



Ancillary Professional Liability Application New Business

Requested Effective Date _____

Required Documents

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

1. Loss runs, dated within 60 days of submission, covering the past ten years
2. Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. Reporting endorsement from current insurance carrier if recently purchased
4. Corporate Healthcare Professional Liability Application, if corporate coverage is desired

A. Applicant Information

Agency Name (if applicable):		MMIC Policy Number (if applicable):
Name of Applicant (First, Middle, Last):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant's Business Address (Street, City, State, Zip Code):		County:
Business Phone:	Fax:	E-mail:
Website:	Date of Birth:	Social Security Number:
Applicant's Home Address (Street, City, State, Zip Code):		
Home Phone:	Fax:	E-mail:
Mailing/Billing Address: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other (specify) Other:		Business Manager / Contact Person:
Telephone:	Fax:	E-mail:
Type of Practice: <input type="checkbox"/> Individual <input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Student <input type="checkbox"/> Other (Specify):		
Are you currently enrolled in a Patient's Compensation Fund (PCF)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Kansas Healthcare Stabilization Fund <input type="checkbox"/> Nebraska Excess Liability Fund <input type="checkbox"/> Wisconsin Patients' Compensation Fund <input type="checkbox"/> Other (specify):		
Are you a member of a network, alliance or IPA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate the name:		

B. Professional Occupation

Specify your professional occupation.

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

C. Current Coverage

Existing Form of Insurance: Occurrence Claims-made If Claims-made, what is your retroactive date? _____

Specify below insurance coverage for the past 5 years:

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

D. Requested Coverage

Limits of Liability (Limits are expressed as per claim and annual aggregate)

\$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000 \$3,000,000/\$5,000,000 \$4,000,000/\$6,000,000

\$5,000,000/\$7,000,000 \$500,000/\$1,000,000 (NE only) \$200,000/\$600,000 (KS PCF Members Only)

Other (specify): _____

For Kansas PCF members only, indicate PCF limits: \$100,000/\$300,000 \$300,000/\$900,000 \$800,000/\$2,400,000

Requested Retroactive Date: _____

If current coverage is claims-made and you are **not** requesting prior acts coverage from MMIC, was a reporting endorsement purchased from the current carrier? Yes No

If yes, attach a copy of the reporting endorsement. If no, explain: _____

E. 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: _____

3. How many hours per week are you working (include patient care, administrative duties, phone calls and teaching): _____

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		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Physician/Surgeon Assistants		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Anesthetists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Midwives		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Practitioners		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Perfusionists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Podiatrists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Dentists		<input type="checkbox"/> Employee <input type="checkbox"/> 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.

F. Education / Training / Work Experience

1. Specify the highest level of education you have completed related to your field of practice:

Non Required Bachelor's Degree Master's Degree Post-Doctorate Degree
 Diploma Associate's Degree Doctorate's Degree Other (specify): _____

2. School of Graduation:	City & State:	Degree:	Year of Graduation:
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3. Facility name/location where internship was served: _____ Dates: _____
4. Facility name/location where residency was served: _____ Dates: _____
5. Are you board certified? Yes No N/A If yes, specify name of board: _____
6. Have you undergone additional medical training? Yes No If yes, indicate type: _____ Dates: _____
7. How many hours have you completed in any continuing education for your field of practice within the last three years? _____
8. Have you completed additional training? Yes No If yes, answer the following:
 Type: _____ Dates: _____
 Type: _____ Dates: _____
9. List medical societies and professional organizations in which you are currently a member: _____

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

11. Do you perform surgical procedures? Yes No

12. 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

13. 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

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

G. 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 F13?
 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
8. 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?
 If yes, explain why and give name of carrier(s). *Missouri applicants do not answer this question. Yes No

