

**PHYSICIANS PROFESSIONAL LIABILITY COST ANALYSIS PROGRAM**

**TO:** Marshall D. Eccher  
Eccher & Associates  
1032 S. Jefferson/ PO Box 7  
Millstadt, IL 62260

**FROM:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The best time to contact me would be: \_\_\_\_\_

Person to contact: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**I am sending you the following items which you will need:**

- \_\_\_\_\_ **Copy of the front page of my current insurance policy** which shows my name, specialty, retroactive date and limits of coverage;
- \_\_\_\_\_ **Brief summary of all prior claims** indicating the date of claim and final outcome of the claim, i.e. dismissed, settled for \$ \_\_\_\_\_; Still open or Judgment with payment of \$ \_\_\_\_\_.

**Additional Information:**

Current Insurance provided by \_\_\_\_\_

Year you began in practice \_\_\_\_\_ Do you provide child delivery \_\_\_\_\_

Specialty \_\_\_\_\_ If yes, estimated deliveries per year \_\_\_\_\_

Do you perform surgery \_\_\_\_\_ Your retroactive date \_\_\_\_\_  
(Prior acts date, i.e. July 1, 1986)

If yes, does this include minor risk procedures \_\_\_\_\_

If yes, does this include major risk procedures \_\_\_\_\_

In what **county** is your practice \_\_\_\_\_ (i.e. Cook, Madison, Franklin)

Limits of coverage \_\_\_\_\_ (i.e. 1,000,000/3,000,000)

**FOR FASTER SERVICE:**

Fax this page along with the above information to **618-476-7172** attention Medical Services Division. **Note: We must receive a copy of the front page of your current policy.**