For office use only:

Medical Mutual℠
PROTECTING OUR PROFESSION

MEDICAL MUTUAL INSURANCE COMPANY OF NORTH CAROLINA
ENTITY PROFESSIONAL LIABILITY APPLICATION

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

(Please type or print in black ink.)

- **A separate application must be completed for each joint venture, partnership, or corporation.**
- **Attach copies of all Articles of Incorporation, Partnership Agreements, etc.**
- **If space is insufficient to answer any questions fully, use the Additional Comments Section at the back of this form, or attach separate documentation.**
- **Answer all questions as they pertain to the entity.**

Practice

Legal Name: _____

Web Site Address: _____

Tax ID: _____ NPI Number: _____

Office Manager or Contact

Full Name: _____

E-mail Address: _____

Phone (_____)_____ Fax (_____)_____

Practice Mailing Address

Address Line 1	Address Line 2	
City	State	Zip Code

Practice Names

If the Applicant does business under any other name, please list all additional names:

_____

Billing Address (if different from mailing address)

Address Line 1	Address Line 2	
City	State	Zip Code

Coverage

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

Desired Coverage Type:

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

Desired Limits (Each Claim/Aggregate)

- ☐ Same as Employer
- ☐ $ 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

Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Phone	**Fax**	
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Phone	**Fax**	
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Phone	**Fax**	
Address Line 1	**Address Line 2**	
City	**State**	**Zip Code**
Phone	**Fax**	

Organization

Type of Practice (select the one most appropriate)

- ❑ Single Specialty Practice
- ❑ Multi-Specialty Practice
- ❑ Blood Bank
- ❑ Emergency Center
- ❑ Laboratory (Pathology)
- ❑ Outpatient Surgery Center
- ❑ Physical Therapy Center
- ❑ Medi Spa
- ❑ University/Teaching Facility
- ❑ Certified Trauma Center
- ❑ Hospital Based Practice
- ❑ MRI/CT (Fixed/Mobile)
- ❑ Free Clinic
- ❑ Rehabilitation/Chronic Disease
- ❑ Urgent Care Center
- ❑ Psychiatric/Substance Abuse Center
- ❑ Community Based Health Center
- ❑ Nursing Home
- ❑ Wellness Center
- ❑ Renal Dialysis
- ❑ State/County Health Department
- ❑ Other _____

If other, please explain:

Type of Organization (select the one most appropriate)

*Note: Non-Profit Organizations must attach list of Board of Directors and Shareholders along with proof of non-profit status.**

- ❑ Solo Incorporated
- ❑ Solo Unincorporated
- ❑ Multi-Shareholder Corporation
- ❑ Non-profit Organization
- ❑ Professional Corporation
- ❑ Government Agency
- ❑ Partnership
- ❑ Joint Venture
- ❑ Other - describe legal entity:

1. If the Applicant is a joint venture, disclose the parties in the joint venture and their percentage participation:

Organization (continued)

2. If the Applicant owns a subsidiary(ies), disclose that subsidiary here and indicate its type of organization:

3. Will the Applicant be covered by any additional professional liability insurance policy with any other insurance company? ❑ Yes ❑ No
   Please explain and provide evidence of such coverage:

Prior Acts Coverage

(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.)

Do you desire Prior Acts coverage for this practice or entity? ❑ Yes ❑ No

If yes, Retroactive Date used by existing carrier _____/_____/_____
(Must attach current Declaration Page or Certificate of Insurance and a signature is required below)

I declare that I have no knowledge of any professional liability claims which have been asserted against this Applicant, 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 furthermore decalre 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 _____

General Information

1. Does the Applicant's collection agency or billing company have authority to file a collection suit at its discretion without prior approval of the Applicant? ❑ Yes ❑ No ❑ N/A

2. Has the Applicant or any of its employees ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental or administrative agency, hospital, or professional association? ❑ Yes ❑ No
   If yes, list name and explain:

3. Has the Applicant or any of its employees ever been indicted for, or convicted of any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges or medical licenses revoked, suspend, restricted, placed on probation, or voluntarily surrendered? ❑ Yes ❑ No
   If yes list name and explain:

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

5. Is the Applicant or any of its employees 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 by any local, State, Federal or other governmental agency? ❑ Yes ❑ No
   If yes, explain:

6. Has the Applicant or any of its employees ever filed for bankruptcy? ❑ Yes ❑ No
   If yes, explain:_____

General Information (continued)

7. Does the Applicant contract with other companies, practices or hospitals to provide service. ❑ Yes ❑ No
   If yes, explain:_____

8. Does the Applicant advertise? ❑ Yes ❑ No
   If yes, explain:_____

9. Does the Applicant maintain current certificates of insurance on file for all doctors and allied healthcare providers employed, contracted, or privileged at its facility(ies)? ❑ Yes ❑ No

10. Does all biomedical equipment receive scheduled preventative maintenance annually by a qualified biomedical equipment technician? ❑ Yes ❑ No
    If yes, is your biomedical equipment checked by your employees on a routine basis? ❑ Yes ❑ No
    If yes, are these check logs maintained in your practice? ❑ Yes ❑ No

11. Does the Applicant reuse any medical devices? ❑ Yes ❑ No
    If yes, does your practice have a Reuse policy? ❑ Yes ❑ No
    Do you follow the manufacturer's guidelines on reuse? ❑ Yes ❑ No

12. Does the Applicant have an Ambulatory Surgery Center? ❑ Yes ❑ No
    If yes, is this facility accredited? ❑ Yes ❑ No
    ASC Accreditation: ❑ JCAHO ❑ AAAHC ❑ Other _____
    Do you allow outside physicians to utilize your facility? ❑ Yes ❑ No
    What is the time in minutes to the nearest fully-equipped hospital? _____
    Do you have a peer review committee? ❑ Yes ❑ No

13. Does the Applicant provide pathology services? ❑ Yes ❑ No
    If yes, is the facility CLIA certified? ❑ Yes ❑ No

14. Does the Applicant provide walk-in clinic services? ❑ Yes ❑ No
    Are the services available 24 hours a day? ❑ Yes ❑ No

15. Does the Applicant dispense medications other than free samples? ❑ Yes ❑ No
    If yes, is a pharmacist employed? ❑ Yes ❑ No
    If yes, has applicable approval been received from the State Pharmacy Board? ❑ Yes ❑ No
    If no, please explain:

16. Does the Applicant provide diagnostic imaging/X-ray services? ❑ Yes ❑ No
    If yes, does the Applicant provide any radiation therapy? ❑ Yes ❑ No
    Does the Applicant interpret results of tests performed at facilities other than those requesting insurance through this application? ❑ Yes ❑ No
    Does the Applicant contract with outside/non-owned facilities to provide diagnostic interpretations? ❑ Yes ❑ No
    If yes, please identify facility and describe contractual obligations:

Does the Applicant provide teleradiology or utilize outside teleradiology services? ❑ Yes ❑ No
If yes, please explain:

Who interprets the results of the tests performed?

Name	Specialty	Status
1.		❑ Employed ❑ Contracted
2.		❑ Employed ❑ Contracted

General Information – Annual Numbers

Clinic Visits: _____ Revenues: ($) _____ Surgeries: _____

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	____/____/_____	____/____/_____	____/____/_____	____/____/_____	____/____/_____

Coverage Information

1. Has this medical practice or entity ever had any professional liability insurance refused, cancelled, or non-renewed? ❑ Yes ❑ No
   If yes, please explain:

2. **Please identify all owners, employed and contracted physicians within your organization, and provide information concerning each member in each category listed in the following table:**

   Note: Use the following for Coverage Status (Column 5) below:
   A=Requesting individual coverage with Medical Mutual.
   B=Current individual Medical Mutual insured.
   C=Applying for coverage elsewhere or covered elsewhere.
   D=Shared Limit Coverage with entity or practice (not available to physicians or dentist)
   E=Other

1. First, Middle & Last Name	2. Degree	3. Specialty	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Coverage Status A,B,C,D, Or E (See Key Above)	6. Medical Mutual Policy Number	7. Percentage of Ownership

3. List any non-physician owners and their percentage of ownership:

Non-Physician/Non-Dentist Personnel

Do you employ or contract with any non-physician or non-dentist personnel? ❑ Yes ❑ No
If yes, please complete the following:

Nurses	_____	Pharmacists	_____	Dental Assistants/Hygienists	_____
CRNA's	_____	Nurse Practitioners	_____	Psychotherapists	_____
Nurse Midwives	_____	Physician Assistants	_____	Licensed Clinical Social Workers	_____
Podiatrists	_____	Chiropractors	_____	Anesthesia Assistants	_____
Other	_____				

If other, please specify:

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 the entity or medical practice, or have any incidents concerning professional services been reported? ❑ 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 the entity or medical practice? ❑ 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 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.

Patient's Name			
Date of Occurrence ___/___/_____	Insurance Carrier		
Location of Occurrence			
Date claim reported ___/___/_____	Date claim closed ___/___/_____	Amount reserved $	Amount paid $
Allegation:			

Patient's Name			
Date of Occurrence ___/___/_____	Insurance Carrier		
Location of Occurrence			
Date claim reported ___/___/_____	Date claim closed ___/___/_____	Amount reserved $	Amount paid $
Allegation:			

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 or Representative 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:

Are you interested in speaking with someone regarding higher limits of coverage for e-MD Network Privacy & Security Coverage and/or Broad Regulatory Protection Coverage? ❑ Yes ❑ No

Additional Comments

Question #	Comments