Curi

Underwritten by a Curi company:

MMIC Insurance, Inc. | UMIA Insurance, Inc.
Arkansas Mutual Insurance Company
MMIC Risk Retention Group, Inc.

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PHYSICIAN RENEWAL QUESTIONNAIRE

A. Applicant Information

Name:			Last 4 SSN:
NPI Number:		Policy Number:	
Company Email Address:		Personal Email Address:	
Home Address:			Phone Number:
City:	State:	County:	ZIP Code:
Billing Address (if different from above):			
Practice Manager/Primary Contact Name:		Phone Number:	Email Address:
Practice Address:		Phone Number:	Website:
Agency:		Agent:	☐ Not Applicable

B. Practice Information

1. List all practice locations and practice states where you will be working (hospitals, offices, and others including DBAs):

2. Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? ☐ Yes ☐ No
   If yes, include proof of coverage, location, and name of entity providing coverage

3. List all professional corporations, associations, partnerships, or other health-care-related entities in which you have ownership.

Name:	Description of Interest:	% Ownership	% of Practice

4. Are you a Medical Director or Trustee at any facilities? If yes, a medical director supplement may be requested.	☐ Yes ☐ No

5. Do you own or have an agreement/contract to provide care at:

- ☐ Correctional Facility
- ☐ In-Home Health
- ☐ Nursing Home
- ☐ Emergency Department
- ☐ Mobile Health Services
- ☐ Other:

C. General Information – If yes, please provide an explanation on page 5 in the Comments section.

1. Have you ever had your membership in any professional society, professional association or regulatory board refused, suspended, revoked, or ever received any criticism or reprimand from any professional society?	☐ Yes ☐ No
2. Have you ever voluntarily surrendered or had any professional license or permit to dispense narcotics or privileges at a hospital, investigated, restricted, refused, suspended, revoked, or placed under probation?	☐ Yes ☐ No
3. Have you ever been sanctioned or terminated from the Medicare or Medicaid program, or any other non-governmental health plan?	☐ Yes ☐ No
4. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	☐ Yes ☐ No
5. In the past 10 years, have you been implicated in, plead guilty to, or been convicted of a criminal offense other than traffic offenses?	☐ Yes ☐ No

D. Professional Liability History

1. Have there been any changes in your practice or specialty? If yes, describe changes: _____	☐ Yes ☐ No

2. Check all of the following that you perform.

- ☐ **No Surgery** – Includes incision of boils and superficial abscess or suturing of skin or superficial fascia.
- ☐ **Minor Surgery** – Includes obstetrical procedures not constituting major surgery or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered major surgery.
- ☐ **Major Surgery** – Includes operations in or upon any body cavity including, but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life.

3. Are you doing clinical research? If yes, please explain: _____	☐ Yes ☐ No
4. Are you doing any non-FDA-approved procedures? If yes, please list procedures: _____	☐ Yes ☐ No
5. Do you perform any home or birthing center deliveries? If yes, how many annual births: _____	☐ Yes ☐ No

6. Are you engaged in any moonlighting activities? If yes, please list where and how many hours: _____	❑ Yes ❑ No
7. Do you work part time? If yes, a part-time supplement may be requested.	❑ Yes ❑ No
8. Do you practice any forms of alternative medicine (e.g., Ayurvedic, Chiropractic, Chinese Holistic, Homeopathic, or Naturopathic)? If yes, please list: _____	❑ Yes ❑ No
9. Do you treat or will you treat celebrities or professional athletes? If yes, list who you will work for: _____	❑ Yes ❑ No
10. Do you work in an emergency room for other than your own patients? If yes, indicate average number of hours worked per week? _____	❑ Yes ❑ No
11. Do you perform weight control surgery? If yes, a bariatric supplement may be requested.	❑ Yes ❑ No
12. Do you perform telemedicine services? If yes, a telemedicine supplement may be requested.	❑ Yes ❑ No

E. Staff

1. Total number of full-time employees: _____
2. Total number of part-time employees: _____
3. Total number of contracted individuals: _____
4. Please list all staff including: physicians, mid-level providers, directors, officers, trustees, dentists, and resident physicians. Additional space on page 5 if needed.

Provider Name (MD, CRNA, etc.)	Specialty	Hours Worked	Employment Status*	Coverage Requested (Y/N)	Prior Acts Date	Hire Date

A separate healthcare provider application could be required for each new physician, mid-level provider, and dentist.

Employment Status:*

- Employee (E)
- Contracted (C)

Additional information may be requested.

PATIENT'S COMPENSATION FUND

Are you currently enrolled in a Patient's Compensation Fund (PCF)?	❑ Yes ❑ No
Have you, at all times subsequent to your retroactive date, been continually qualified/covered by the state fund? If yes, indicate name of fund:_____	❑ Yes ❑ No

INSURANCE FRAUD WARNINGS

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other 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.

TENNESSEE AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is fraudulent or material to our interests or the policy, then we may take action, including denying coverage for a claim or other covered event or rescinding, canceling, or non-renewing the policy or coverage. It is understood that misstatements, misrepresentations, omissions or concealments on the part of the insured are not fraudulent unless made with intent to knowingly defraud.

IN ALL STATES OTHER THAN THOSE LISTED ABOVE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading information concerning any fact material there to, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

ADDITIONAL COMMENTS

NOTICE AND AGREEMENTS

ARIZONA: I understand all statements and descriptions in any application for an insurance policy or in negotiations therefor, by or in behalf of me, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless: Fraudulent; Material either to the acceptance of the risk, or to the hazard assumed by the insurer; The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

IN ALL STATES OTHER THAN THOSE LISTED ABOVE: **:** I hereby declare that the above statements/responses made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of this application are true and I agree that this application, and any Attachments, shall be the basis of the contract with one of the following companies depending on admitted states, MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. I agree to notify MMIC Insurance Inc, UMIA Insurance Inc, or Arkansas Mutual Insurance Company Inc. if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in professional specialty, scope of practice, new contract, new location, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any intentional material misrepresentation or intentional omission made by me on this application, may act to render any contract of insurance null and without effect. I understand that if I fail to comply with these terms, I may have no coverage for any claim under any policy of insurance for which I am applying. I also understand that MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance.

Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to one of the following companies depending on admitted states, MMIC Insurance Inc, UMIA Insurance Inc, Arkansas Mutual Insurance Company Inc. any information regarding me, which MMIC Insurance Inc, UMIA Insurance Inc, or Arkansas Mutual Insurance Company Inc., in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I represent that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations. I agree that a copy of my signature may be relied upon as if it were the original. My signing of this application does not bind the insurance company to sell nor does it bind the applicant to purchase the insurance.

Authorized Signature: _____ Date: _____

Print Name: _____

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