



Risk Transfer Insurance Alliance

Premium Indication Request

(Please complete one form per physician, make copies as necessary)

Name: _____

Practice Name: _____

Specialty: _____

Please check any of the following that apply:

No Surgery Minor Surgery Major Surgery

Full Time Part Time (____ patient hours per week)

Present Insurance Company: _____

Limits: _____ Effective Date: _____

Coverage Type: Occurrence or Claims Made Retroactive Date: _____

Please attach a list of any paid or pending claims, including the following*:

- date
- date closed
- insurance company providing coverage
- description of incident

*All information should be legible

Name (print): _____ Date: _____

Signature: _____

If you have any questions or if you would like to setup an appointment, please call our toll free number listed below.

Please check the best way(s) to contact you:

Fax: _____

Email Address: _____

Phone: _____

Mail: _____

Please return to: **Risk Transfer Insurance Alliance, LLC**
175 Federal Street, Suite 725
Boston, MA 02110-2202

Fax: 617-423-7541