# CORPORATE HEALTHCARE
## MEDICAL PROFESSIONAL LIABILITY APPLICATION

**Medical Mutual Insurance Company of North Carolina**

**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: | License #: | 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):**

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other (specify):

☐ Limited Liability Company ☐ Nonprofit ☐ Professional Corporation/Association (PC or PA)

| | |
|---|---|
| **1.** Are there any healthcare provider owners that are not requesting coverage? If yes, list here: | ☐ Yes ☐ No |
| **2.** Does the Applicant have subsidiaries? If yes, complete the table below. | ☐ Yes ☐ 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? |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ 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?

☐ Blood Bank
☐ Embryo Storage
☐ Emergency/Urgent Care Center
☐ Free Clinic
☐ Home Health Care
☐ Imaging / X-Ray Center
☐ Laboratory
☐ Medi Spa
☐ Nursing Home
☐ Pharmacy
☐ Psychiatric/Substance Abuse Center
☐ Surgery Center
☐ Trauma Center
☐ Weight Loss Center

**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?<br>If no, explain: | ☐ Yes ☐ No |

**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? | ☐ Yes ☐ No |
| **3.** | Is there a formal peer review process to evaluate and improve the performance of providers? | ☐ Yes ☐ No |
| **4.** | Are all providers' credentials and previous employment histories thoroughly verified before hiring? | ☐ Yes ☐ No |
| **5.** | Are criminal background checks, including screenings for sexual offenses, conducted for all providers at both the state and national levels? | ☐ Yes ☐ No |
| **6.** | Are new providers closely supervised or proctored during their initial clinical work to ensure competency? | ☐ Yes ☐ 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? | ☐ Yes ☐ No |
| **2.** | Does the Applicant permit outside providers to use the Applicant's premises? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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?<br>If yes, include organization name, description of services provided and percentage of practice. | ☐ Yes ☐ No |
| **5.** | Does the Applicant employ or contract with a sports team physician for any high school, college, university, semi-professional or professional team?<br>If yes, include team name, percentage of practice and contractual relationship in your explanation. | ☐ Yes ☐ No |
| **6.** | Does the Applicant or any of its providers use telehealth to provide services?<br>If yes, answer the following questions.<br>a) Specify the percentage of overall practice that utilizes telehealth services:<br>b) What types of services are offered?<br>c) Does the Applicant offer these services to patients in states outside of your primary practice location? If yes, list each state:<br>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? | ☐ Yes ☐ No<br><br><br><br>☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| **7.** | Does the Applicant or any of its providers offer services at a correctional institution, including jail, prison or state psychiatric facility?<br>If yes, include facility name and percentage of practice in your explanation. | ☐ Yes ☐ No |
| **8.** | Does the Applicant or any of its providers offer services at a senior living, nursing home or long-term care facility?<br>If yes, include facility name and percentage of practice in your explanation. | ☐ Yes ☐ 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.<br>If yes, please provide details on the procedures, including the type, purpose and any relevant clinical trials or regulatory approvals. | ☐ Yes ☐ 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? | ☐ Yes ☐ No |
| **11.** | Does the Applicant or any of its providers store and/or dispense controlled substances?<br>If yes, answer the following questions:<br>a) List types of controlled substances:<br>b) Is the Applicant and providers in compliance with all applicable state regulations, including state pharmacy laws? | ☐ Yes ☐ No<br><br><br>☐ Yes ☐ 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. | ☐ Yes ☐ 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. | ☐ Yes ☐ No |

| | | |
|---|---|---|
| **14.** | Are any of the Applicant's providers engaging in any procedures outside the scope of their specialty, licensure and/or training? | ☐ Yes ☐ No |
| **15.** | Have any of the Applicant's providers ever been investigated, arrested, indicted or convicted of any crime, including allegations of sexual misconduct of any kind? | ☐ Yes ☐ No |
| **16.** | Within the past ten (10) years, have any of the Applicant's providers been under investigation by a state medical licensing agency, medical review board, hospital or healthcare facility? | ☐ Yes ☐ No |
| **17.** | Are any of the Applicant's providers currently suffering from any condition that impairs their judgment or that would otherwise adversely affect their ability to practice medicine in a competent, ethical and professional manner? | ☐ Yes ☐ No |

## J. CLAIM HISTORY

**In answering these questions, consider all coverage being applied for:**

| | | |
|---|---|---|
| **1.** | Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors, including any person for whose acts or omissions the Applicant is legally responsible for?<br>If yes, have all claims and suits been disclosed to us? ☐ Yes ☐ No | ☐ Yes ☐ No |
| **2.** | Is the Applicant aware of any potential claims including alleged injury, incidents or circumstances that might reasonably lead to a claim or suit being brought against the Applicant, the Applicant's owners, employees or contractors (including any person for whose acts or omissions the Applicant is legally responsible for) even if the claim or suit would be without merit? This includes any request for medical records related to an adverse outcome.<br>If yes, have they all been reported to your current or prior professional liability carrier? ☐ Yes ☐ No | ☐ Yes ☐ No |
| **3.** | Is the Applicant aware of any claims, suits or potential claims that have not been reported to the Applicant's current or prior professional liability carrier? | ☐ Yes ☐ No |

## K. COMMENTS SECTION

**Please include section and question number.**

## 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:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**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

**Application Abbreviations**

i. CM – Claims-Made COI – Certificate of Insurance
ii. CRNA's - Certified Registered Nurse Anesthetist
iii. DBAs – Doing Business As
iv. DEA - Drug Enforcement Administration
v. DO – Doctor of Osteopathic Medicine
vi. ECT – Electroconvulsive Therapy
vi. EMTs – Emergency Medical Technicians
vii. ENT – Ear, Nose and Throat
viii. FDA – Food and Drug Administration
ix. FLEX – Federation Licensing Examination
x. MD – Doctor of Medicine
xi. NPI – National Practitioner Identifier
xii. OCC - Occurrence
xiii. RN/LPN/LVN – Registered Nurse/Licensed Practical Nurse/Licensed Vocational Nurse
xiv. USMLE – United States Medical Licensing Examination