

Healthcare Professionals Liability Application New Business

Requested Effective Date

Required Documents

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

- I. 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:	Social Security Number:						
Applicant's Home Address (Street, City, State, 2	Zip Code):						
Home Phone:	Home Phone: Fax:		E-mail:				
Mailing/Billing Address: Home Busines	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 Physical Therapist Physical Therapy-/ Physician/Surgeon Cert. Registered N Podiatrist Psychologist Respiratory Thera Social Worker X-ray Technician Other (specify): (Describe duties in 	-Owner Assistant Assistant Nurse Anesthetist				

C. Current Coverage								
Existing Form of Insurance: Occurrence Claims-made If Claims-made, what is your retroactive date?								
Specify below insurance coverage	•							
Carrier name	Policy	# Coverage Date		verage Dates	s	Limits		Retroactive Date
D. Requested Coverage			<u> </u>					
Limits of Liability (Limits are expr \$1,000,000/\$3,000,000 \$5,000,000/\$7,000,000 \$250,000/\$750,000 (IN PCF N For Kansas PCF members only, in] \$2,000,000/\$] \$500,000/\$ I 1embers Only	\$4,000,000 ,000,000 ()) (NE only)	□ \$3,) □ \$20 □ Oth	00,000/ her (sp		S PCF Memb	000,000/\$6,000,000 bers Only)] \$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?YesNo If yes, attach a copy of the reporting endorsement. If no, explain:								
E. Practice Information								
I. If you are employed, indicate t	he name of yo	our employ	yer:					
2. If you are an independent cont	-		·	hich you hav	/e cont	racted healtl	ncare service	s:
3. How many hours per week ar								
4. List each professional corpora	tion, associatio	on, partne					in which you	
Name				Descriptio	n of In	terest		% of Practice
Complete one Health	care Corpora	te Applic	ation fo	r each orga	nizatio	on listed abo	ove, if cover	age is desired.
5. Do you, as an individual, emplo	oy or contract	other he	althcare	professionals	s?	Yes 🗌 No	If yes, com	plete the following:
Туре	Number	E	mployr	ment	Cu	ırrent Insu	rer	MMIC Policy # (if applicable)
Physician/Surgeon			oyee 🗌	Contractor				
Physician/Surgeon Assistants			oyee 🗌	Contractor				
Nurse Anesthetists Nurse Midwives			oyee	Contractor				
Nurse Practitioners			oyee 🗌	Contractor				
Perfusionists	1		oyee	Contractor				
Podiatrists			oyee	Contractor				
Dentists			oyee	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 edu	I. Specify the highest level of education you have completed related to your field of practice:							
Image: Second state in the								
2. School of Graduation:	Sociale 3 De	City & S			-		viner (specil)	/): Year of
			iale.		Degre			Graduation:
APHP001 07/2024			2				Н	ealthcare Professionals Application

3. Facility name/location where internship	Dates:			
4. Facility name/location where residency was served: Data				
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	n any continuing education for your field of prac	tice within the last three years?		
8. Have you completed additional training?	Yes No If yes, answer the following			
Туре:	Dates:			
Туре:	Dates:			
9. List medical societies and professional or	rganizations in which you are currently a member	er:		
	No If yes, what is your BNDD/DEA number:			
, 1 6 1	Yes No			
12.List each state where you are licensed to	o practice, license number and the percentage c	•		
State	License/Certification Number	% of Patients		
13. List all places where you have practiced	I your profession during the past 5 years:			
Facilit	y/Practice	Dates (month/year to month/year)		
		to		
		to		
		to		
<u> </u>		to to		
, , , ,	ctice or specialty during the past five years?	to		
14. Has there been any change in your prac If yes, describe changes:	ctice or specialty during the past five years?	to to		
If yes, describe changes:	ctice or specialty during the past five years?	to to		
If yes, describe changes: G. Underwriting Questions		to to		
If yes, describe changes:		to to		
If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following 1. Are you employed full time by the Fed	questions in the Comments section. leral Government or are you in the military serv	to to Yes 🗌 No		
If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following 1. Are you employed full time by the Fed	questions in the Comments section.	to to Yes 🗌 No		
If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following 1. Are you employed full time by the Fed 2. Has your license or certification ever by probation been invoked? 3. Are you aware of any complaint or involution	questions in the Comments section. leral Government or are you in the military serv been suspended, restricted, revoked, or volunta restigation with respect to your license to pract	to to Yes No ice? Yes No rily surrendered, or has Yes No ce, your BNDD/DEA Yes No		
If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following I. Are you employed full time by the Fed 2. Has your license or certification ever by probation been invoked? 3. Are you aware of any complaint or involucense, your privileges or participation	questions in the Comments section. leral Government or are you in the military service been suspended, restricted, revoked, or volunta	to to Yes No ice? Yes No rily surrendered, or has Yes No ce, your BNDD/DEA ? Yes No		
 If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following Are you employed full time by the Fed Has your license or certification ever the probation been invoked? Are you aware of any complaint or involucense, your privileges or participation to review organization notified you of its 	questions in the Comments section. leral Government or are you in the military service been suspended, restricted, revoked, or volunta restigation with respect to your license to pract in at or with any hospital or other medical facility medical society or medical board, HMO, licensin intention to consider imposing any such change	to to Yes No ice? Yes No rily surrendered, or has Yes No ce, your BNDD/DEA Yes No g authority or peer		
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 If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following Are you employed full time by the Fed Has your license or certification ever the probation been invoked? Are you aware of any complaint or involucense, your privileges or participation of the second second	questions in the Comments section. leral Government or are you in the military service been suspended, restricted, revoked, or voluntativestigation with respect to your license to pract to at or with any hospital or other medical facility medical society or medical board, HMO, licensing intention to consider imposing any such change r membership? Dism, narcotics addiction or mental illness? dates of treatment, results of treatment and cu	to to Yes No Yes No ice? Yes No rily surrendered, or has Yes No ce, your BNDD/DEA Yes No g authority or peer of status, penalties, Yes No rrent status. This letter Yes No		
 If yes, describe changes: G. Underwriting Questions Explain any "yes" answers to the following Are you employed full time by the Fed Has your license or certification ever the probation been invoked? Are you aware of any complaint or involucense, your privileges or participation to review organization notified you of its privileges, participation, certification on formation of the probate and the provide and the provide any professional service 	questions in the Comments section. leral Government or are you in the military service been suspended, restricted, revoked, or voluntativestigation with respect to your license to pract to at or with any hospital or other medical facility medical society or medical board, HMO, licensing intention to consider imposing any such change r membership?	to to Yes No Yes No ice? Yes No rily surrendered, or has Yes No ce, your BNDD/DEA Yes No ce, your BNDD/DEA Yes No rent status, penalties, Yes No rrent status. This letter Yes No other than those listed		
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H. Claim Information

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

Ехр	bain any yes answers to the following questions in the Comments section.	
Ι.	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. If yes, indicate the number of previous and/or pending claims or suits:	🗌 Yes 🗌 No
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. If yes, please attach copies of your claim notification letters sent to your current or prior professional liability carrier for each potential claim.	🗌 Yes 🗌 No
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
	ase complete the Prior Claim/Suit Information Addendum for each claim, suit, or potential claim id ove. Make additional copies as needed. Do not include claims with MMIC.	lentified
	Comments	
Sec	ction F urle seties	
& (Question Explanation	

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another

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

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Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Insurance Guaranty Association Law

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association 4640 West 77th Street, Suite 342 Edina, Minnesota 55436 (952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.