



Physicians And Surgeons 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)		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other Specify Other:	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"/> Intern/Resident <input type="checkbox"/> Fellowship <input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Owner <input type="checkbox"/> Partner <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. 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

C. 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: _____

D. 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. 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.

4. If you, as an individual, employ or contract physicians or surgeons, complete the following:

Employee or Contractor Name	Specialty*	Category* (1 through 5) (see question F3)	Procedures Performed* (see question F4)	Policy # (if insured by MMIC)	Limit of Liability

*Not necessary to complete if insured by MMIC.

5. If you, as an individual, employ or contract other medical professionals, complete the following:

Type	Number	Employment	Current Insurer	MMIC Policy # (if applicable)
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		
RNs/LPNs/LVNs		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Other (describe):		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		

E. Education / Training / Work Experience (If a CV is attached, proceed to question E5.)

1. School of Graduation: _____ City & State: _____ Year of Graduation: _____

2. If you are a foreign medical school graduate, have you obtained an ECFMG certificate?
 Yes
 No
 N/A
 Indicate which certification you obtained and the year certified:
 ECFMG
 Fifth Pathway
 Year Certified: _____

3. Facility name and location where internship was served: _____
 Specialty: _____ Dates: _____

4. Facility name and location where residency was served: _____
 Specialty: _____ Dates: _____

5. Have you undergone additional medical training?
 Yes
 No
 If yes, indicate type: _____ Dates: _____

6. What is your medical specialty? _____ What is your medical sub-specialty? _____

7. Are you certified by an approved specialty board? Yes No If yes, certifying board name(s): _____

Date(s) of initial certification: _____ Date(s) of recertification: _____

8. If you are not certified, are you board eligible? Yes No If yes, date eligibility expires: _____

9. List each state where you are licensed to practice, license number and the percentage of patients seen in each state:

State	License Number	% of Patients

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

Name/Location	Name/Location

11. 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

12. Has there been any change in your practice or specialty during the past five years? Yes No

If yes, describe changes:

F. Classification

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

<p>Percentage (Non-Surgical)</p> <p>_____ Administrative Medicine</p> <p>_____ Aerospace Medicine</p> <p>_____ Allergy</p> <p>_____ Anesthesiology</p> <p>_____ Broncho-Esophagology</p> <p>_____ Cardiovascular Disease</p> <p>_____ Dermatology</p> <p>_____ Diabetes</p> <p>_____ Emergency Medicine</p> <p>_____ Endocrinology</p> <p>_____ Family Practice/General Practice</p> <p>_____ Fetal and Maternal Medicine</p> <p>_____ Forensic Medicine</p> <p>_____ Gastroenterology</p> <p>_____ General Preventive Medicine</p> <p>_____ Genetic Counseling</p> <p>_____ Geriatrics</p> <p>_____ Gynecology</p> <p>_____ Hematology</p> <p>_____ Hospitalist</p> <p>_____ Hypnosis</p> <p>_____ Infectious Diseases</p> <p>_____ Intensive Care Medicine</p> <p>_____ Internal Medicine</p> <p>_____ Laryngology</p> <p>_____ Legal Medicine</p> <p>_____ Neonatology</p> <p>_____ Neoplastic Diseases</p>	<p>Percentage (Non-Surgical)</p> <p>_____ Nephrology</p> <p>_____ Neurology</p> <p>_____ Nuclear Medicine</p> <p>_____ Nutrition</p> <p>_____ Obstetrics/Pre-Natal Care</p> <p>_____ Occupational Medicine</p> <p>_____ Oncology</p> <p>_____ Ophthalmology</p> <p>_____ Orthopedics</p> <p>_____ Otolaryngology</p> <p>_____ Otorhinology</p> <p>_____ Pain Management*</p> <p>_____ Pathology</p> <p>_____ Pediatrics</p> <p>_____ Pharmacology-Clinical</p> <p>_____ Psychiatry</p> <p>_____ Physical Medicine/Rehabilitation</p> <p>_____ Psychology</p> <p>_____ Psychoanalysis</p> <p>_____ Psychosomatic Medicine</p> <p>_____ Public Health</p> <p>_____ Pulmonary Diseases</p> <p>_____ Radiology</p> <p>_____ Rheumatology</p> <p>_____ Rhinology</p> <p>_____ Sports Medicine</p> <p>_____ Weight Reduction/Control*</p> <p>_____ Other*</p>	<p>Percentage (Surgical)</p> <p>_____ Abdominal</p> <p>_____ Bariatric</p> <p>_____ Cardiac</p> <p>_____ Cardiovascular</p> <p>_____ Colon & Rectal</p> <p>_____ Dermatology</p> <p>_____ Endocrinology</p> <p>_____ Foot and Ankle</p> <p>_____ Gastroenterology</p> <p>_____ General</p> <p>_____ Geriatrics</p> <p>_____ Gynecology</p> <p>_____ Hand</p> <p>_____ Head & Neck</p> <p>_____ Laryngology</p> <p>_____ Neonatal</p> <p>_____ Nephrology</p> <p>_____ Neurosurgery</p> <p>_____ Obstetrics</p> <p>_____ Obstetrics-Gynecology</p> <p>_____ Ophthalmology</p> <p>_____ Orthopedic excluding Spinal Surgery</p> <p>_____ Orthopedic including Spinal Surgery</p> <p>_____ Otorhinology</p> <p>_____ Plastic</p> <p>_____ Plastic-Otorhinology</p> <p>_____ Thoracic</p> <p>_____ Traumatic</p> <p>_____ Urological</p> <p>_____ Vascular</p> <p>_____ Other*</p>
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*Describe in Comments section.

2. Do you perform obstetrical procedures? Yes No If yes, answer the following questions:

Average number of deliveries you perform annually: _____

Number of c-sections: _____

Number of VBACs: _____

3. Indicate each of the following that you perform. Check **each** box that applies.

- Category 1** No surgical procedures performed other than incision of boils and superficial abscess, 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 c-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)

4. Please check the following medical procedures you perform:

- | | |
|--|--|
| <input type="checkbox"/> Autologous Fat Injection | <input type="checkbox"/> Epidurals |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> ERCP (Endoscopic Retrograde Cholangiopancreatography) |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Lasers (describe) |
| <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Catheterization – arterial, cardiac, or diagnostic, other than: | <input type="checkbox"/> Lymphangiography |
| a. Occasional emergency insertion of pulmonary wedge, | <input type="checkbox"/> Liposuction |
| pressure recording catheters, or temporary pacemakers. | <input type="checkbox"/> Pneumoencephalography |
| b. Urethral catheterization | <input type="checkbox"/> Pneumatic or mechanical esophageal dilation (not with buogie or olive) |
| c. Umbilical cord catheterization for diagnostic purposes or | <input type="checkbox"/> Needle biopsy (describe) |
| for monitoring blood gasses in newborns receiving oxygen. | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Chelation therapy | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Closed fracture reduction – other than fingers or toes | <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Vasectomies |
| <input type="checkbox"/> Cryosurgery – other than use on benign or premalignant dermatological lesions | <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) |
| <input type="checkbox"/> Conscious sedation | |
| <input type="checkbox"/> D & C performed under local anesthesia | |
| <input type="checkbox"/> Discograms | |
| <input type="checkbox"/> ECT (describe): _____ | |

NONE OF THE ABOVE

G. Underwriting Questions

Explain any “yes” answers to the following questions in the Comments section.

- | | |
|---|--|
| 1. Do you staff an emergency room for purposes other than to maintain hospital privileges?
If yes, include hospital name, location, number of hours per month and relationship in your explanation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you practice in or staff an urgi-center or similar minor emergency clinic? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you perform surgery or obstetrical procedures at a location other than a licensed hospital?
If yes, include location and distance (travel time) to the nearest hospital in your explanation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are you employed full time by the Federal Government or are you in the military service? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you engaged in any “moonlighting” activities? If yes, indicate the number of hours per month: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. 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. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you render patients unconscious for treatment in your office or other nonhospital facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you provide professional services on behalf of a professional sporting team?
If yes, include name of team, percentage of practice and relationship in your explanation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Are you employed or contracted by any facility as a medical director or similar role?
If yes, include name of facility in your explanation. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Do you perform utilization review services for a fee for others? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Insurance Guaranty Association Law

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
4640 West 77th Street, Suite 342
Edina, Minnesota 55436
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.