



7165 Delmar Blvd.
Suite 215
St. Louis, MO 63130
314-721-2366

Express Quote

Complete this form and fax it back to 314-721-2377. We will provide your preliminary premium indication within a week.

Physician Information

Physician Name: _____

Specialty: _____ Are you full or part time: _____

Retroactive Date Requested: _____ If part time, weekly hours worked: _____

Do you perform invasive procedures, if yes please list types: _____

Claims History: Has a claim been filed against you in the last 10 years? If yes, please list the number of claims and a brief summary of each claim. (Use additional pages if necessary)

Practice Information

Practice Name: _____

Practice Address: _____

How many physicians are in your practice? _____

Contact Person and Phone Number or Email address: _____

Current Policy Information

Who is your current carrier: _____

What is your current premium? _____

What is your renewal date? _____

Do you have a Claims-Made policy or Occurrence Policy? _____ Limits: _____

The above information is true. I understand that this information is confidential and being submitted to Galen solely for the purpose of receiving a preliminary premium indication.

Physician Signature/Date: _____

Thank you for taking the time to complete this questionnaire. A Galen application must be completed before insurance is offered.