



Please complete form, print and fax or mail with attachments. If more space is needed for any response, use a separate sheet.

ProAssurance Casualty Company • 125 Flat Creek Trail, Fayetteville, GA 30214  
 Phone: 770-486-3435 • Fax: 770-486-3395 • Toll-Free: 866-372-3435

## LAWYERS PROFESSIONAL LIABILITY INSURANCE QUICK QUOTE

FIRM NAME: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_ FEDERAL TAX ID NUMBER: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**IMPORTANT:** Please attach a sample copy of the firm's letterhead and a copy of your current Policy Declarations Page.

PRACTICE AREA PERCENTAGES (TOTAL MUST EQUAL 100%)					
A. ADMINISTRATIVE/ GOVERNMENT:	_____%	J. COPYRIGHTS/ PATENT/TM:	_____%	U. PERSONAL INJURY/ PROPERTY DAMAGE:	
B. ADMIRALTY: Plaintiff	_____%	K. CORPORATE:	_____%	Plaintiff	_____%
Defense	_____%	L. CRIMINAL:	_____%	Defense	_____%
C. ANTI-TRUST/TRADE:	_____%	M. ENTERTAINMENT/ SPORTS LAW:	_____%	V. PUBLIC UTILITIES:	_____%
D. APPELLATE:	_____%	N. ENVIRONMENTAL:	_____%	W. REAL ESTATE:	_____%
E. BANKING (Regulatory Exclusion applies):	_____%	O. ERISA/EMPLOYEE BENEFITS:	_____%	X. SECURITIES:	_____%
F. BANKRUPTCY:	_____%	P. ESTATE/PROBATE TRUSTS/WILLS:	_____%	Y. TAXATION:	_____%
G. COLLECTIONS/ CONSUMER CLAIMS:	_____%	Q. FAMILY LAW:	_____%	Z. WORKERS COMPENSATION:	
H. COMMERCIAL- CIVIL LITIGATION:		R. IMMIGRATION:	_____%	Claimant	_____%
Plaintiff	_____%	S. INVESTMENT COUNSELING/MONEY MANAGEMENT:	_____%	Employer/Carrier	_____%
Defense	_____%	T. LABOR RELATIONS:	_____%	AA. ARBITRATION/ MEDIATION:	_____%
I. COMMUNICATIONS (FCC/FPSC):	_____%			ZZ. OTHER: - (describe if over 5%):	_____%
				<b>TOTAL:</b>	_____%

LIST ATTORNEYS BY NAME (Attach separate sheet if necessary)	DATE OF BIRTH	YEAR ADMITTED TO THE GEORGIA BAR	YEARS IN PRIVATE PRACTICE	YEAR JOINED THIS FIRM	% OF OUT-OF-STATE PRACTICE

CURRENT COVERAGE (Complete all items)	
Current Carrier:	_____
Policy Expiration Date:	_____
Retroactive Prior Acts Date:	_____
Annual Premium:	_____
Coverage: Current Limit:	_____ / _____
Requested Limit:	_____ / _____
Current Deductible:	_____
Requested Deductible:	_____

- Name of any "of counsel" lawyer \_\_\_\_\_
- Number of claims filed/incidents filed against you in the past five years? Filed? \_\_\_\_\_ Pending? \_\_\_\_\_  
Total Paid: \$ \_\_\_\_\_ Total Reserved: \$ \_\_\_\_\_
- Is the firm aware of any circumstance(s) or acts(s) which may give rise to a claim?  Yes  No
- Has the firm ever had coverage declined?  Yes  No
- Number of Docket Control Systems? \_\_\_\_\_  
Computerized?  Yes  No
- Has any attorney with the firm ever been disciplined or denied the right to practice?  Yes  No

**This form is for quotation purposes only. Coverage cannot be bound by completion of this form.**