PodiatryChoice

AN RPS SIGNATURE PROGRAM

HAROLD DIERS

Premium Indication Form

Podiatrist Name: ____

Practice Name, (if different): ____

Primary Practice Zip code ______________Additional State Zip Code & % of Practice ___________

Phone____

Email____

Current Professional Liability Insurance Carrier_________________

Expiration Date: ________________ Retroactive Date: __________________

◯ Claims Made   ◯ Occurrence Form

Limits ◯ $1/3M or ◯ Other____________________

Date First Licensed _____________

Average Weekly Hours Worked_________
***Note:** Hours practiced include consulting, paperwork, lab time, and hospital hours.

Risk Management in the 12 months? ◯ Yes ◯ No

Do your Professional Services include IV Conscious Sedation or General Anesthesia? ◯ Yes ◯ No

Claims or Disciplinary Actions Pending? ◯ Yes ◯ No (If yes, please provide details below)

Details:

Fax to 402-484-5887 or Email to nick@hdiers.com

*** Premium indications provided are not firm quotations and are not bindable. Terms, limits, deductibles, conditions and price may change upon receipt, review and acceptance of a completed application and supporting documentation by the company. A binding quotation will not be issued without the company's full underwriting**

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