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MMIC Insurance, Inc.
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Healthcare Professionals Liability Application
New Business

Requested Effective Date _____

Required Documents
In addition to this application, the following information is required:

1. ☐ Loss runs, dated within 60 days of submission, covering the past ten years
2. ☐ Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. ☐ Reporting endorsement from current insurance carrier if recently purchased
4. ☐ Corporate Healthcare Professional Liability Application, if corporate coverage is desired

A. Applicant Information

Agency Name (if applicable):		MMIC Policy Number (if applicable):
Name of Applicant (First, Middle, Last):		Gender: ☐ Male ☐ Female
Applicant's Business Address (Street, City, State, Zip Code):		County:
Business Phone:	Fax:	E-mail:
Website:	Date of Birth:	Social Security Number:
Applicant's Home Address (Street, City, State, Zip Code):		
Home Phone:	Fax:	E-mail:
Mailing/Billing Address: ☐ Home ☐ Business ☐ Other (specify) Other:		Business Manager / Contact Person:
Telephone:	Fax:	E-mail:

Type of Practice: ☐ Individual ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Student ☐ Other (Specify):

Are you currently enrolled in a Patient's Compensation Fund (PCF)? ☐Yes ☐No
If yes, answer the following question and indicate the fund name.

Have you, at all times subsequent to your retroactive date, been continually qualified/covered by the state fund? ☐Yes ☐No

☐ Kansas Healthcare Stabilization Fund ☐ Nebraska Excess Liability Fund ☐ Wisconsin Patients' Compensation Fund
☐ Indiana Patients' Compensation Fund ☐ Other (specify):

Are you a member of a network, alliance or IPA? ☐Yes ☐No If yes, indicate the name:

B. Professional Occupation

Specify your professional occupation.

- ☐ Chiropractor
- ☐ Chiropractor Assistant
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Dietician or Nutritionist
- ☐ EEG/EKG Technician
- ☐ Laboratory Supervisor or Director
- ☐ Medical Office Assistant
- ☐ Medical Technician
- ☐ Midwife
- ☐ Nurse
- ☐ Nurse Aide/Homemaker
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Occupational Therapist-Aide
- ☐ Operating Room Technician
- ☐ Optician
- ☐ Optometrist
- ☐ Optometry-Assistant
- ☐ Oral Surgeon
- ☐ Orthotist/Prothetist
- ☐ Paramedic/EMT
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Pharmacy Assistant
- ☐ Physical Therapist-Employed
- ☐ Physical Therapist-Owner
- ☐ Physical Therapy-Assistant
- ☐ Physician/Surgeon Assistant
- ☐ Cert. Registered Nurse Anesthetist
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ Respiratory Therapist-Aide
- ☐ Social Worker
- ☐ X-ray Technician
- ☐ Other (specify): _____ (Describe duties in Comments section)

C. Current Coverage

Existing Form of Insurance: ☐ Occurrence ☐ Claims-made If Claims-made, what is your retroactive date? _____

Specify below insurance coverage for the past 5 years:

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

D. Requested Coverage

Limits of Liability (Limits are expressed as per claim and annual aggregate)

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $3,000,000/$5,000,000 ☐ $4,000,000/$6,000,000
☐ $5,000,000/$7,000,000 ☐ $500,000/$1,000,000 (NE only) ☐ $200,000/$600,000 (KS PCF Members Only)
☐ $250,000/$750,000 (IN PCF Members Only) ☐ Other (specify):

For Kansas PCF members only, indicate PCF limits: ☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

Requested Retroactive Date: _____

If current coverage is claims-made and you are **not** requesting prior acts coverage from MMIC, was a reporting endorsement purchased from the current carrier? ☐ Yes ☐ No
If yes, attach a copy of the reporting endorsement. If no, explain:

E. Practice Information

1. If you are employed, indicate the name of your employer:
2. If you are an independent contractor, name each entity with which you have contracted healthcare services:
3. How many hours per week are you working (include patient care, administrative duties, phone calls and teaching): _____
4. List each professional corporation, association, partnership or other healthcare related entity in which you have an ownership:

Name	Description of Interest	% of Practice

Complete one Healthcare Corporate Application for each organization listed above, if coverage is desired.

5. Do you, as an individual, employ or contract other healthcare professionals? ☐ Yes ☐ No If yes, complete the following:

Type	Number	Employment	Current Insurer	MMIC Policy # (if applicable)
Physician/Surgeon		☐ Employee ☐ Contractor		
Physician/Surgeon Assistants		☐ Employee ☐ Contractor		
Nurse Anesthetists		☐ Employee ☐ Contractor		
Nurse Midwives		☐ Employee ☐ Contractor		
Nurse Practitioners		☐ Employee ☐ Contractor		
Perfusionists		☐ Employee ☐ Contractor		
Podiatrists		☐ Employee ☐ Contractor		
Dentists		☐ Employee ☐ Contractor		

6. Do you, as an individual, employ or contract other medical professionals to provide services? ☐ Yes ☐ No
If yes, specify their profession (i.e. RN, LPN, etc.) and the number for each occupation in the Comments section.

F. Education / Training / Work Experience

1. Specify the highest level of education you have completed related to your field of practice:
☐ Non Required ☐ Bachelor's Degree ☐ Master's Degree ☐ Post-Doctorate Degree
☐ Diploma ☐ Associate's Degree ☐ Doctorate's Degree ☐ Other (specify): _____

2. School of Graduation:	City & State:	Degree:	Year of Graduation:

3. Facility name/location where internship was served: Dates:

4. Facility name/location where residency was served: Dates:

5. Are you board certified? ☐ Yes ☐ No ☐ N/A If yes, specify name of board:

6. Have you undergone additional medical training? ☐ Yes ☐ No If yes, indicate type: Dates:

7. How many hours have you completed in any continuing education for your field of practice within the last three years?

8. Have you completed additional training? ☐ Yes ☐ No If yes, answer the following:
   Type: Dates:
   Type: Dates:

9. List medical societies and professional organizations in which you are currently a member:

10. Do you prescribe drugs? ☐ Yes ☐ No If yes, what is your BNDD/DEA number: _____

11. Do you perform surgical procedures? ☐ Yes ☐ No

12. List each state where you are licensed to practice, license number and the percentage of patients seen in each state:

State	License/Certification Number	% of Patients

13. List all places where you have practiced your profession during the past 5 years:

Facility/Practice	Dates (month/year to month/year)
	to
	to
	to
	to
	to

14. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No
    If yes, describe changes:

G. Underwriting Questions

Explain any "yes" answers to the following questions in the Comments section.

1.	Are you employed full time by the Federal Government or are you in the military service?	☐ Yes ☐ No
2.	Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked?	☐ Yes ☐ No
3.	Are you aware of any complaint or investigation with respect to your license to practice, your BNDD/DEA license, your privileges or participation at or with any hospital or other medical facility?	☐ Yes ☐ No
4.	Has any hospital, medical association, medical society or medical board, HMO, licensing authority or peer review organization notified you of its intention to consider imposing any such change of status, penalties, privileges, participation, certification or membership?	☐ Yes ☐ No
5.	Have you ever been treated for alcoholism, narcotics addiction or mental illness? If yes, please attach a letter outlining dates of treatment, results of treatment and current status. This letter should be from your treating physician or institution.	☐ Yes ☐ No
6.	Do you provide any professional services to patients (including telemedicine) in states other than those listed under question F13? If yes, include states, type of service and annual number of encounters in your explanation.	☐ Yes ☐ No
7.	Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? If yes, include proof of coverage, location, and name of entity providing coverage.	☐ Yes ☐ No
8.	Has any insurer cancelled, declined coverage, refused renewal, or modified coverage (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) on an individual basis for any similar insurance? If yes, explain why and give name of carrier(s). *Missouri applicants do not answer this question.	☐ Yes ☐ No

H. Claim Information

Explain any "yes" answers to the following questions in the Comments section.

1. Have any claims or suits ever been made against you, your employees, or any professional corporation, association or partnership to which you belong or have belonged arising out of the performance of professional services rendered or which should have been rendered by you or by any person for whose acts or omissions you are legally responsible. ☐ Yes ☐ No
   If yes, indicate the number of previous and/or pending claims or suits: ____
2. Are you aware of any potential claims including alleged injury, incidents, or circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? This includes your knowledge of any facts that could reasonably lead to a claim or suit. ☐ Yes ☐ No
   If yes, please attach copies of your claim notification letters sent to your current or prior professional liability carrier for each potential claim.
3. Are you aware of any claims, suits, or potential claims that have not been reported to your current or prior professional liability insurance carrier? ☐ Yes ☐ No

Please complete the Prior Claim/Suit Information Addendum for each claim, suit, or potential claim identified above. Make additional copies as needed. Do not include claims with MMIC.

I. Comments

Section & Question	Explanation

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects the person to criminal and civil penalties.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If this policy is issued on a claims-made basis, the policy will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: I authorize access by and release to MMIC Insurance, Inc. of any and all information pertaining to underwriting and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: MMIC Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of MMIC Insurance, Inc. to discuss any such information within its committees and boards and to communicate conclusions relating thereto Applicant and administrative or executive personnel of his or her employer or prospective employer.

APPLICANT ACKNOWLEDGEMENT: I hereby certify the foregoing information is true and correct and that any and all claims or potential claims have been reported to my current carrier. I understand that, if granted prior acts coverage by MMIC Insurance, Inc., no insurance will be provided for any claim, suit or potential claim known at the effective date that has or has not been reported to another insurance carrier.

Signature of Applicant

Date