



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

### C. Practice Information

1. If you are employed, indicate the name of your employer:

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2. If you are an independent contractor, name each entity with which you have contracted healthcare services:

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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.

**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.

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



