Quick Quote Form

Name of Applicant _____ M___ F___

Contact Name _____ Current Insurer _____

Address _____ City/Town _____ Zip_____

Office Phone _____ Fax _____

Best time to call: _____

Current Specialty _____

Please circle if you wish: Full-Time or Part-Time Coverage

Group practice (circle one): Yes / No

Requested Effective Date: _____

Current Policy Form (circle one): Claims-Made Occurrence

What year did you complete medical school? _____

Circle one:

Yes / No Has any hospital ever taken action to suspend, revoke or restrict your medical staff privileges?

Yes / No Did you complete a fellowship?

Yes / No Do you currently practice or plan to practice medicine or surgery outside the state of New Jersey?

Yes / No Have you had any medical malpractice claims, settlements or judgements against you during the previous ten years?

Yes / No If your previous policy was claims-made, did you, or are you planning to obtain an extended reporting period (tail) endorsement?

Yes / No Have you ever practiced without professional liability insurance?

You can:
Fax it to us at 609-520-0225
Email it to us at info@njpure.com
Mail it to NJ PURE, 214 Carnegie Center Drive, Suite 301, Princeton, NJ, 08540.
Pick up the phone and call 877.265.7873, Monday – Thursday 8:30 am – 5 pm or Friday 8:30 am – 4:30 pm.