



INDICATION REQUEST Informal Quote

DENTIST NAME: _____ CLIENT# _____

SPECIALTY: _____ DEGREE: _____

EMAIL ADDRESS: _____

OFFICE NUMBER: _____

FAX NUMBER: _____

OFFICE ADDRESS: _____

CURRENT CARRIER: _____ CURRENT PREMIUM _____

START DATE WITH CURRENT CARRIER / RETROACTIVE DATE: _____

RENEWAL DATE: _____

NUMBER OF YEARS PRACTICING IN NORTH CAROLINA: _____

CURRENT COVERAGE LIMITS: _____

IS THIS A CLAIMS MADE OR OCCURENCE TYPE OF POLICY? _____

REQUESTED LIMITS (please circle): \$1M/\$3M \$2M/\$4M \$3M/5M

EMPLOYMENT STATUS (please circle): ASSOCIATE OWNER

HOURS WORKING (please circle): FULL/TIME PART/TIME

ADDITIONAL DENTISTS IN THE PRACTICE: _____

DO YOU PROVIDE SEDATION? _____

WHAT TYPE OF SEDATION IS USED (please circle): IV SEDATION ORAL SEDATION

CLAIMS HISTORY / BOARD ACTION: _____

WOULD YOU BE INTERESTED IN RECEIVING INFORMATION FOR COMMERCIAL
COVERAGE? _____

◆ ONCE THIS FORM HAS BEEN COMPLETED SIMPLY FAX IT TO: RENEE (919) 878-7593

