PHYSICIAN
MEDICAL PROFESSIONAL LIABILITY APPLICATION

Medical Mutual Insurance Company of North Carolina

curi.com

Check applicable box: **Requested Effective Date:** _____

- ☐ New Applicant
- ☐ Applying for coverage under Curi policy number: _____
- ☐ Applying for SLOT coverage under Curi policy number: _____

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**:

- If there are claims, suits or incidents, prior carrier claim history covering 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
- Current curriculum vitae (CV)
- Corporate Healthcare Medical Professional Liability Application if corporate coverage is desired
- 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			
Name (first, middle, last):			MD ☐ DO ☐ Other _____
NPI #:	Social Security #:	Date of Birth:	Gender: Male ☐ Female ☐
Email:	Office Phone:	Office Contact:	
Website:		County:	
Mailing Address:			
Billing Address (if different than mailing):			
Home Address:		Home Phone:	

C. EDUCATION (If CV is attached, proceed to question C1 below.)					
Medical School		State/Country	From	To	Completed Yes ☐ No ☐
Residency 1	Specialty	State/Country	From	To	Completed Yes ☐ No ☐
Residency 2	Specialty	State/Country	From	To	Completed Yes ☐ No ☐
Fellowship	Specialty	State/Country	From	To	Completed Yes ☐ No ☐

1. Are you a graduate of a foreign medical school? Yes ☐ No ☐ If yes, complete the following questions:
Are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? Yes ☐ No ☐
Have you passed the FLEX or USMLE? Yes ☐ No ☐

2. 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: _____

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

3. Explain any gaps in your education history: ☐ NA

4. If you practice or have practiced under a different name, specify here: ☐ NA

D. MEDICAL LICENSE & DEA REGISTRATION

1. Specify below all states in which you hold a license.

State	License Number	Expiration Date	Status	% of Practice
			☐ Active ☐ Inactive	
			☐ Active ☐ Inactive	
			☐ Active ☐ Inactive	
			☐ Active ☐ Inactive	

1. Do you prescribe controlled substances? ☐ Yes ☐ No If yes, what is your DEA Registration number:

2. Has your medical license or DEA Registration ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted? ☐ Yes ☐ No If yes, please explain:

E. COVERAGE REQUESTED

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

☐ Same as employer ☐ $1,000,000/$3,000,000 ☐ Other (specify): _____

2. 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 your 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 you are approved by us for Prior Acts coverage.

F. COVERAGE AND PRACTICE HISTORY

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

Coverage Dates	Carrier	Limits of Liability	Form Type CM or Occ	Prior Acts Date if CM	City and State of Practice Location

1. 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? ☐ Yes ☐ No

If yes, explain why and give name of carrier(s). *Missouri applicants do not answer this question.

2. Have you ever practiced without professional liability insurance, or have you ever had a lapse in coverage? If yes, please explain below: ☐ Yes ☐ No

3. Has there been any change in your practice or specialty during the past five (5) years? ☐ Yes ☐ No

If yes, describe changes and include dates:

4. Explain any gaps in your practice history: ☐ NA

5. Have you previously had coverage with a Curi underwriting company*? ☐ Yes ☐ No
If yes, list policy number and company:

*Curi underwriting companies: 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.

G. PATIENT COMPENSATION FUNDS (PCF)

1. Are you 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 your prior acts date, have you been continually qualified/covered by the PCF? If no, please explain:	☐ Yes ☐ No
3. Specify the state and name of the fund:	

H. CURRENT PRACTICE LOCATIONS

1. Specify below the practice locations for which you are applying for coverage. For number of hours, use average hours per week.

Practice/Facility Name	Street Address, City & State	Specify Employee, Contractor or Owner	# of Hours

2. Specify below other practice locations for which you are working and **NOT** requesting coverage.

Practice/Facility Name	City & State	Carrier	Specify if Employee, Contractor or Owner	# of Hours

3. Do you work part-time? If yes, answer the following questions: ☐ Yes ☐ No
a) Total number of hours worked **per week** (on average), including patient care, hospital rounds, phone consultations and administrative responsibilities:
b) On call hours:
c) Specify when you started part-time work:

I. OWNERSHIP INTEREST IN HEALTHCARE LEGAL ENTITIES ☐ NA

1. List each professional corporation, partnership or other healthcare legal entity (including Medi Spas) in which you have an ownership or check NA above.

Legal Entity Name	Description of Ownership Interest (shareholder, partner, member, etc.)	% of Ownership	Is coverage desired?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If coverage is desired, complete one Corporate Healthcare Professional Liability Application for each entity.

J. STAFFING AND CONTRACTUAL RELATIONSHIPS

1. Do you employ or contract with other medical professionals? ☐ Yes ☐ No If yes, complete the following:

Type	Number	Employment	Carrier	Is coverage desired?
Physicians		☐ Employee ☐ Contractor		☐ Yes ☐ No
Physician Assistants		☐ Employee ☐ Contractor		☐ Yes ☐ No
Nurse Practitioners		☐ Employee ☐ Contractor		☐ Yes ☐ No
Nurse Midwives		☐ Employee ☐ Contractor		☐ Yes ☐ No
CRNAs		☐ Employee ☐ Contractor		☐ Yes ☐ No
Anesthesia Assistants		☐ Employee ☐ Contractor		☐ Yes ☐ No
Perfusionists		☐ Employee ☐ Contractor		☐ Yes ☐ No
Psychotherapists		☐ Employee ☐ Contractor		☐ Yes ☐ No
Clinical Social Workers		☐ Employee ☐ Contractor		☐ Yes ☐ No
Podiatrists		☐ Employee ☐ Contractor		☐ Yes ☐ No

Dentists		☐ Employee ☐ Contractor		☐ Yes ☐ No
Chiropractors		☐ Employee ☐ Contractor		☐ Yes ☐ No
RNs/LPNs/LVNs		☐ Employee ☐ Contractor		☐ Yes ☐ No
Other:		☐ Employee ☐ Contractor		☐ Yes ☐ No
Other:		☐ Employee ☐ Contractor		☐ Yes ☐ No
Other:		☐ Employee ☐ Contractor		☐ Yes ☐ No

2. Do you oversee, supervise or have a consulting relationship with anyone not listed above? ☐ Yes ☐ No
If yes, please explain:

3. Do you contract, supervise or employ any residents or fellows? ☐ Yes ☐ No
If yes, please explain:

4. Do you contract with a third party to provide medical professional services on your behalf? ☐ Yes ☐ No
If yes, please explain:

K. HOSPITAL PRIVILEGES ☐ NA

1. List the name and location of all hospitals and facilities where you hold staff or courtesy privileges. If you do not maintain privileges, check NA above.

Hospital/Facility	City/State	Type (select all that apply)
		☐ Pending ☐ Full ☐ Courtesy ☐ Restricted ☐ Other
		☐ Pending ☐ Full ☐ Courtesy ☐ Restricted ☐ Other
		☐ Pending ☐ Full ☐ Courtesy ☐ Restricted ☐ Other
		☐ Pending ☐ Full ☐ Courtesy ☐ Restricted ☐ Other

2. Have your hospital privileges ever been suspended, denied, revoked, restricted, voluntarily surrendered or otherwise sanctioned or has probation been invoked? ☐ Yes ☐ No If yes, please explain:

L. MEDICAL SPECIALTY

1. Specify the percentage of time devoted to the following specialties (total should equal 100%):

____ Allergy and Immunology
____ Anesthesiology
____ Bariatrics
____ Cardiology
____ Cardiovascular
____ Colon and Rectal
____ Dermatology
____ Dermatology - Elective Plastics
____ Emergency Medicine
____ Endocrinology
____ ENT - Non-Elective Plastics
____ ENT - Elective Plastics
____ Family/General Practice
____ Gastroenterology
____ General Surgery
____ Geriatrics
____ Gynecology
____ Hand & Foot
____ Hematology/Oncology
____ Hospitalist
____ Infectious Disease
____ Internal Medicine
____ Intensive Care/Critical Care
____ Neonatology
____ Nephrology
____ Neurology
____ Neurosurgery
____ Obstetrics*
____ Obstetrics & Gynecology*
____ Occupational Medicine
____ Ophthalmology
____ Ophthalmology - Corrective Surgery
____ Orthopaedic - No Spine
____ Orthopaedic - Including Spine
____ Pain Management
____ Pathology
____ Pediatrics
____ Perinatology/Maternal & Fetal Med
____ Physical Medicine & Rehabilitation
____ Plastic Surgery - Reconstructive Only
____ Plastic Surgery - Cosmetic
____ Psychiatry - Including ECT
____ Public Health
____ Pulmonary Disease
____ Radiology-Diagnostic
____ Radiology-Interventional
____ Rheumatology
____ Thoracic
____ Trauma
____ Urgent Care
____ Urology
____ Vascular
____ Other (describe):

*Obstetrical Services Underwriting Questionnaire is required.

M. SURGICAL CATEGORY

Specify the surgical category that applies:

☐ No Surgical Procedures	Contemplates no surgical procedures performed.
☐ Minor Surgical Procedures	Contemplates minimally invasive procedures that do not open body cavities or permanently impair a patient's physical or physiological function; procedures are performed on superficial tissue, such as cuts, wounds, or foreign objects, and can be done with minimal equipment and local anesthesia. Procedures can be performed in a doctor's office and patients are conscious during the procedure.
☐ Surgery	Contemplates surgical procedures that involve opening a body cavity, removing an organ or body part or repairing a large body part; may also include procedures that may cause permanent physical or physiological impairment, or procedures that involve extensive tissue dissection.

N. RADIOLOGY PROCEDURES

1. Do you perform invasive radiology procedures? ☐ Yes ☐ No

If no, proceed to the next section. If yes, please list below the top five (5) most invasive procedures you perform:

O. UNDERWRITING QUESTIONS

Please explain all "yes" responses in the Comments section with the exception of question #1.

1. Does your practice have a comprehensive risk management program in place to minimize liability, enhance patient safety and ensure compliance with relevant regulations?	☐ Yes ☐ No
2. Are you 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.	☐ Yes ☐ No
3. Are you using telehealth to provide services? If yes, answer the following questions. a) Specify the percentage of your practice that utilizes telehealth services: b) What types of services are being provided? c) Do you offer these services to patients in states outside your primary practice location? If yes, list each state: d) Are you compliant with state licensing requirements for telehealth services in the state you are located in and each state where patients reside?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
4. Do you provide services at a correctional institution, including jail, prison or state psychiatric facility? If yes, include facility name and percentage of practice in your explanation.	☐ Yes ☐ No
5. Do you provide services at a senior living, nursing home or long-term care facility? If yes, include facility name and percentage of practice in your explanation.	☐ Yes ☐ No
6. Are you working on behalf of an organization in a role such as administrator, medical director, officer, or a similar position, where the organization is insured elsewhere? If yes, include the name of the organization, description of services you provide and specify if you have coverage elsewhere for these duties in your explanation.	☐ Yes ☐ No
7. Are you currently utilizing or planning 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.	☐ Yes ☐ No
8. Do you serve as an expert witness or litigation consultant? If yes, please include within your explanation the frequency and circumstances under which you offer these services and specify if you have coverage elsewhere for these duties?	☐ Yes ☐ No
9. Are you storing and/or dispensing medications? If yes, answer the following questions: a) List types of medications here: b) Are you in compliance with all applicable state regulations, including state pharmacy laws?	☐ Yes ☐ No ☐ Yes ☐ No
10. Are you writing prescriptions for compounded medications or compounding medications on site? If yes, explain in Comments section including types of medication.	☐ Yes ☐ No

11.	Do you perform Independent Medical Examinations or Aviation Medical Exams as part of your practice? If yes, include percentage of practice in your explanation.	☐ Yes ☐ No
12.	Are you engaging in any procedures outside the scope of your specialty, licensure and/or training?	☐ Yes ☐ No
13.	Have you ever been investigated, arrested, indicted or convicted of any crime, including allegations of sexual misconduct of any kind?	☐ Yes ☐ No
14.	Have you ever been under investigation by a state medical licensing agency, medical review board, hospital or healthcare facility?	☐ Yes ☐ No
15.	Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?	☐ Yes ☐ No

P. CLAIM INFORMATION

	In answering these questions, consider all coverage being applied for:	
1.	Have any claims or suits ever been made against you, your employees or contractors, including any person for whose acts or omissions you are legally responsible for? If yes, have all claims and suits been disclosed to us? ☐ Yes ☐ No	☐ 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, your employees or contractors (including any person for whose acts or omissions you are 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. If yes, have they all been reported to your current or prior professional liability carrier? ☐ Yes ☐ No	☐ 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 carrier?	☐ Yes ☐ No

Q. COMMENTS SECTION

Please include section and question number.

R. 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, prospective or current employer. To review detailed information on how we collect and use your personal information, visit the company website at curi.com.

APPLICANT ACKNOWLEDGEMENT: I declare this information is complete and accurate. I acknowledge a continuing duty to supplement any information that may materially affect this application. I acknowledge 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 my current or prior carrier. I understand the company will not provide coverage for any claim, suit or potential claim known on the effective date.

Applicant Signature	Print Name	Date

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