



Corporate Healthcare Professional Liability Application

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 for each organization
5. Certificates of Insurance for all medical professionals listed in section E and not insured with MMIC.

Renewal applicants are not required to provide items 1 through 3.

A. Applicant Information

Agency Name (if applicable)		MMIC Policy Number (if applicable)	
Legal Entity Name		Tax ID Number	
Principle Business Address (Street, City, State, Zip Code)			County
Business phone	Fax	E-mail	Web Site
Office Location #2 (Street, City, State, Zip Code) Use Comments section for additional locations.			County
Business Manager/Contact Person	Telephone	Fax	E-mail
Mailing/Billing Address (If different from principle business address listed above)			County

Type of Legal Entity:

- Solo Incorporated
 Multi-shareholder Corporation, Partnership, Limited Liability Company
 Joint Venture (indicate parties in venture and percentage ownership in Comments section)
 Other (specify): _____

Is Applicant currently enrolled in a Patient's Compensation Fund (PCF)? Yes No

If yes, answer the following question and indicate the fund name.

Has Applicant, at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? Yes No

- Kansas Healthcare Stabilization Fund
 Nebraska Excess Liability Fund
 Wisconsin Patients' Compensation Fund
 Other (specify): _____

B. Current Coverage (Renewal applicants are not required to complete this section)

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

C. Requested Coverage (Renewal applicants are not required to complete this section)

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 Applicant is **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: _____

D. Practice Information

1. Specify description of operations:

- Private Doctor's Office
 Urgent Care Facility
 Community Clinic - Not for Profit
 Abortion Clinic
 Birthing Center
 Family Planning Clinic
 Physician-owned and operated lab used for other than doctor/owner patients
 Other (describe): _____

The definition of "owners" includes shareholders, partners and members.

2. Specify the number of owners of the Applicant: _____

3. Are all owners insured with MMIC or applying for coverage (if new business applicant)?
 Yes
 No

4. Are there any subsidiaries of the Applicant?
 Yes
 No
 If yes, specify the following:

Subsidiary Name	Description of Operations	% of Ownership	Date Acquired	Current Carrier	Coverage Desired?

If a subsidiary is not 100% owned by the Applicant, specify owners and percentage of ownership in the Comments section.

5. List all states in which the Applicant provides professional services, including the percentage of practice for each state: _____

6. Does the Applicant or any of its owners or employed or contracted physicians supervise any residents or interns?
 Yes
 No

If yes, specify facility, specialty and number supervised: _____

7. Does the Applicant or any of its owners or employed or contracted physicians supervise any healthcare providers other than those employed or contracted at the Applicant's practice?
 Yes
 No

If yes, specify facility, specialty and number supervised: _____

8. Specify total number of employees for each of the following:

Total number of employees: _____
 Total number of non-medical employees: _____
 Total number of physician employees: _____
 Total number of non-physician medical professional employees: _____

9. Specify total number of contractors for each of the following:

Total number of contractors: _____
 Total number of non-medical contractors: _____
 Total number of physician contractors: _____
 Total number of non-physician medical professional contractors: _____

10. Does Applicant employ or contract with any of the following healthcare providers?
 Yes
 No

If yes, indicate the number of employed/contracted providers for each occupation:

_____ Chiropractor	_____ Nurse Practitioner	_____ Optometrist	_____ Psychologist
_____ Medical/Lab Technician	_____ Nurse	_____ Physician/Surgeon Assistant	_____ Respiratory Therapist
_____ Surgical Assistant	_____ Occupational Therapist	_____ Physical Therapist	

