Medical Mutual℠
PROTECTING OUR PROFESSION

For office use only:

MEDICAL MUTUAL INSURANCE COMPANY OF NORTH CAROLINA

ADVANCED PRACTICE PROVIDER PROFESSIONAL LIABILITY APPLICATION

Non-Assessable Claims-Made, Claims-Made Plus or Occurrence Coverage

(Please type or print in black ink.)

- **Please answer all questions completely and as they relate to the coverage being applied for.**
- **If space is insufficient to answer any questions fully, use the Additional Comments Section at the back of this form, or attach separate documentation.**

Applicant

Full Name _____
(First) (Middle) (Last)

Suffix ❑ Sr. ❑ Jr. ❑ I ❑ II ❑ III ❑ IV ❑ V

Gender ❑ **Male** ❑ **Female** **NPI Number:**_____

Professional Designation ❑ CNM ❑ CRNA ❑ DC ❑ LPN ❑ NP ❑ OD ❑ LCSW
❑ OT ❑ PA ❑ Pharm ❑ PhD ❑ PT ❑ RN ❑ Psychologist ❑ Other _____

Do you practice or have you practiced under any other name? ❑ Yes ❑ No If yes, please list below:

Name_____
(First) (Middle) (Last)

Medical License Number _____ **Date of Birth** _____/_____/_____ **Social Security Number**_____

E-mail Address _____ **Office Contact &Telephone Number** _____

Coverage

Practice State	Practice County	Desired Effective Date
		_____/ _____ / _____

1. Are you applying for coverage in a "slot" position? ❑ Yes ❑ No
   If yes, please complete the application as it relates to the intended slot duties.

2. Are you applying for coverage relating to vicarious liability (VL) for your employer? ❑ Yes ❑ No
   (VL applies when you maintain your own coverage that will remain in force. You must attach a current certificate of insurance.)

Desired Coverage Type:

Claims-Made: ❑ **Claims-Made Plus** (Check Availability)**:** ❑ **Occurrence** (Check Availability): ❑

Desired Limits (Each Claim/Aggregate) Choose One Option

- ❑ Same As Employer
- ❑ Shared with Employer *(if available)*
- ❑ $ 500,000/$1,500,000 (PA only)
- ❑ $1,000,000/$3,000,000
- ❑ $2,000,000/$4,000,000
- ❑ $3,000,000/$5,000,000
- ❑ Current Cap Limit-Available in Virginia only
- ❑ Other: Indicate limits desired below:
  Limits must be approved by Underwriting

_____

Practice Locations (for which you are applying for coverage)

I practice at this location: ❑ Primary Practice Location

Practice Name		
Address Line 1	Address Line 2	
City	State	Zip Code

List Other Locations at which you Practice

Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Practice Name		
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**

Home Address

Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Home Phone		
( )		

Prior Acts Coverage (Claims-Made only)

NOTE: Prior Acts Coverage is optional and subject to underwriting approval. For your protection, do not forfeit your right to purchase extended reporting period endorsement coverage from your current carrier.)

Are you requesting Prior Acts coverage? ❑ Yes ❑ No If Yes, Retroactive Date used by existing carrier _____/_____/__

(Must attach current Declaration Page or Certificate of Insurance)

I declare that I have no knowledge of any professional liability claims which have been asserted against me, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I further more declare that I have no knowledge of any occurrence, incident, or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, incident, or circumstance should be given to your carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident, or circumstance.

I declare that the above is true, complete, and correct to the best of my knowledge, information, and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

Authorized Representative of Applicant _____

Professional/Clinical Education

Institution		State
From ___/___/_____	To ___/___/_____	Date of Graduation ___/___/_____
Diploma/Certification received:		

Institution		State
From ___/___/_____	To ___/___/_____	Date of Graduation ___/___/_____
Diploma/Certification received:		

Do you have specialized training? ❑ Yes ❑ No

If yes, please list area of specialization:

Professional/Clinical Experience

Employer (Most recent)	State	From ___/___/_____	To ___/___/_____
Employer (Prior Experience)	State	From ___/___/_____	To ___/___/_____
Employer (Prior Experience)	State	From ___/___/_____	To ___/___/_____

Explain any gaps in time in your Medical Education/Training and Practice History:

Coverage Information

How many hours will you work per week, on average with this employer? _____

Do you work outside the employment of this employing physician or group? ❑ Yes ❑ No
If yes, please explain, including name of employer, type of work, and hours:

Are you presently covered as an individual insured on another professional liability insurance policy? ❑ Yes ❑ No
If yes, will that policy continue in force? ❑ Yes ❑ No
Please explain:

**Please submit a Certificate of Insurance to verify coverage.*

Insurance History

	Current Carrier	1st Prior Carrier	2nd Prior Carrier	3rd Prior Carrier	4th Prior Carrier
Insurance Company					
Policy Number					
Coverage form	❑ Claims-Made ❑ Occurrence ❑ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ❑ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ❑ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ❑ Claims-Made Plus	❑ Claims-Made ❑ Occurrence ❑ Claims-Made Plus
Dates of Coverage	From:___/___/____ To:___/___/_____	From:___/___/____ To:___/___/_____	From:___/___/____ To:___/___/_____	From:___/___/____ To:___/___/_____	From:___/___/____ To:___/___/_____
Liability Limit					
Deductible	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____	❑ No ❑ Yes $_____
Retroactive Date	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____

Please answer the following:

1. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked, or restricted? ❑ Yes ❑ No
   If yes, please explain:

2. Has your professional liability carrier ever canceled or non-renewed your coverage or surcharged your premium? ❑ Yes ❑ No
   If yes, please explain:

3. Have you ever been or are you currently under a "consent order" or are you currently under proctored or other supervisory arrangement in your delivery of professional medical services? ❑ Yes ❑ No
   If yes, please explain and/or attach a copy of the consent order or proctoring documents.

4. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, mental or physical impairment or anger management? ❑ Yes ❑ No
   If yes, please explain and provide dates and location of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

5. Have you ever been diagnosed with, or treated for, a medical condition which could affect your ability to render medical professional services? ❑ Yes ❑ No
   If yes, please explain and provide a copy of your treating physician's letter clearing you to practice medicine.

6. Are you currently under contract or enrolled with any Interventional/Rehabilitation Program? ❑ Yes ❑ No
   If yes, explain:

7. Have you ever been charged with any felony criminal activity? ❑ Yes ❑ No
If yes, please explain:

8. Has any claim or suit for alleged sexual misconduct ever been brought against you? ❑ Yes ❑ No
If yes, please explain:

9. Have your hospital privileges ever been denied, restricted, suspended, revoked, or voluntarily surrendered within the past 3 years? ❑ Yes ❑ No
If yes, please explain:

10. Have you ever been questioned, investigated by, or requested to appear before any of the following:
A state licensing board or equivalent? ❑ Yes ❑ No
A specialty or medical association? ❑ Yes ❑ No
A Medicare/Medicaid agency, or other local, State or Federal governmental agency? ❑ Yes ❑ No
Other_____ ❑ Yes ❑ No
If yes to any of the above, please explain:

11. Has the applicant self-reported any fact(s), circumstance(s), or occurrence(s) to any local, State, Federal or other governmental agency? ❑ Yes ❑ No
If yes, explain:

12. Are you aware of any fact(s), circumstance(s), or occurrence(s), which could require self-reporting to or become the target of a formal investigation instituted against you by any local, State, Federal or other governmental agency? ❑ Yes ❑ No
If yes, explain:

13. Are you owner or part owner of a medical practice or Medi Spa? ❑ Yes ❑ No

14. Do you perform any cosmetic procedures? ❑ Yes ❑ No
(If yes, a Cosmetic Questionnaire must be completed)

Complete the following questions below applicable to your designation:

❑ **Physician Assistant (PA) or Nurse Practitioner (NP)**

1. Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? ❑ Yes ❑ No
(COVERAGE CANNOT BE ISSUED WITHOUT SITE AND SUPERVISOR APPROVAL FROM THE BOARD) – (if state applicable)
If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

If approved, give name and address of supervising physician:

2. Check the sites where you will perform your duties:

❑ Office w/ supervising physician always present ❑ Office w/ supervising physician occasionally present
❑ Hospital

Please note that the required written documents must be in place and accessible outlining your supervising physician's availability for consultation, collaboration, and evaluation of your medical acts.

❑ Certified Nurse Midwife

1. Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? ❑ Yes ❑ No

If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

If approved, give name and address of supervising physician:

Please note that the required written documents must be in place and accessible outlining your supervising physician's availability for consultation, collaboration, and evaluation of your medical acts.

2. Are you familiar with appropriate prescribing standards within Midwifery? ❑ Yes ❑ No

3. Do you perform or assist with deliveries in non-hospital settings? ❑ Yes ❑ No

4. Do you practice at a site away from the direct supervision of your approved supervising physician? ❑ Yes ❑ No
If yes, please explain:

❑ Certified Nurse Anesthetist (CRNA) or Anesthesia Assistant (AA)

1. Please provide the name and address of your supervising physician(s).

Please note that the required written documents must be in place and accessible outlining your supervising physician's availability for consultation, collaboration, and evaluation of your medical acts.

Claims History

Attach current Loss Run (No more than 90 days old) for previous 10 years of practice. (A *loss run* is a document from your previous professional liability carrier(s) verifying claims, suits, or reported incidents). **Your application will not be processed without this information.**

1. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? ❑ Yes ❑ No

2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? ❑ Yes ❑ No
If yes, has it been reported to your current carrier? ❑ Yes ❑ No
If no, report immediately to your current carrier. Our policy will not provide coverage for this incident. Please attach proof of reporting.

If you answered **Yes** to **#1** or **#2** above, please complete the following for each such circumstance. If you need more space, use comments section or attach additional sheet on back.

Claims History (continued)

Patient's Name			
Date of Occurrence ____/____/________	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/________	Date claim closed ____/____/________	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Patient's Name			
Date of Occurrence ____/____/________	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/________	Date claim closed ____/____/________	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Patient's Name			
Date of Occurrence ____/____/________	Insurance Carrier		
Location of Occurrence			
Date claim reported ____/____/________	Date claim closed ____/____/________	Amount reserved $	Amount paid $
Full description of Allegation and Resolution:			

Authorization and Release

(This authorization and release must be signed by the Applicant.)

I, the undersigned applicant, understand that this is an application and is not an insurance binder. I declare the representations in this application to be true and complete and understand that the policy if issued, is conditioned upon the truth and completeness of the representations in this application. I further understand that the falsity or incompleteness of any representations made in this application for insurance could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

I, the undersigned applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

_____ / / _____

Signature of applicant Date

Name and address of agent:

_____

_____

_____ / / _____

Signature of agent Date Agent's License No.

NOTICE TO APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Please return completed application to your agent or to the Company:

Additional Comments

Question #	Comments