QUICK QUOTE

To: Deena Mader **/ OMIC Sales**

Fax: (415) 771-7087

From: _____

Date: _____

PRACTICE NAME: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

COUNTY (OR COUNTIES): _____

PHYSICIAN NAME	RETROACTIVE DATE *	LIABILITY LIMITS	HOURS PER WEEK	MEDICAL OR SURGICAL

PHYSICIAN(S) PERFORM: ☐ LASIK/PRK ☐ CK ☐ REFRACTIVE LENS EXCHANGE ☐ PHAKIC IMPLANTS ☐ INTACS
☐ FACELIFTS (COSMETIC) ☐ LIPOSUCTION ☐ ROP SCREENING OR TREATMENT

NEED COVERAGE FOR: ☐ OPTOMETRIST(S)? (IF YES, HOW MANY? _____ ☐ SEPARATE OR ☐ SHARED LIMITS?)
☐ NURSE ANESTHETIST(S)? (IF YES, HOW MANY? _____ ☐ SEPARATE OR ☐ SHARED LIMITS?)
☐ OSF (OUTPATIENT SURGICAL FACILITY - SURGERY CENTER OR OFFICE SURGICAL SUITE)

Coverage for OSFs at shared limits is provided at no extra charge if limited to practice members.

Please indicate if ☐ shared or ☐ separate limits are required. If separate limits, please list:

Annual number OPHTHALMIC_____REFRACTIVE_____AND NON-OPHTHALMIC_____PROCEDURES)

If shared limits give above numbers ONLY for non-practice utilizers of your facility.

CURRENT POLICY EFFECTIVE DATE? _____

WHO SHOULD THE RATE INDICATION BE SENT TO? _____

WHICH DO YOU PREFER? _____ ( ) _____ ( ) _____
EMAIL PHONE FAX

*Located on policy declarations page of claims-made policy (IF POLICY IS "OCCURENCE" FORM CHECK HERE ☐)

QUESTIONS? Contact Deena Mader at 415-202-4628 or dmader@omic.com.

INTERNAL USE ONLY

MKTG CODE: PV WEB

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