

**Advanced Physicians' Insurance**  
Risk Retention Group, Inc.

**FAXBACK PROFILE FORM**

**CONTACT INFORMATION**

Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**PRACTICE INFORMATION**

\_\_\_\_\_  
Primary Area of Practice  No Surgery  Minor Surgery  Major Surgery

\_\_\_\_\_  
Secondary Area of Practice  No Surgery  Minor Surgery  Major Surgery

\_\_\_\_\_  
Secondary Area of Practice  Full Time  Part Time Practice: \_\_\_\_\_ Number of hours

\_\_\_\_\_  
Year started part time

Sole Practitioner  Group: \_\_\_\_\_ Number physicians \_\_\_\_\_ Corporation  
name

Percent of Practice

\_\_\_\_\_  
Home Visits \_\_\_\_\_ Assisted Living Visits \_\_\_\_\_ Nursing Home Visits

\_\_\_\_\_  
Office Visits \_\_\_\_\_ Other (describe) \_\_\_\_\_

**CURRENT POLICY INFORMATION**

\_\_\_\_\_  
Current insurer

\_\_\_\_\_  
Policy expiration date

\_\_\_\_\_  
Retroactive date (if claims made) # of years in practice

Number of years without a  
paid claim or notice of intent:

1-5  6-10  10-20

Limit of Liability:  \$100,000/\$300,000  \$200,000/\$600,000

For additional information or to request a quotation, please fax or email us at:  
**Fax: 602-297-6695 | [info@advancedphysiciansinsurance.com](mailto:info@advancedphysiciansinsurance.com)**

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