

PROFESSIONAL LIABILITY APPLICATION PHYSICIANS AND SURGEONS CLAIMS-MADE

A claims-made policy covers claims or suits first made against you during the policy period arising out of the performance of professional services rendered on or after the retroactive date shown on the policy.

1. Agency name (If applicable)		Producer	2. MMIC Policy number (if applicable)	
3. Agent address (Street, City, State, Zip Code)				
4. Name of applicant (First, Middle, Last)				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
5. Applicant's business address (Street, City, State, Zip Code)				County
Business phone	Fax	E-mail	6. Do you have a Web site address? (If so, please specify URL) <input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Applicant's home address (Street, City, State, Zip Code)

Home phone	Fax	E-mail
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8. Mailing/Billing address
 Home Business Other (Street, City, State, Zip Code)

Telephone	Fax	E-mail
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COMPLETION OF QUESTIONS 10-17 AND 34 ARE OPTIONAL FOR RENEWAL APPLICATIONS

10. Effective date of coverage	11. Date of birth	12. Social Security Number	13. Existing form of insurance <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made
14. Current Carrier	15. If Claims-made are you applying for prior acts coverage from MMIC? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, did you purchase a reporting endorsement from your current carrier? (Attach copy of endorsement) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain _____	

16. Prior insurance past 5 years **Attach copy of most recent policy, which provides the retroactive date, limits and current coverage dates.**

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

17. Limits of liability
 \$200,000/\$600,000 (NE only)
 \$1,000,000/\$3,000,000
 \$2,000,000/\$4,000,000
 \$3,000,000/\$5,000,000
 \$4,000,000/\$6,000,000
 Specify other: \$ _____ per claim/\$ _____ annual aggregate

18. Are you currently enrolled in a Patient's Compensation Fund (PCF)?
 Yes No
 Nebraska
 Wisconsin
 Other

19. Indicate type of practice:
 Individual
 Intern/resident
 Fellowship
 Employee
 Independent Contractor
 Owner
 Partner
 Other

20. Are you a member of a network or alliance?
 Yes No
If yes, indicate the name: _____

21. List each professional corporation, professional association and partnership and other health care related services in which you have an ownership

Name	Description of your interest	% of your practice

Complete one Healthcare Corporate Application for each organization listed.

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

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

24. If you as an individual contractor, employ or contract physicians/surgeons, please complete the following:

Employee or Contractor Name	Specialty*	Indicated Category* (1 through 5) (see question 32)	Procedures Performed* (see question 33)	Policy Number (if insured by MMIC)	Limit of Liability

(*Not necessary to complete if insured by MMIC)

If you as an individual, employ or contract medical professionals, complete questions 25 and 26)

25. Indicate the number of the following employed/contracted professionals:

Current insurer (include policy numbers if written by MMIC)

- Physician & Surgeon assistants _____
- Nurse Anesthetists _____
- Nurse Midwives _____
- Nurse Practitioners _____
- Perfusionists _____
- Podiatrists _____
- Dentists _____

26. If you, as an individual, employ or contract other medical professionals to provide services, indicate their professional occupations (i.e., RN, LPN, etc.) and the number for each occupation.

27. What is your medical specialty? _____

28. Are you certified by an approved specialty board(s)?

What is your medical sub-specialty? _____

Yes No (Attach copy of certificate(s))

If yes, list certifying board name(s)	Date(s) of initial certification	Date(s) of recertification	If no, are you board eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date eligibility expires _____

29. Indicate the percentage of time devoted to the following medical and/or surgical activities: (Total should equal 100%)

- Percentage**
- ___ Administrative Medicine
 - ___ Aerospace Medicine
 - ___ Allergy
 - ___ Anesthesiology
 - ___ Broncho-Esophagology
 - ___ Cardiovascular Disease
 - ___ Dermatology
 - ___ Diabetes
 - ___ Emergency Medicine
 - ___ Endocrinology
 - ___ Family Practice or General Practice
 - ___ Fetal and Maternal Medicine
 - ___ Forensic Medicine
 - ___ Gastroenterology
 - ___ General Preventive Medicine
 - ___ Genetic Counseling
 - ___ Geriatrics
 - ___ Gynecology
 - ___ Hematology
 - ___ Hypnosis
 - ___ Infectious Diseases
 - ___ Intensive Care Medicine
 - ___ Internal Medicine
 - ___ Laryngology
 - ___ Legal Medicine
 - ___ Neonatology
 - ___ Neoplastic Diseases

- Percentage**
- ___ Nephrology
 - ___ Neurology
 - ___ Nuclear Medicine
 - ___ Nutrition
 - ___ Obstetrics/Pre-Natal Care
 - ___ Occupational Medicine
 - ___ Oncology
 - ___ Ophthalmology
 - ___ Orthopedics
 - ___ Otolaryngology
 - ___ Otolaryngology
 - ___ Pain Management*
 - ___ Pathology
 - ___ Pediatrics
 - ___ Pharmacology-Clinical
 - ___ Psychiatry
 - ___ Physical Medicine and Rehabilitation
 - ___ Psychiatry
 - ___ Psychoanalysis
 - ___ Psychosomatic Medicine
 - ___ Public Health
 - ___ Pulmonary Diseases
 - ___ Radiology
 - ___ Rheumatology
 - ___ Rhinology
 - ___ Sports Medicine
 - ___ Weight Reduction/Control*
 - ___ Other _____

Percentage Surgical Activities

- ___ Abdominal
- ___ Bariatric
- ___ Cardiac
- ___ Cardiovascular
- ___ Colon & Rectal
- ___ Dermatology
- ___ Endocrinology
- ___ Foot and Ankle
- ___ Gastroenterology
- ___ General
- ___ Geriatrics
- ___ Gynecology
- ___ Hand
- ___ Head & Neck
- ___ Laryngology
- ___ Neonatal
- ___ Nephrology
- ___ Neurosurgery
- ___ Obstetrics
- ___ Obstetrics-Gynecology
- ___ Ophthalmology
- ___ Orthopedic excluding Spinal Surgery
- ___ Orthopedic including Spinal Surgery
- ___ Otorhinolaryngology
- ___ Plastic
- ___ Plastic-Otorhinolaryngology
- ___ Thoracic
- ___ Traumatic
- ___ Urological
- ___ Vascular
- ___ Other * _____

*Please describe in "Comments" section on page 5

30. Do you perform obstetrical procedures (If yes, complete question 31.)

Yes No

31. Average number of deliveries you perform annually

Number of c-sections

Number of VBACs

32. Indicate each of the following that you perform: (Please check **each** box that applies.)

- Category 1**.....No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia, or circumcision.
- Category 2**.....Assist in surgery on your own patients and/or perform minor surgical procedures.
- Category 3**.....Obstetrical procedures and/or prenatal care beyond the first trimester not including Cesarean sections.
- Category 4**.....All other types of surgery and operations performed under general or regional anesthesia. (Number of surgeries performed annually: _____)
- Category 5**.....Administration of anesthesia (other than local).

33. Please check the following medical procedures you perform:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Autologous Fat Injection <input type="checkbox"/> Angiography <input type="checkbox"/> Arteriography <input type="checkbox"/> Botox Injections <input type="checkbox"/> Catheterization – arterial, cardiac, or diagnostic, other than: <ul style="list-style-type: none"> a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers. b. Urethral catheterization c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gasses in newborns receiving oxygen. <input type="checkbox"/> Chelation therapy <input type="checkbox"/> Closed fracture reduction – other than fingers or toes <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cryosurgery – other than use on benign or premalignant dermatological lesions <input type="checkbox"/> Conscious sedation <input type="checkbox"/> D & C performed under local anesthesia <input type="checkbox"/> Discograms <input type="checkbox"/> ECT (describe) _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Epidurals <input type="checkbox"/> ERCP (Endoscopic Retrograde Cholangiopancreatography) <input type="checkbox"/> Lasers (describe) _____ <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Lymphangiography <input type="checkbox"/> Liposuction <input type="checkbox"/> Pneumoencephalography <input type="checkbox"/> Pneumatic or mechanical esophageal dilation (not with buogie or olive) <input type="checkbox"/> Needle biopsy (describe) _____ <input type="checkbox"/> Myelography <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae <input type="checkbox"/> Vasectomies <input type="checkbox"/> Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation (describe) _____ |
|--|---|

NONE OF THE ABOVE

34. Medical Education (attach copy of CV)

a. School of graduation	City, State	Degree <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other _____	Year graduated
b. If you are a foreign medical school graduate, have you obtained an ECFMG certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Indicate which certification you obtained and the year certified: <input type="checkbox"/> ECFMG <input type="checkbox"/> Fifth Pathway Year Certified: _____	
c. Indicate the facility name and location where your internship was served.		Specialty	From (MO/YR) To (MO/YR)
d. Indicate the facility name and location where your residency was served.		Specialty	From (MO/YR) To (MO/YR)
e. Additional medical training? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate type (i.e. Fellowship): _____		Did you complete your residency? <input type="checkbox"/> Yes <input type="checkbox"/> No	

35. Name all the places where you practiced your profession during the last five years

_____ _____ _____ _____	Time Period From (MO/YR) To (MO/YR) _____ _____ _____ _____
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36. List each state where you are licensed to practice, your corresponding license number and the percentage of patients seen in each state

State	License Number	% of patients seen, examined or treated in each state
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

37. Has there been any change in your practice or specialty during the past five years? (If yes, describe) Yes No

38. Indicate the name and location of all facilities, including nonhospital facilities where you hold staff or courtesy privileges:

Name	Location

Explain any "yes" answers to questions 39 and 40 in the "Comments" section on page 5

39. a. Do you staff an emergency room for purposes other than to maintain hospital privileges?..... Yes No
 (If yes, include hospital name, location, number of hours per month, relationship, etc., in your explanation)
- b. Do you practice in or staff an urg-center or similar minor emergency clinic? Yes No
- c. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital? Yes No
 (If yes, include location and distance (travel time) to the nearest hospital in your explanation)
- d. Are you employed full time by the Federal Government or are you in the military service?..... Yes No
- e. Are you engaged in any "moonlighting" activities? Yes No
 If yes, indicate the number of hours per month spent moonlighting
- f. Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities?..... Yes No
- g. Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? (If so, please complete a Healthcare Facilities application) Yes No
- h. Do you render patients unconscious for treatment in your office, or other nonhospital facility?..... Yes No
- i. Do you provide professional services on behalf of any college, university, semi-professional, or professional sporting team?..... Yes No
 (If yes, include name of team, percentage of practice and relationship in your explanation)
- j. Do you perform surgery on professional athletes? Yes No
- k. Are you employed or contracted by any facility as a medical director or similar role? (If yes, include name of facility in your explanation.) Yes No
- l. Do you perform utilization review services for a fee for others?..... Yes No
- m. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked? Yes No
- n. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked?..... Yes No
- o. Are you aware of any complaint or investigation with respects to your license to practice, your BNDD (DEA) license, your privileges or participation at or with any hospital or other medical facility? Yes No
- p. 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
- q. Have you ever been denied a medical license or been denied certification by a specialty board?..... Yes No
- r. 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
- s. Are you currently under contract to provide services on behalf of a PPO or HMO? (If yes, include in your explanation the name of the PPO or HMO and the type of services that you have contracted to provide) Yes No
- t. Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program?..... Yes No
- u. Do you provide any diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed under question 36? (If yes, include states, type of service and annual number of encounters in your explanation) Yes No
- v. Do you advertise your medical practice? (Attach copies of print ads) Yes No
 Newspaper Magazine Radio Television Direct Mail Other
- w. Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? Yes No
 (If yes, include proof of coverage, location, and name of entity providing coverage.)
- x. 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.) Yes No
- y. Have you ever practiced without professional liability insurance? Yes No

