?	Yes	No	
PROCEDURE INFORMATION			
I perform:			
Acupuncture		IV Therapies	
Bio-Identical Hormonal Therapy		Prolotherapy	
Chelation Therapy		Thermography	
Cosmetics (i.e. Botox)		Urgent Care	
Please choose a surgical category:	No Surgery	Minor Surgery	Major Surgery
ADDITIONAL INFORMATION			
How did you hear about Fairway Physicians Insurance Co.? _____			