602.808.2111 | Fax 602.627.7033 | 1.800.352.0402 | PO Box 33180 Phoenix, AZ 85067-3180

Medical Facility Application

A. Applicant

Name of Facility: ______________________ Date Facility Established: ______________

Type of Facility: ______________________ Taxpayer ID Number ______________

Requested Effective Date: ______________________

Mailing Address: ____

____

Business Manager|Contact Person: ______________________ Phone: ______________ (AREA CODE) FAX #: ______________ (AREA CODE)

E-Mail Address: ______________________ Website Address: ______________

I request Medical Professional Liability Coverage to commence ______________ 12:01 a.m., Standard Time. I understand that no event before that date will be covered, and that this is an application for insurance, not an insurance binder.

Limits of Liability: (check one box)

- ○ $1,000,000/$3,000,000
- ○ $1,000,000/$1,000,000*
- ○ $2,000,000/$4,000,000
- ○ $2,000,000/$2,000,000*
- ○ $3,000,000/$5,000,000
- ○ $3,000,000/$3,000,000*

*Combined per occurrence and aggregate

Please list the licenses/certifications/accreditations held by the facility.

Agency: ______________ Agency: ______________

Issue Dt: ______________ Issue Dt: ______________

Expire Dt: ______________ Expire Dt: ______________

B. General Information

Professional Office Premises (list all locations):

Street Number Suite # City | State | Zip Code

Street Number Suite # City | State | Zip Code

Street Number Suite # City | State | Zip Code

Street Number Suite # City | State | Zip Code

Prior names of group or DBA names: ______________________________

____

Facility Specific Information

1. Please include a brief description of the types of procedures performed at the facility:

____

____

____

____

2. Please answer each question below that is applicable to your facility.

	Current Year	Estimate for Upcoming Year
a. **Surgical facility** – estimated # of procedures performed annually		
b. **Laboratory | radiology** – estimated annual gross receipts		
c. **Clinic** – estimated # of patient visits annually		
d. **Emergency room | urgent care facility** – estimated # of patient visits annually		
e. **Birthing center** – estimated # of births		
f. **Inpatient beds** – average daily occupied beds		

3. Do you use any of the following in your facility: ☐ conscious sedation or ☐ general anesthesia?
   If yes, for what procedures, who administers it, and who monitors and recovers the patient?

4. Does the Applicant anticipate any facility expansions within the next year? ○ Yes ○ No
   If "Yes", please provide details on a separate sheet of paper.
5. Is General Liability Insurance carried by your facility? ○ Yes ○ No
   If "Yes", please provide a current certificate of insurance.
6. Please indicate any additional insureds to be included under your facility's General Liability, including an explanation of their interest:

C. Personnel | (Shareholders, Partners, Medical Director) Also complete the enclosed Facility Roster.

1. Please list the individual shareholders or partners of the facility:

2. Name of Medical Director, if any:

D. Staff Privileges | Risk Management | Loss Control

1. Are all medical staff members required to maintain medical professional liability insurance? ○ Yes ○ No
2. Do you require minimum limits of 1M? ○ Yes ○ No
3. Is there a written, formalized Risk Management program? ○ Yes ○ No

E. For New Business Only

1. Has the facility or any non-physician employee ever been involved in a malpractice claim or lawsuit? ○ Yes ○ No
   If "Yes", **please attach a detailed narrative description of the medical facts**. Also provide the following information:
   - Patient name, age and sex.
   - Dates and type of treatment involved.
   - Nature of problems or allegations.
   - Was a suit filed?
   - Disposition or current status.
   - Name of insurance carrier defending you.
   - Include copies of all records, such as x-ray reports, office and laboratory reports, office and hospital notes, operative reports and any other relevant information.

2. Has the facility or any of its employees ever:
   a. had a complaint filed with a regulatory authority? ○ Yes ○ No
   b. had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? ○ Yes ○ No
3. Do you wish to apply for Prior Acts Coverage? ○ Yes ○ No

IMPORTANT: Prior Acts Coverage is optional and subject to separate underwriting approval. Unless you are specifically notified by MICA that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Extended Reporting Coverage (tail coverage) from your current carrier.

   a. If yes to #3 above, please complete the following questions:
   b. Please indicate your current retroactive date. ______________________

      Attach a copy of the most recent claims-made policy issued to you. This must contain the retroactive date noted in question #3 above.
   c. At all times from the date noted in question #3, have you been continuously insured under a claims-made type of policy? ○ Yes ○ No

      If "No', please explain.
   d. Do you have any knowledge or information of any incidents, conduct or circumstances which you have reason to believe may lead to a claim or lawsuit against you? ○ Yes ○ No
   e. Have you reported any incidents, conduct or circumstances (which have not yet resulted in a claim or lawsuit) to another insurance carrier? ○ Yes ○ No

      If yes, will that insurance carrier be providing coverage and defending you for any reports you have made to them? ○ Yes ○ No
   f. Do you have knowledge or information of any claims or lawsuits made against you that have not been reported to another insurance carrier? ○ Yes ○ No
   g. Are you aware of any oral or written indication that a patient is considering legal action against you? ○ Yes ○ No
   h. Have you received any request for medical records from a patient or a patient's representative? ○ Yes ○ No
   i. Have you received a summons, complaint, petition, subpoena, citation or any other legal process or documentation that indicates that legal proceedings have been commenced against you? ○ Yes ○ No
   j. Are you under or have you been informed about an investigation or review by any state licensing entity or board, the Drug Enforcement Administration, hospital, health care facility, managed care organization, governmental or regulatory agency or any other entity or agency for any reason relative to your practice of medicine or care of patients? ○ Yes ○ No

Application For Reporting Policy of Medical Malpractice Liability Insurance

The undersigned hereby applies to Mutual Insurance Company of Arizona (MICA) for a reporting policy. The undersigned has read the Policy and understands that such coverage is limited to the language in Section IV. Additional Insureds of the MICA Policy and is subject to Underwriting approval. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under this policy if issued, unless they are fraudulent, material either to the acceptance of risk, or to the hazard assumed by the Company, or if the Company in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would have not provided coverage with respect to hazard resulting in the loss, if the true facts had been made known to the Company as required by the application for the policy or otherwise.

Applicant's Authorization and Certification

I authorize Mutual Insurance Company of Arizona to release information to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services requested by Mutual Insurance Company of Arizona pursuant to an agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, physician counseling and related services.

I understand that this is an application for insurance, not an insurance binder. I hereby certify that I personally have read the above application for such insurance and declare that all statements made are complete and true.

Notice To Colorado Applicants

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

I certify that all statements in this application are true, material, and complete.

____

SIGNATURE OF APPLICANT (OFFICER)

____

DATE

____

NAME AND TITLE

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE YOUR LETTERHEAD.

If you have any question about any part of this application, a Customer Service Representative is available to assist you at 602.808.2111 or 1.800.352.0402.