MMIC

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MMICGroup.com

Ancillary Professional Liability Renewal Application

A. Applicant Information

Name of Applicant (First, Middle, Last)		MMIC Policy Number (if applicable)
Applicant's Business Address (Street, City, State, Zip Code)		County:
Business Phone:	Fax:	E-mail:
Website:		
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 ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Student ☐ 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. Professional Occupation

Specify your professional occupation.

- ☐ Chiropractor
- ☐ Chiropractor Assistant
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Dietician or Nutritionist
- ☐ EEG/EKG Technician
- ☐ Laboratory Supervisor or Director
- ☐ Medical Office Assistant
- ☐ Medical Technician
- ☐ Midwife
- ☐ Nurse
- ☐ Nurse Aide/Homemaker
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Occupational Therapist-Aide
- ☐ Operating Room Technician
- ☐ Optician
- ☐ Optometrist
- ☐ Optometry-Assistant
- ☐ Oral Surgeon
- ☐ Orthotist/Prothetist
- ☐ Paramedic/EMT
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Pharmacy Assistant
- ☐ Physical Therapist-Employed
- ☐ Physical Therapist-Owner
- ☐ Physical Therapy-Assistant
- ☐ Physician/Surgeon Assistant
- ☐ Cert. Registered Nurse Anesthetist
- ☐ Podiatrist
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ Respiratory Therapist-Aide
- ☐ Social Worker
- ☐ X-ray Technician
- ☐ Other (specify): _____ (Describe duties in Comments section)

C. 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:

4. 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.

5. Do you, as an individual, employ or contract other healthcare professionals? ☐Yes ☐No If yes, complete the following:

Type	Number	Employment	Current Insurer	MMIC Policy # (if applicable)
Physician/Surgeon		☐ Employee ☐ Contractor		
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		

6. Do you, as an individual, employ or contract other medical professionals to provide services? ☐Yes ☐No
If yes, specify their profession (i.e. RN, LPN, etc.) and the number for each occupation in the Comments section.

D. Training / Work Experience

1. Are you board certified? ☐ Yes ☐ No ☐ N/A If yes, specify name of board:

2. How many hours have you completed in any continuing education for your field of practice within the last three years?

3. List medical societies and professional organizations in which you are currently a member:

4. Do you prescribe drugs? ☐ Yes ☐ No If yes, what is your BNDD/DEA number: _____

5. Do you perform surgical procedures? ☐ Yes ☐ No

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

State	License/Certification Number	% of Patients

7. 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
	to

8. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No
If yes, describe changes:

E. Underwriting Questions

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

1. Are you employed full time by the Federal Government or are you in the military service? ☐ Yes ☐ No
2. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? ☐ Yes ☐ No
3. 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
4. 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

5. Have you ever been treated for alcoholism, narcotics addiction or mental illness?
   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

6. Do you provide any professional services to patients (including telemedicine) in states other than those listed under question D6?
   If yes, include states, type of service and annual number of encounters in your explanation. ☐ Yes ☐ No

7. 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

F. Claim Information

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

1. Are you aware of any claims, suits or potential claims that have **not** been reported to MMIC? ☐ Yes ☐ No
   If yes, provide a brief description of each claim(s) in the Comments section and answer the following:
   Will claim(s) be reported to MMIC Claim Department? ☐ Yes ☐ No
   If no, explain (e.g. is this claim covered by a different insurance carrier?):

G. Comments

Section & Question	Explanation

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.

I hereby certify the foregoing information is true and correct.

Signature of Applicant

Date