

Gulf Atlantic Legal Defense Insurance
Premium Indication/Self-Insurance Comparison
E-mail: Underwriting@gulfatlantic.com
Fax (850) 385-1657
Phone (850) 385-8555, ext. 4105

General Information

Name: _____ MD DO
County: _____ Medical License No.: _____
E-mail: _____ Personal/Cell Phone: _____ Office Phone: _____ Fax: _____

Policy/Practice Information

Policy Start Date: _____ Retroactive Date (if you want prior acts coverage): _____

Your Practice Specialty: _____ Your Subspecialty: _____

Do you currently have insurance? Yes No

If Yes, what are your limits? Defense Only \$100,000/\$300,000 \$250,000/\$750,000
\$1,000,000/\$3,000,000

Personalized Self Insurance Comparison

If you currently have coverage, would you like a personalized ***Self-Insurance Comparison***? Yes No

If Yes, please complete the following additional questions:

- a. What is your current insurance premium? _____
- b. How many years have you been in practice? _____
- c. Have you been sued for malpractice in the past that resulted in a settlement or judgment?
Yes No
- d. If so, how many times? _____

Acknowledgment and Release

You acknowledge that the premium indication provided by us is just an estimate and does not constitute a quote or offer for coverage. An offer or quote is only available upon the submission of a full Application for Coverage and underwriting review, and the quoted premium may be higher or lower than the premium indication. If you have requested a personalized Self Insurance Comparison, you agree that these are just estimations of savings or costs and are for illustrative purposes only. Self insurance by its definition involves the assumption of risk by the physician, and the financial benefits or detriments associated with self insuring will depend on factors personal to your practice. You acknowledge that you are not relying on our Self Insurance Comparison in making your decision to self insure, that any decision to self insure is yours alone, and you release Gulf Atlantic from all liability arising from your use of our Self Insurance Comparison.

Applicant Signature: _____ Date: _____

Preferred Method of Contact: E-mail Text Fax Mail

[If by mail, provide preferred address: _____]