PHCA

Michael Boggio, VP/Partner
Direct: (973) 797 0474

Exclusively for OBGYNs

We have been committed to providing financial protection to OBGYNs for over 20 years and have developed a program that makes our rates the most competitive in New Jersey. Our focus on group benefits has enabled us to provide significant savings for physicians and their practices.

There is no need to wait for your renewal date to begin to save money. It is easy to transfer your coverage midterm and we will assist you in the process for a seamless transition.

Eliminate the uncertainty of premium spikes, take control of your expenses and reinforce the protection of your reputation with our exclusive risk management tools

Below is a brief review of our member benefits:

- **Premiums**:
    - For full-time OBs – our premiums are the most competitive in the state, Coverages are underwritten by MDAdvantage, A-" as rated by A.M. Best.
    - For part-time OBs – we offer significantly reduced rates.
- **Group protection**: Our group protection strategy protects you from premium spikes by reducing the impact of individual claims
- **Expanded coverage:** Our clients can see obstetrical patients through to full-term
- **Free options:**
    - Claims consultant available full-time
    - Specialized consent forms
    - $50,000 in coverage for RAC-Audit (MPAI) and HIPPA (PDS) coverage
    - $50,000 in coverage for Employment Practice Liability Insurance (EPLI)

Continued on Page 2

GET A QUOTE

I know your time is valuable so we've made it easy for you to request an accurate quote.

1. You can call us at: **(973) 227-0025** and talk with one of our Malpractice Account Specialists.
2. You can receive a premium indication by completing a Quick Quote Form (see below) and faxing it to: **(973) 227 - 4026.**
3. Visit us online at www.mbsinsure.com **and** www.chadlersolutions.com

Sincerely,

Michael R. Boggio
Insurance Administrator and Broker- PHCA

NON-BINDING QUICK QUOTE FORM-INFORMATION (PER PHYSICIAN)

1. Name: ____
2. Address: ____
3. City: _______________________________ State: NJ _______________ Zip code: _______________
4. Date of Birth: ________________________ License number: ____________________________________
5. Specialty: ___________________________ Best Contact Number: ________________________________
6. FAX: _______________________________ E-Mail: ____
7. Hospital Affiliation: ____

COVERAGE OPTIONS

8. Occurrence Coverage: YES NO
   Claims-Made Coverage: YES NO Retroactive Date: ________________________
9. Full time hours worked: ____________________
   Part time 1-20 hrs worked per week OR less than 65 deliveries yearly: __________
10. Is corporate entity coverage desired? Yes No
    Number of members: ________________
    Corporation Name:
    ____
11. Number of Years in Practice: _____________
12. 12. Any claims in past 10 years? Yes No
13. Any board actions? Yes No