Medical Mutual℠
PROTECTING OUR PROFESSION

For office use only:

MEDICAL MUTUAL INSURANCE COMPANY OF NORTH CAROLINA
ENTITY PROFESSIONAL LIABILITY APPLICATION – SHARED LIMITS COVERAGE
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 bottom of this form, or attach separate documentation.**
- **Answer all questions as they pertain to the entity.**

Practice

Full Name _____

Suffix ❑ Sr. ❑ Jr. ❑ I ❑ II ❑ III ❑ IV **Professional Designation** ❑ MD ❑ DO

Web Site Address _____

Tax ID _____ **NPI**: _____

Office Manager

Full Name _____

Email _____

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:

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) Choose One Option – NOTE: LIMITS WILL BE SHARED WITH OWNER OF ENTITY

❑ $ 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

1. 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:

2. Type of Organization (select the one most appropriate).

- ❑ Solo Incorporated
- ❑ Solo Unincorporated
- ❑ Professional Corporation
- ❑ Other - describe legal entity:

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

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

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

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:

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