



APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY REPORTING POLICY

ADDITIONAL INSURED - PHYSICIAN

Name (first, middle, last): _____ other names used (aka/prior) _____ professional degree _____

Gender: Male Female (Information about gender does not affect the application or underwriting process. It is used for statistical purposes only.)

Office phone: () _____ Fax: () _____

Office address: _____ City / State / Zip: _____

Home phone: () _____ Fax: () _____

Home address: _____ City / State / Zip: _____

Preferred Mailing address: Home Office Email address: _____

Do you have a website? Yes No If "yes", please indicate your website address: _____

Social Security #: _____ Date of Birth: _____

Are you a U.S. citizen? Yes No If "no", please attach a copy of your work permit.

Medical license number for primary state of practice: _____ Date Issued: _____ Expiration date if temporary: _____

Other States Licensed: (list states, number and date) _____

DEA Number: _____ Any Restrictions: Yes No

If "yes", please explain: _____

Specialty: _____ Subspecialty: _____

Please describe your current/proposed practice and any anticipated/planned practice activity (development) over the next several years.

I request Medical Professional Liability Coverage to commence _____ 12:01 a.m., Standard Time.

I understand that no event before that date will be covered, and that this is an application for insurance, not an insurance binder.

Limits of Liability: (check one box)

\$1,000,000/\$3,000,000

\$2,000,000/\$4,000,000

\$3,000,000/\$5,000,000

\$1,000,000/\$1,000,000*

\$2,000,000/\$2,000,000*

\$3,000,000/\$3,000,000*

*Combined per occurrence and aggregate

Please provide a full and complete explanation to any yes response on this application in writing on your letterhead and return with your completed application. Please reference on this application that additional information is attached. Please attach a copy of your letterhead. Please be certain to sign and date the application on page 7.

MEDICAL TRAINING:

Please include a current copy of your curriculum vitae (CV). Attaching a CV does not preclude the need to fully complete this application.

1. a. Medical School: _____ Year Graduated: _____

Name of School

City/State

If you are a foreign medical school graduate, are you certified by the Educational Council for Foreign Medical Graduates? Yes No

If yes, date certified: _____

b. First Year Post-Graduate Training: _____ From: _____

Name of Hospital

Month / Year

City / State

To: _____

Month / Year

c. Residency (1): _____ From: _____
 Name of Hospital _____ Month / Year
 City / State _____ To: _____
 Specialty: _____ Residency Completed? Yes No
 If "no", Please Explain: _____

Residency (2): _____ From: _____
 Name of Hospital _____ Month / Year
 City / State _____ To: _____
 Specialty: _____ Residency Completed? Yes No
 If "no", Please Explain: _____

d. Add'l. Training(1): _____ From: _____
 Name of Hospital or Facility _____ City/State _____ Month / Year
 Type of Training: _____ To: _____
 Add'l. Training(2): _____ From: _____
 Name of Hospital or Facility _____ City/State _____ Month / Year
 Type of Training: _____ To: _____

e. Were you ever warned about your performance or placed on any type of probation during your training? Yes No

f. Are you Board Certified? Yes No _____ Date: _____
 Name of Board

If you are not Board Certified, are you Eligible to take the Boards in your specialty? Yes No

Do you plan to take the Board exam (both the written and oral exams)? Yes No

If you are no longer eligible to take the Board exams, please state the reason why. _____

Have you ever been denied Board certification or recertification? Yes No

If "yes", please state reason. _____

PRACTICE INFORMATION

2. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.)
Please account for all time since medical school. Please explain any gaps in your education or professional practice history.

City / State	From	To
_____	_____ Month / Year	_____ Month / Year
_____	_____ Month / Year	_____ Month / Year
_____	_____ Month / Year	_____ Month / Year

3. Please list all office locations where you will practice your profession.

Street Number and Suite _____ City / State _____
 Street Number and Suite _____ City / State _____
 Street Number and Suite _____ City / State _____

4. Please list all hospitals where you have or are applying for staff privileges.

5. Will you be practicing as (check **all** that apply):

- An Individual: _____
- A Solo Corporation - Name of Corporation: _____
- A Shareholder of a Medical Corporation - Name of Corporation and Names of other Shareholders: _____

A Partner in a Medical Partnership - Name of Partnership and Name(s) of Partner(s): _____

A Professional Association - Name of Professional Association and Names of Associates: _____

An Employed Physician - Name of Employer. (Please specify if employed by an Individual, Corporation, Partnership, IPA, HMO): _____

An Independent Contractor - Name of Physician, Corporation or Partnership with whom you contract: _____

Sharing office space and/or expenses only - Names of Associates: _____

Please indicate the effective date of any Solo Corporation, Medical Corporation, Partnership, or Professional Association noted above: _____

Are you practicing as part of any affiliation not noted in question 5? Yes No

If "yes", please explain: _____

6. a. Do you have any Physicians or Surgeons in your employ? Yes No

If "yes", please name: _____

b. Do you employ, contract with or supervise any non-physician health care providers? Yes No

If "yes", please write the number of such persons and their name where appropriate:

	Number	Name
Acupuncturist	_____	_____
Cardiac Perfusionist	_____	_____
Dentist	_____	_____
Nurse Anesthetist	_____	_____
Nurse Midwife	_____	_____
Licensed Midwife	_____	_____
Nurse Practitioner	_____	_____
Optometrist	_____	_____
Physical Therapist	_____	_____
Certified Physicians Assistant	_____	_____
Psychologist	_____	_____
Surgical Assistant	_____	_____
Other (e.g. aestheticians, chiropractors, etc.)	_____	_____

c. Do you wish to make application to MICA for coverage as an Additional Insured? Yes No

(See Policy Section IV. Additional Insureds of the policy.)

d. If "no", do these individuals carry professional liability insurance? Yes No

e. Do you verify annually the existence of such coverage? Yes No

Due to the exposure represented by the above health care providers, additional premium may be charged for these individuals and additional information may be required.

7. Do you own or operate any of the following facilities: Please check all that apply.

<input type="checkbox"/> Birthing center	<input type="checkbox"/> Blood bank
<input type="checkbox"/> City, county, state or federal agency	<input type="checkbox"/> Clinic with bed and board facilities
<input type="checkbox"/> Emergency treatment facility (freestanding)	<input type="checkbox"/> Emergency treatment facility (hospital)
<input type="checkbox"/> Freestanding surgical facility	<input type="checkbox"/> Hospital
<input type="checkbox"/> Hospital, convalescent	<input type="checkbox"/> Hospital, psychiatric
<input type="checkbox"/> Industrial firm medical care facility	<input type="checkbox"/> Laboratory
<input type="checkbox"/> Nursing home	<input type="checkbox"/> Sanitorium
<input type="checkbox"/> Surgical suite within office	<input type="checkbox"/> Urgent care clinic
<input type="checkbox"/> X-ray or imaging facility	<input type="checkbox"/> Other health care facility _____

8. For any healthcare facility noted in the previous question, does the facility provide medical services to individuals who ARE NOT patients of any of the physicians listed in question 5? Yes No

29. Are you treating patients over the Internet to include the prescription of medications? Yes No
30. Are you practicing as a hospitalist? If "yes," percentage of time: _____ Yes No
 For purposes of this question, a hospitalist is defined as a hospital-based physician (excludes specialties of anesthesiology, pathology, radiology and emergency medicine) who treats only hospitalized patients.
31. Do you perform bariatric surgery or weight control surgery? Yes No

UNDERWRITING INFORMATION

32. Do you permit business entities to use your office space to provide **their** services? Yes No
 If "yes", please describe the activities: _____

33. While your MICA policy is in force, will you be:
- | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hours per day | Days per week |
|---|--|---------------|---------------|
| a. Active in military service? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| b. Employed by State, Federal or local public entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| c. Providing services to patients who are solicited from out-of-state for medical services to be rendered in the state noted on this application as your address of record? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| d. Practicing medicine or providing consultations, including any by telemedicine, outside the state noted on this application as your address of record? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
- If the answer to any of the above is "yes", please provide a complete explanation: _____

- e. Do you have other malpractice coverage for any of the above practice activities? Yes No
34. a. Have you ever been denied privileges by a medical staff, hospital, health care facility, managed care organization, or any other health care entity in any state? If "yes", please provide an explanation on a separate sheet. Yes No
- b. Have you ever voluntarily surrendered your privileges or resigned from the medical staff at a hospital, health care facility, managed care organization, or any other health care entity in any state while under investigation or to avoid possible disciplinary action? If "yes", please provide an explanation on a separate sheet. Yes No
- c. Have you ever been investigated, warned, reprimanded, censured, sanctioned, placed on probation, suspended, other than a temporary suspension for delinquent medical records, or asked to resign by a medical staff, hospital, health care facility, managed care organization, or any other health care entity in any state? If "yes", please provide an explanation on a separate sheet. Yes No
- d. Have you ever been the subject of an official or non-official proceeding or hearing brought by a medical staff, hospital, managed care organization, or any other health care entity in any state to modify, restrict, limit, reduce, suspend, non-renew, or revoke your privileges or that could place your exercise of such privileges under supervision, observation, or any other type of review? If "yes", please provide an explanation on a separate sheet. Yes No
35. Has any insurance carrier ever declined, surcharged, rated up, restricted, canceled or refused to renew your professional liability insurance? Yes No
 If "yes", give details: _____

36. Prior Coverage Data: Provide the following information on all previous professional liability carriers who have insured you for at least the last ten(10) years. (Please complete one of the enclosed Experience Verification letters and submit to each prior carrier listed.)

Name of Carrier	Policy Dates	Type of Coverage check one	If Claims-Made, was an Extended Reporting Endr. (tail coverage) purchased
_____	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	_____
_____	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	_____
_____	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	_____
_____	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	_____
_____	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	_____

37. Do you carry any other medical professional liability coverage or excess medical professional liability coverage? Yes No
38. Have you ever practiced without professional liability insurance? Yes No
39. Do you wish to apply for "Prior Acts"* Coverage? If "yes", a separate Prior Acts Application must be submitted. Yes No
 * "Prior Acts" coverage means coverage for occurrences which happened on or after the Retroactive Date and before the MICA Inception Date IF COVERAGE IS APPROVED.

40. Have you ever been involved in a malpractice Claim,** lawsuit, incident or occurrence? Yes No
 If “yes”, **please attach a detailed narrative description of the medical facts.** Also provide the following information.
 Patient name, age and sex.
 Dates and type of treatment involved.
 Nature of problems or allegations. Was a suit filed? Disposition or current status.
 Name of insurance carrier defending you.
 Include copies of all records, such as x-ray reports, office and laboratory reports, office and hospital notes, operative reports and any other relevant information.
 ** As defined in the MICA Policy, “Claim” means either a demand received by an Insured for damages or a complaint, lawsuit, demand for arbitration or other legal process served on an Insured. “occurrence” means an event or series of events resulting in injury, neither intended or expected from the standpoint on an Insured, which may give rise to a claim.
41. In the course of your career:
- a. Have you ever been convicted of, or pleaded guilty or no contest to, a crime other than a traffic violation? Yes No
 - b. Have you suffered from or been treated for substance abuse, disability, mental illness or serious physical illness/injury? Yes No
 - c. Has your license to practice medicine or permit to prescribe or dispense narcotics or other controlled substances in any state ever been restricted, limited, voluntarily surrendered, suspended, or revoked? If “yes”, please provide an explanation on a separate sheet. Yes No
 - d. Has your application for a license to practice medicine or permit to prescribe or dispense narcotics or other controlled substances in any state ever been denied? If “yes”, please provide an explanation on a separate sheet. Yes No
 - e. Have you ever been investigated, disciplined, censured, reprimanded, fined, or placed under probation or stipulation (either voluntarily or otherwise) by any state licensing entity or board, the Drug Enforcement Administration, or any other governmental or regulatory agency? If “yes”, please provide an explanation on a separate sheet. Yes No
 - f. Have you ever had a complaint against you submitted to any such entity, board, or agency? If “yes”, please provide an explanation on a separate sheet. Yes No
 - g. Have you ever been notified to respond to or appear before any such entity, board, or agency for a complaint against you? If “yes”, please provide an explanation on a separate sheet. Yes No
 - h. Have you ever received an advisory letter, a letter of concern, a letter of admonition, a letter of reprimand, or a decree of censure from any such entity, board, or agency? If “yes”, please provide an explanation on a separate sheet. Yes No
 - i. Have you ever entered into any voluntary stipulation, order, or similar action with any such entity, board, or agency? If “yes”, please provide an explanation on a separate sheet. Yes No
 - j. Has Medicare/Medicaid ever brought documented charges against you for alleged fraud or inappropriate fees? Yes No
 - k. Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct? Yes No
 - l. Have you ever been subject to disciplinary proceedings or to a review affecting your participation in a foundation, HMO, PPO, IPA, Medicare/Medicaid or similar entity or have you ever been notified of an intent to pursue such action? Yes No

Remarks: Please attach a detailed narrative.

APPLICANT’S AUTHORIZATION AND CERTIFICATION

I authorize the release of all information to MICA from:

1. Any medical school or hospital where I have received training.
2. Any person(s) with whom I received training, such as preceptorship, which I am using as a basis for specialty training and requesting coverage.
3. Any hospital at which I have applied for privileges, whether those privileges were granted or not.
4. Past and present Medical Associations, Societies, Specialty Boards and the regulatory body granting me a license to practice medicine in any State.
5. Any insurance company to which I have applied for medical malpractice coverage, whether such coverage was granted or not.
6. Any employer for whom I performed medical services, whether as an employee or an independent contractor.
7. Any credit reporting agency or Equifax, Dunn & Bradstreet or similar organization.

I understand that information requested by MICA will also include, but not necessarily be limited to:

1. Any incident, claim or suit in which I may be or may have been involved.
2. Denial, suspension, revocation, or disciplinary recommendation or action relating to staff privileges at a hospital, clinic, employer, or any other person connected with my providing medical services.
3. Censure probation or any disciplinary action taken by any medical licensing authority or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities.

I understand that the information will be used in addition to my application in making MICA's decisions.

I agree that the persons providing the information, their agents, directors and employees shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I also authorize MICA to release any such information, as well as any and all other information which MICA may have, to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services to MICA pursuant to an agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, physician counseling and related services.

I consent to MICA obtaining reviews from other physicians if necessary or appropriate to evaluate my application.

I understand that this is an application for insurance, not an insurance Binder.

Certificates of Insurance to Hospitals and Credentialing Organizations: Information regarding your policy number, limits of liability and effective date of coverage may be released to hospitals and credentialing organizations requesting such verification and to those hospitals listed on your application upon issuance of a MICA policy. Should your insurance coverage with MICA terminate, a notice indicating the termination date may be sent to those hospitals and credentialing organizations holding certificates.

I hereby certify that I have read the above application and that all statements made in this application are true, material and complete. I understand that: (1) if the policy is issued, this is done by MICA in reliance upon these representations; and (2) all statements and descriptions in this application for this insurance policy or in negotiations therefor, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under this policy if issued, unless they are fraudulent, material either to the acceptance of risk, or to the hazard assumed by the company, or if the company in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would have not provided coverage with respect to hazard resulting in the loss, if the true facts had been made known to the company as required by the application for the policy or otherwise.

I have read the policy and understand that coverage is limited to the language in Section IV. Additional Insureds of the MICA policy and is subject to Underwriting approval. I also certify that I have read the attached "Restrictions Applying to Additional Insured Coverage."

NOTICE TO COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO NEW MEXICO APPLICANTS: 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.

Signature of Applicant: _____

Print Name: _____ Date: _____

INSURED'S AUTHORIZATION

I HEREBY REQUEST THE ABOVE APPLICANT BE ADDED TO MY POLICY AS (Check One).

AN ADDITIONAL INSURED ROTATOR

I UNDERSTAND THAT SUCH COVERAGE IS LIMITED TO THE LANGUAGE IN SECTION IV. ADDITIONAL INSUREDS OF THE MICA POLICY AND IS SUBJECT TO UNDERWRITING APPROVAL.

Requested Effective Date: _____

Signature of Insured: _____ Date: _____

(or Officer if Insured is a Group)

Print Name: _____

Note: You are required to notify MICA immediately of any change in your practice. Failure to do so may jeopardize coverage.

Return only fully completed applications to Mutual Insurance Company of Arizona.

If you have any questions about any part of this application, a Customer Service Representative is available to assist you at 602.808.2111 or 1.800.352.0402.