

CORPORATE HEALTHCARE

MEDICAL PROFESSIONAL LIABILITY

APPLICATION



MMIC® Insurance, Inc.
curi.com

Check applicable box:

- ☐ New Applicant or
☐ Add to existing Curi policy number: _____

Requested Effective Date: _____

Application Instructions

- Please print or type all responses clearly and answer all questions as instructed.
- If you need more space than is given, continue in the Comments section at the end of the application or attach a separate document.
- Coverage will not be bound until this application is completed and signed and all required documents are provided.

Required Documents

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

- Prior carrier Claim History **for all risks** requesting coverage for the past ten (10) years dated within sixty (60) days of the application submission date
- Declarations page or COI from current insurance carrier, including prior acts date if claims-made coverage
- Organizational Ownership Chart reflecting all legal entities and DBAs
- Risk Management Program and/or Quality Improvement Plan
- Roster of current Employed and Contracted Providers as specified in G3 and include COI for any provider not requesting coverage
- Obstetrical Services Underwriting Questionnaire if obstetrical services are provided

A. BROKER INFORMATION

Broker Office:	Producer:
Mailing Address:	
Producer Email Address:	Phone:

B. APPLICANT INFORMATION

Applicant (Legal Name):			
Mailing c/o or Attn, if applicable:			
Mailing Address:			
Billing Address:			
Physical Address:			
Tax ID:	NPI:	County:	
License #:	Website:		
Administrator:	Phone:	Email:	
Risk Manager:	Phone:	Email:	
Claim Contact:	Phone:	Email:	
Medical Director:	Phone:	Email:	
Type of Legal Entity (check all that apply):			
<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other (specify):			
<input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Nonprofit <input type="checkbox"/> Professional Corporation/Association (PC or PA)			
1. Are there any healthcare provider owners that are not requesting coverage? If yes, list here:			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the Applicant have subsidiaries? If yes, complete the table below.			<input type="checkbox"/> Yes <input type="checkbox"/> No
If coverage is desired, complete one Corporate Healthcare Medical Professional Liability Application for each entity.			

Subsidiary Legal Entity Name	Description of Operations	% of Ownership*	Date Acquired or Formed	Current Carrier	Is coverage desired?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

**If a subsidiary is not 100% owned by the Applicant, list owners and percentage of ownership in the Comments section.*

3. Does Applicant operate under any other name including DBAs? ☐ Yes ☐ No If yes, specify below.

4. List all accreditations and certifications:

C. PRACTICE INFORMATION

1. Provide a description of operations:

2. Does the Applicant own or operate any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Imaging / X-Ray Center | <input type="checkbox"/> Psychiatric/Substance Abuse Center |
| <input type="checkbox"/> Embryo Storage | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Surgery Center |
| <input type="checkbox"/> Emergency/Urgent Care Center | <input type="checkbox"/> Medi Spa | <input type="checkbox"/> Trauma Center |
| <input type="checkbox"/> Free Clinic | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Weight Loss Center |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Pharmacy | |

3. List below all practice locations.

Location Address	City and State

D. COVERAGE REQUESTED

1. Limits of Liability (limits are expressed as per claim/aggregate):

- ☐ \$1,000,000/\$3,000,000 ☐ Other (specify):

2. Limit structure: ☐ Separate Limits or ☐ Shared Limits (shared with providers on the policy)

3. Coverage Type: ☐ Claims-Made ☐ Occurrence ☐ Other (specify):

If claims-made, answer the following questions.

Is prior acts coverage being applied for? ☐ Yes ☐ No Prior Acts (Retroactive) Date:

If yes, attach a copy of the current carrier declaration page or COI showing the prior acts date.

If no, was an extended reporting period (tail coverage) purchased from current carrier? ☐ Yes ☐ No

If no, explain:

For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless Applicant is approved by us for Prior Acts coverage.

E. CURRENT COVERAGE

Specify below insurance information for the past ten (10) years starting with Applicant's most recent carrier.

Coverage Dates	Carrier	Limits of Liability	Form Type CM or Occ	Prior Acts Date if CM

1. Has any insurer cancelled, declined coverage, refused renewal, or modified coverage (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) for similar insurance? ☐ Yes ☐ No
If yes, explain why and give name of carrier(s). *Missouri applicants do not answer this question.

2. Has Applicant ever had a lapse in coverage or not carried insurance? If yes, explain below: ☐ Yes ☐ No

3. Has Applicant previously had coverage with a Curi underwriting company listed below*? ☐ Yes ☐ No
If yes, list policy number:
*Arkansas Mutual Insurance Company, MMIC Insurance, Inc., MMIC Risk Retention Group, Inc., Medical Mutual Insurance Company of North Carolina, Medical Security Insurance Company, MPIE, UMIA Insurance, Inc.

F. PATIENT COMPENSATION FUNDS (PCF)

1. Is Applicant currently enrolled in a Patient Compensation Fund (PCF)? If yes, answer the following questions. If no, proceed to the next section. ☐ Yes ☐ No

2. Subsequent to Applicant's prior acts date, has the Applicant and all eligible employees been continuously covered/qualified under the PCF? ☐ Yes ☐ No
If no, explain:

3. Specify the state and name of the fund:

G. STAFFING

1. Provide the total number of employees, including non-medical staff:

2. Specify number of employed and contracted medical professionals listed below working on behalf of the Applicant.

Type	Employed	Contracted	Type	Employed	Contracted
Physicians (MDs & DOs)			Dentists		
Residents			Oral Surgeons		
Interns & Externs			Heart/Lung Perfusionists		
CRNA's			Psychotherapists		
Certified Nurse Midwives			Clinical Social Workers		
Podiatrists			Nurse Practitioners		
Chiropractors			Physician Assistants		

3. **Please complete a Curi Corporate Healthcare Provider Roster (spreadsheet) for all providers listed above. Or provide your own roster and include the following information.**

- Full Name (First, Middle Initial, Last), Designation, Gender, Date of Birth, Email, Home Address
- Social Security Number, NPI Number, State Medical License Number(s)
- Medical Specialty and Surgical Category (No Surgical Procedures, Minor Surgical Procedures or Surgery)
- Employment Status (employed, contracted, owner). If owner, % of ownership.
- Hours worked for any part-time providers, including date when part-time work began
- Prior Acts Date (if claims-made)
- Specify if coverage is desired and limits. If coverage is not desired, specify carrier, limits and include COI.

4. Specify number of employed and contracted medical professionals listed below working on behalf of the Applicant.

Type	Employed	Contracted	Type	Employed	Contracted
Anesthesia Assistants			Psychologists		
EMTs/Paramedics			RN/LPN/LVN		
Estheticians			Speech Therapists		
Laboratory Technicians			Social Workers		
Occupational/Physical Therapists			Surgical Assistants		
Optometrists			X-Ray Technicians		
Pharmacists			Other:		

H. QUALITY ASSURANCE & RISK MANAGEMENT

Explain any "no" responses in the Comments section.

1. Does the Applicant have a comprehensive risk management program in place to reduce liability, enhance patient safety and ensure regulatory compliance? ☐ Yes ☐ No

2. Is there an ongoing program for quality assessment and continuous improvement of clinical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is there a formal peer review process to evaluate and improve the performance of providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are all providers' credentials and previous employment histories thoroughly verified before hiring?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are criminal background checks, including screenings for sexual offenses, conducted for all providers at both the state and national levels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are new providers closely supervised or proctored during their initial clinical work to ensure competency?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I. UNDERWRITING QUESTIONS

In answering the following questions, consider all employed and contracted providers working on behalf of the Applicant today and within the past five (5) years. Explain all "yes" responses in the Comments section.

1. Does the Applicant contract with a third party to provide professional services on behalf of the Applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the Applicant permit outside providers to use the Applicant's premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are any providers performing duties beyond the scope of their responsibilities for the Applicant, for which coverage is being requested under this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are any providers working on behalf of a separate organization in a role such as administrator, medical director, officer, or a similar position, where coverage is being requested under this policy? If yes, include organization name, description of services provided and percentage of practice.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Applicant employ or contract with a sports team physician for any high school, college, university, semi-professional or professional team? If yes, include team name, percentage of practice and contractual relationship in your explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the Applicant or any of its providers use telehealth to provide services? If yes, answer the following questions. a) Specify the percentage of overall practice that utilizes telehealth services: b) What types of services are offered? c) Does the Applicant offer these services to patients in states outside of your primary practice location? If yes, list each state: d) Is the Applicant and all providers compliant with state licensing requirements for telehealth services in the state where providers are located and each state where patients reside?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does the Applicant or any of its providers offer services at a correctional institution, including jail, prison or state psychiatric facility? If yes, include facility name and percentage of practice in your explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the Applicant or any of its providers offer services at a senior living, nursing home or long-term care facility? If yes, include facility name and percentage of practice in your explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Does the Applicant or any of its providers currently utilize or plan to utilize any novel or experimental medical procedures, treatments, devices or technologies in your practice? This may include the use of non-FDA approved devices or medications. If yes, please provide details on the procedures, including the type, purpose and any relevant clinical trials or regulatory approvals.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do any of the Applicant's providers act as an expert witness or litigation consultant, for which coverage is being requested under this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does the Applicant or any of its providers store and/or dispense controlled substances? If yes, answer the following questions: a) List types of controlled substances: b) Is the Applicant and providers in compliance with all applicable state regulations, including state pharmacy laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Do any of the Applicant's providers write prescriptions for compounded medications or is medication compounded on site? If yes, explain in Comments section including types of medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Do any of the Applicant's providers perform Independent Medical Examinations or Aviation Medical Exams on behalf of the Applicant? If yes, include percentage of practice in your explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No

L. NOTICES, STATEMENTS AND ACKNOWLEDGEMENTS

APPLICATION: All application information is considered important. Signing this application does not bind insurance. We must review and formally approve or reject the application.

FRAUD WARNING/STATEMENT: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information on an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines and denial of insurance benefits. Refer to the State Fraud Warning Notices document for your state specific fraud warning notice which will replace this notice, if applicable.

CLAIMS-MADE AND REPORTED DISCLOSURE: If any portion of the policy is issued on a claims-made and reported basis, such portions will apply only to claims first made against you during the policy period arising out of the performance of professional services occurring on or after the prior acts date shown on the policy. Claims must be reported to us during the policy period or under an extended reporting period endorsement.

PRIVACY STATEMENT: We may communicate the results of the application to your authorized representative. To review detailed information on how we collect and use your personal information, visit the company website at curi.com.

APPLICANT ACKNOWLEDGEMENT: Applicant declares this information, including any provider roster, is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this application. Applicant acknowledges the applicable state fraud warning notice as shown on the State Fraud Warning Notices document.

PRIOR ACTS ACKNOWLEDGEMENT: All claims or potential claims have been reported to the Applicant's current or prior carrier. The Applicant understands the company will not provide coverage for any claim, suit or potential claim known on the effective date.

Applicant Signature

Title

Date

Print Signature

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
Edina, Minnesota 55435
(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.