Curi

**MMIC Insurance, Inc.**
**curi.com**

# Physicians And Surgeons Professional 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) | ☐ MD ☐ DO ☐ Other Specify Other: | 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 ☐ Intern/Resident ☐ Fellowship ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ 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. 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## C. 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:

## D. 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. 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.***

4. If you, as an individual, employ or contract physicians or surgeons, complete the following:

| Employee or Contractor Name | Specialty* | Category* (1 through 5) (see question F3) | Procedures Performed* (see question F4) | Policy # (if insured by MMIC) | Limit of Liability |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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*Not necessary to complete if insured by MMIC.

5. If you, as an individual, employ or contract other medical professionals, complete the following:

| Type | Number | Employment | Current Insurer | MMIC Policy # (if applicable) |
|---|---|---|---|---|
| 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 | | |
| RNs/LPNs/LVNs | | ☐ Employee ☐ Contractor | | |
| Other (describe): | | ☐ Employee ☐ Contractor | | |

## E. Education / Training / Work Experience (If a CV is attached, proceed to question E5.)

| 1. School of Graduation: | City & State: | Year of Graduation: |
|---|---|---|

2. If you are a foreign medical school graduate, have you obtained an ECFMG certificate? ☐ Yes ☐ No ☐ N/A

Indicate which certification you obtained and the year certified: ☐ ECFMG ☐ Fifth Pathway Year Certified:

3. Facility name and location where internship was served: _____

Specialty: Dates:

4. Facility name and location where residency was served: _____

Specialty: Dates:

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

6. What is your medical specialty? What is your medical sub-specialty?

7. Are you certified by an approved specialty board? ☐ Yes ☐ No If yes, certifying board name(s): _____

Date(s) of initial certification: _____ Date(s) of recertification: _____

8. If you are not certified, are you board eligible? ☐ Yes ☐ No If yes, date eligibility expires:

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

| State | License Number | % of Patients |
|---|---|---|
| | | |
| | | |
| | | |

10. Indicate the name and location of all facilities, including nonhospital facilities, where you hold staff or courtesy privileges:

| Name/Location | Name/Location |
|---|---|
| | |
| | |
| | |

11. 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 |

12. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No

If yes, describe changes:

## F. Classification

1. Indicate the percentage of time devoted to the following medical and/or surgical activities: (Total should equal 100%)

**Percentage (Non-Surgical)**

_____ Administrative Medicine
_____ Aerospace Medicine
_____ Allergy
_____ Anesthesiology
_____ Broncho-Esophagology
_____ Cardiovascular Disease
_____ Dermatology
_____ Diabetes
_____ Emergency Medicine
_____ Endocrinology
_____ Family Practice/General Practice
_____ Fetal and Maternal Medicine
_____ Forensic Medicine
_____ Gastroenterology
_____ General Preventive Medicine
_____ Genetic Counseling
_____ Geriatrics
_____ Gynecology
_____ Hematology
_____ Hospitalist
_____ Hypnosis
_____ Infectious Diseases
_____ Intensive Care Medicine
_____ Internal Medicine
_____ Laryngology
_____ Legal Medicine
_____ Neonatology
_____ Neoplastic Diseases

**Percentage (Non-Surgical)**

_____ Nephrology
_____ Neurology
_____ Nuclear Medicine
_____ Nutrition
_____ Obstetrics/Pre-Natal Care
_____ Occupational Medicine
_____ Oncology
_____ Ophthalmology
_____ Orthopedics
_____ Otology
_____ Otorhinolaryngology
_____ Pain Management*
_____ Pathology
_____ Pediatrics
_____ Pharmacology-Clinical
_____ Physiatry
_____ Physical Medicine/Rehabilitation
_____ Psychiatry
_____ Psychoanalysis
_____ Psychosomatic Medicine
_____ Public Health
_____ Pulmonary Diseases
_____ Radiology
_____ Rheumatology
_____ Rhinology
_____ Sports Medicine
_____ Weight Reduction/Control*
_____ Other*

**Percentage (Surgical)**

_____ Abdominal
_____ Bariatric
_____ Cardiac
_____ Cardiovascular
_____ Colon & Rectal
_____ Dermatology
_____ Endocrinology
_____ Foot and Ankle
_____ Gastroenterology
_____ General
_____ Geriatrics
_____ Gynecology
_____ Hand
_____ Head & Neck
_____ Laryngology
_____ Neonatal
_____ Nephrology
_____ Neurosurgery
_____ Obstetrics
_____ Obstetrics-Gynecology
_____ Ophthalmology
_____ Orthopedic excluding Spinal Surgery
_____ Orthopedic including Spinal Surgery
_____ Otorhinolaryngology
_____ Plastic
_____ Plastic-Otorhinolaryngology
_____ Thoracic
_____ Traumatic
_____ Urological
_____ Vascular
_____ Other*

*Describe in Comments section.

2. Do you perform obstetrical procedures? ☐ Yes ☐ No If yes, answer the following questions:

Average number of deliveries you perform annually: Number of c-sections: Number of VBACs:

3. Indicate each of the following that you perform. Check **each** box that applies.

☐ **Category 1** No surgical procedures performed other than incision of boils and superficial abscess, suturing of skin and superficial fascia or circumcision.

☐ **Category 2** Assist in surgery on your own patients and/or perform minor surgical procedures.

☐ **Category 3** Obstetrical procedures and/or prenatal care beyond the first trimester not including c-sections.

☐ **Category 4** All other types of surgery and operations performed under general or regional anesthesia.
Number of surgeries performed annually: _____

☐ **Category 5** Administration of anesthesia (other than local)

4. Please check the following medical procedures you perform:

☐ Autologous Fat Injection
☐ Angiography
☐ Arteriography
☐ Botox Injections
☐ Catheterization – arterial, cardiac, or diagnostic, other than:
  a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.
  b. Urethral catheterization
  c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gasses in newborns receiving oxygen.
☐ Chelation therapy
☐ Closed fracture reduction – other than fingers or toes
☐ Colonoscopy
☐ Cryosurgery – other than use on benign or premalignant dermatological lesions
☐ Conscious sedation
☐ D & C performed under local anesthesia
☐ Discograms
☐ ECT (describe): _____
☐ Epidurals
☐ ERCP (Endoscopic Retrograde Cholangiopancreatography)
☐ Lasers (describe)
☐ Laparoscopy
☐ Lymphangiography
☐ Liposuction
☐ Pneumoencephalography
☐ Pneumatic or mechanical esophageal dilation (not with buogie or olive)
☐ Needle biopsy (describe)
☐ Myelography
☐ Radiation therapy
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
☐ Vasectomies
☐ Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation (describe)

☐ **NONE OF THE ABOVE**

## G. Underwriting Questions

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

| | | |
|---|---|---|
| 1. | Do you staff an emergency room for purposes other than to maintain hospital privileges? If yes, include hospital name, location, number of hours per month and relationship in your explanation. | ☐ Yes ☐ No |
| 2. | Do you practice in or staff an urgi-center or similar minor emergency clinic? | ☐ Yes ☐ No |
| 3. | Do you perform surgery or obstetrical procedures at a location other than a licensed hospital? If yes, include location and distance (travel time) to the nearest hospital in your explanation. | ☐ Yes ☐ No |
| 4. | Are you employed full time by the Federal Government or are you in the military service? | ☐ Yes ☐ No |
| 5. | Are you engaged in any "moonlighting" activities? If yes, indicate the number of hours per month: | ☐ Yes ☐ No |
| 6. | Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? | ☐ Yes ☐ No |
| 7. | Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? If so, please complete a Healthcare Facilities Application. | ☐ Yes ☐ No |
| 8. | Do you render patients unconscious for treatment in your office or other nonhospital facility? | ☐ Yes ☐ No |
| 9. | Do you provide professional services on behalf of a professional sporting team? If yes, include name of team, percentage of practice and relationship in your explanation. | ☐ Yes ☐ No |
| 10. | Are you employed or contracted by any facility as a medical director or similar role? If yes, include name of facility in your explanation. | ☐ Yes ☐ No |
| 11. | Do you perform utilization review services for a fee for others? | ☐ Yes ☐ No |
| 12. | Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked? | ☐ Yes ☐ No |
| 13. | Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? | ☐ Yes ☐ No |
| 14. | 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 |

| | | |
|---|---|---|
| 15. | 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 |
| 16. | Have you ever been denied a medical license or been denied certification by a specialty board? | ☐ Yes ☐ No |
| 17. | Have you ever been treated for alcoholism, narcotics addiction or mental illness?<br>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 |
| 18. | Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program? | ☐ Yes ☐ No |
| 19. | Do you provide any diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed under question E9?<br>If yes, include states, type of service and annual number of encounters in your explanation. | ☐ Yes ☐ No |
| 20. | Do you work part-time? If yes, indicate number of hours worked per week providing patient care, hospitals rounds, administrative duties, phone calls and teaching: | ☐ Yes ☐ No |
| 21. | 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 |
| 22. | 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?<br>If yes, explain why and give name of carrier(s). *Missouri applicants do not answer this question. | ☐ Yes ☐ No |
| 23. | Have you ever practiced without professional liability insurance? | ☐ Yes ☐ No |
| 24. | Do you use an electronic healthcare records (EHR) system?<br>If yes, please complete the EHR Supplemental Application. | ☐ 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.<br>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.<br>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 |

**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 |
|---|---|
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**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

# 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.