UNDERWRITING REQUIREMENTS

Checklist for Advanced Healthcare Professionals (AHP)

Certified Registered Nurse Anesthetist (CRNA)
Certified Nurse Midwife (CNM)
Nurse Practitioner (NP)
Physician Assistant (PA)

AHP Application & Supplements

- ☐ Application for Medical Professional Liability Reporting Policy - Advanced Healthcare Professional.
- ☐ Application for Prior Acts Coverage, if applying for prior acts coverage.
- ☐ Payment Plan Selection/Electronic Funds Transfer.
- ☐ Provide a copy of your current declarations page or a certificate of insurance as evidence of your current coverage.

Additional information may be required by the underwriter. E-Med Protection Application for higher limits available upon request.

Your responses may contain sensitive information. Please mail or fax your application submission to MICA. MICA Underwriting, 2602 E. Thomas Rd., Phoenix, AZ 85016 or 602.627.7033 (fax).

If you have any questions or need help filling out the applications, please contact us at 602.808.2111.

602.808.2111 | Fax 602.808.8309 | 1.800.352.0402 | 2602 E Thomas Rd Phoenix, AZ 85016-8202

Application for Medical Professional Liability Reporting Policy
Advanced Healthcare Professional

Please provide a full and complete explanation to any yes response on this application in writing and return with your completed application. Please reference on this application that additional information is attached. Please be certain to sign and date the application on page 5.

Name: _____
LAST | FIRST | MIDDLE PROFESSIONAL DEGREE

_____
OTHER NAMES USED (AKA/PRIOR)

Gender: ☐ Male ☐ Female Information about gender does not affect the application or underwriting process. It is used for statistical purposes only.

Office phone: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Fax #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Office address: _____

_____
CITY | STATE | ZIP

Home phone: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Cell #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Home address: _____

_____
CITY | STATE | ZIP

Preferred Mailing Address: ☐ Home ☐ Office Email: _____

Do you have a website? ☐ Yes ☐ No Website: _____

Social Security: _____ Date of Birth: _____

State license|certificate: Primary state ____ Lic. # _____ Dt. Issued: _____ Temp. expiration dt. _____

Other States Licensed: _____
LIST STATES, NUMBER AND DATE

I wish to have coverage while practicing as:

☐ Certified Nurse Midwife ☐ Certified Registered Nurse Anesthetist
☐ Nurse Practitioner ☐ Physician Assistant

Please describe your current/proposed practice and any anticipated/planned practice activity (development) over the next several years. _____

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/$6,000,000* ☐ $2,000,000/$4,000,000 ☐ $3,000,000/$5,000,000

*Combined per occurrence and aggregate

Do you wish to apply for Prior Acts* Coverage? (If "Yes", a separate Prior Acts Application must be submitted.) ☐ Yes ☐ No

* "Prior Acts" coverage means coverage for events which happened on or after the Retroactive Date and before the MICA Inception Date **if coverage is approved**.

Scope of Practice

1. Indicate all that apply to your current professional practice.

☐ Adult	☐ Emergency Room	☐ Long Term Care	☐ Psychiatric
☐ Anesthesia	☐ Family Practice	☐ Midwifery	☐ Rehabilitation Care
☐ Behavioral | Mental Health	☐ Geriatrics	☐ Neonatology	☐ Retail Clinic
☐ Community Health	☐ Gynecology	☐ Nursing Home	☐ Surgical Assisting
☐ Cosmetic Procedures	☐ Home Health Care	☐ Obstetrics	☐ Surgi-Center
☐ Correctional Facility	☐ Hospice	☐ Pediatrics	☐ Urgent Care
☐ Critical Care | ICU	☐ Hospital	☐ Primary Care	☐ Other, please specify: _____

2. Average/est. # of hours worked per week: _____

Medical Training

Please include a current copy of your curriculum vitae (CV). Attaching a CV does not preclude the need to fully complete this application. Please provide information regarding your medical education.

Institution|Program: _____ _____
NAME OF INSTITUTION | CITY | STATE | COUNTRY

_____ From _____ to _____
DEGREE | CERTIFICATION | MONTH | YR | MONTH | YR

Other: _____ _____
NAME OF INSTITUTION | CITY | STATE | COUNTRY

_____ From _____ to _____
DEGREE | CERTIFICATION | MONTH | YR | MONTH | YR

Practice Information

1. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) **Please account for all time since training. Please explain any gaps in your education or professional practice history.**

Name of Employer | City | State	Month | Year	Month | Year
_____	From: _____	to _____
_____	From: _____	to _____
_____	From: _____	to _____

2. Please list all office locations where you will practice your profession.

Street Number | Suite	City | State
_____	_____
_____	_____
_____	_____

3. If applicable, please list all hospitals where you have or are applying for staff privileges.

_____ _____ _____
_____ _____ _____
_____ _____ _____

4. Will you be practicing as: (please check **all** that apply)

   ☐ An Individual: _____

   ☐ A Solo Corporation - Name of Corporation: _____

   Any DBAs or trade names? If yes, please list:

   _____

   ☐ A Member of a Medical Corporation or Partnership - Name of Corporation or Partnership:

   _____

   ☐ An Employee - Name of Employer (Please specify if employed by an Individual, Corporation, Partnership, IPA, HMO):

   _____

   ☐ An Independent Contractor - Name of Individual, Corporation or Partnership with whom you contract: _____

   ☐ Sharing office space and/or expenses only - Names of Associates:

   _____

5. Are you practicing as part of any affiliation not noted in question 4? ☐ Yes ☐ No

   If 'yes', please explain: _____

6. Do you employ, contract with or supervise any other healthcare providers? ☐ Yes ☐ No

   If 'yes', please explain: _____

7. Name of licensed physician with whom you collaborate. _____

Additional Underwriting Information

1. Have you ever:

   a. Been convicted of, been charged with, been formally arraigned, or pleaded guilty or no contest to, a crime other than a traffic violation? ☐ Yes ☐ No

   b. Suffered from or been treated for alcohol or substance abuse, disability, mental illness or serious illness/injury? ☐ Yes ☐ No

   c. Had a complaint filed against you with your state licensing/regulatory board, the Drug Enforcement Administration, or any other governmental or regulatory agency? ☐ Yes ☐ No

   d. Had any professional license/permit or narcotics license investigated, disciplined, reprimanded, suspended, revoked, restricted, placed under probation, rejected, or denied? ☐ Yes ☐ No

   e. Been warned about your performance or placed on any type of probation during your training? ☐ Yes ☐ No

   If the answer to any of the above is 'yes', please explain:

   _____

2. Have you ever been involved in a malpractice claim, suit or incident? ☐ Yes ☐ No

   If 'yes', please complete the claim narrative addendum for each claim, lawsuit, incident, or occurrence.

3. Has any insurance carrier ever declined, surcharged, rated-up, restricted, cancelled or refused to renew your medical professional liability insurance? ☐ Yes ☐ No

   If 'yes', please provide details: _____

4. Do you have any medical-related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ☐ Yes ☐ No

   If 'yes', please provide an explanation. You may be required to provide proof of coverage.

   _____

5. Do you carry any other medical professional liability coverage or excess medical professional liability coverage? ☐ Yes ☐ No

   If 'yes', please provide an explanation. You may be required to provide proof of coverage.

   _____

6. Please answer the following questions if you hold staff privileges at any hospital or outpatient facility: ☐ Yes ☐ No

   a. Have your staff privileges ever been the subject of a hearing or corrective action or procedure, or been denied, suspended, revoked, restricted or modified in any way? ☐ Yes ☐ No

   b. Have you ever resigned from a facility while under investigation or to avoid possible disciplinary action? ☐ Yes ☐ No

   c. Have you been the subject of a facility inquiry wherein your patient care was questioned? ☐ Yes ☐ No

   If the answer to any of the above is "yes", please explain:

   _____

Applicant's Authorization and Certification

I authorize the release of all information to MICA from:

1. Any medical school or hospital where I have received training.
2. Any person(s) with whom I received training, such as preceptorship, which I am using as a basis for specialty training and requesting coverage.
3. Any hospital at which I have applied for privileges, whether those privileges were granted or not.
4. Past and present Medical Associations, Societies, Specialty Boards and the regulatory body granting me a license to practice medicine in any State.
5. Any insurance company to which I have applied for medical professional liability coverage, whether such coverage was granted or not.
6. Any employer for whom I performed medical services, whether as an employee or an independent contractor.

I understand that information requested by MICA will also include, but not necessarily be limited to:

1. Any incident, claim or suit in which I may be or may have been involved.
2. Denial, suspension, revocation, or disciplinary recommendation or action relating to staff privileges at a hospital, clinic, employer, or any other person connected with my providing medical services.
3. Censure probation or any disciplinary action taken by any medical licensing authority or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities.

I understand that the information will be used in addition to my application in making MICA's decisions.

I agree that the persons providing the information, their agents, directors and employees shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I also authorize MICA to release any such information, as well as any and all other information which MICA may have, to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services to MICA pursuant to an agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, counseling and related services.

I understand that all healthcare providers, whether shareholders, members or partners, employees, or common law employees (independent contractors), of the group must use the same broker of record, regardless of whether the MICA policy is issued as a group master policy or as a group policy for the business enterprise with individual policies for each healthcare provider.

I understand that this is an application for insurance, not an insurance Binder.

Certificates of Insurance to Hospitals and Credentialing Organizations: Information regarding your policy number, limits of liability and effective date of coverage may be released to hospitals and credentialing organizations requesting such verification and to those hospitals listed on your application upon issuance of a MICA policy. Should your insurance coverage with MICA terminate, a notice indicating the termination date may be sent to those hospitals and credentialing organizations holding certificates.

I hereby certify that I have read the above application and that all statements made in this application are true and complete. I understand that: (1) if the policy is issued, this is done by MICA in reliance upon these representations; and (2) all statements and descriptions in this application for this insurance policy or in negotiations therefor, shall be deemed to be representations and not warranties. 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, and 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.

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 made are true, material and complete and I am authorized to sign this form.

SIGNATURE OF APPLICANT _____ DATE _____

NAME _____

Note: You are required to notify MICA immediately of any change in your practice. Failure to do so may jeopardize coverage. Return only fully completed applications to Mutual Insurance Company of Arizona.

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

602.808.2111 | Fax 602.808.8309 | 1.800.352.0402 | 2602 E Thomas Rd Phoenix, AZ 85016-8202

Application for Medical Professional Liability Claims Narrative Addendum

Applicant's Name (please print): _____

Please supply the following information for question 41 of the Application for Medical Professional Liabil-ity Reporting Policy.

Print or type answers to each of the following questions in detail. If more than one claim exists, photocopy this sheet for each claim. **Full disclosure of the information requested below is necessary.**

_____ _____
PATIENT/PLAINTIFF'S NAME INSURANCE CARRIER INVOLVED

Date of Occurrence: _____ Date Reported: _____ Date Closed (if applicable): _____

What is the status of the claim? (check only one)

☐ Pending ☐ Settled out of Court ☐ Found for Plaintiff at Trial
☐ Summary Judgment ☐ Dismissed ☐ Found for Defendant At Trial

If damages were paid, either by settlement or court award, what was the dollar amount?
Paid on your behalf: $_____ Paid by all parties: $_____

What is/was your status? (check only one) ☐ Primary Defendant ☐ Codefendant ☐ Other

A) Provide a concise description of the incident which led to the claim or suit (attach additional page(s) if needed).

B) What were you alleged to have done incorrectly or failed to have done correctly?

C) Provide other details you believe to be pertinent to the incident/claim/suit.

D) Identify any other parties who are/were involved and/or named in the incident/claim/suit.

I hereby certify that all statements made in this application are true, material and complete. I understand that: (1) if the policy is issued, this is done by MICA in reliance upon these representations; and (2) all statements and descriptions in this application for this insurance policy or in negotiations therefor, shall be deemed to be representations and not warranties. 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.

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

_____ _____
APPLICANT'S SIGNATURE DATE

602.808.2111 | Fax 602.808.8309 | 1.800.352.0402 | 2602 E Thomas Rd Phoenix, AZ 85016-8202

Application For Medical Professional Liability
Prior Acts Coverage
Advanced Healthcare Professional

Name: _____
PLEASE PRINT

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") form your current carrier.

1. Please state the earliest date for which you are requesting Prior Acts Coverage. _____

2. At all times from the date noted in question #1, have you been continuously insured under a claims-made type of policy? ☐ Yes ☐ No
   If "No," please explain. _____
   _____

3. Has any portion of your practice been performed outside the state of your current practice? ☐ Yes ☐ No
   If "Yes," please list the states, dates and the percentage of practice each year.
   _____
   _____

4. Has your specialty or the medical procedures you perform changed in any way since the date noted by you in question #1? ☐ Yes ☐ No
   If "Yes," please specify. _____

5. Did you practice with other healthcare providers in an employer-employee relationship, ostensible or formal partnership, medical association, or medical corporation during the period for which you are requesting Prior Acts Coverage? ☐ Yes ☐ No
   If "Yes," do you continue to have ownership interest in any entity(ies)? ☐ Yes ☐ No
   If "Yes," list the full name(s) of the entity (ies) and healthcare providers with whom you practiced and the period of your association. (Attach additional pages as needed.)

Entity	Healthcare Providers	From | To

6. Did you employ, contract with or supervise any other health care provider(s) during the period for which you are requesting Prior Acts Coverage? ☐ Yes ☐ No
   If "Yes," list the full name(s), position and dates. In addition, indicate whether he/she maintained individual professional liability insurance in his/her name or was covered under your policy. (Attach additional pages as needed.)

Name	Position	From | To	Coverage in whose name?
			☐ Their ☐ Your
			☐ Their ☐ Your

7a. 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

b. 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

c. 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

d. Are you aware of any oral or written indication that a patient is considering legal action against you? ☐ Yes ☐ No

e. Have you received any request for medical records from a patient or a patient's representative? ☐ Yes ☐ No

f. 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

g. 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

If you answered "Yes" to questions 7a-7g, please provide details below. (Attach additional pages as needed.) Report all incidents identified in 7a-7g to your current insurance carrier.

8. Attach a copy of the most recent claims-made type policy issued to you. This must contain the retroactive date noted in question #1 above. If it does not, attach all policies pertaining to the continuous claims-made coverage which you have had back to the date stated in question #1. Please include any Endorsements specifying the type and name of Additional Insureds listed on prior policies.

Please note: Please understand that there may be differences in coverage between that provided by your prior carrier and MICA coverage. Please read the MICA Policy carefully.

The period of Prior Acts coverage shall not count as years of continuous MICA coverage under qualification for extension of the reporting period without payment of additional premium under Section XIII. Conditions, Extended Reporting Period of the MICA Policy nor under any successor to that section.

I understand that this is an application for Prior Acts Coverage, not a Binder.

I hereby certify that I have read the above application and that all statements made in this application are true and complete. I understand that: (1) if the policy is issued, this is done by MICA in reliance upon these representations; and (2) All statements and descriptions in this application for this insurance policy or in negotiations therefor, shall be deemed to be representations and not warranties. 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, and 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.

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

SIGNATURE OF APPLICANT DATE

Please note: You are required to notify MICA immediately of any change in your practice. Failure to do so may jeopardize coverage. 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.

Payment Plan Selection/Change Form

Part A. Please select one payment plan and method from the options below. Your selected plan will remain in effect for the term of the policy.

Policyholder's Name **(please print)**:
Policy Number: TBD

☐ **Annually**: Policyholders who elect the annual payment option are eligible to receive a 4% discount.

Please note that not all policies and coverage forms may be eligible for the 4% discount due to established minimum premium limitations.

☐ Process my payments by Electronic Funds Transfer (EFT). **Please complete and return Part B.**

☐ I'll make my payments by check, credit card or by eCheck, not by Electronic Funds Transfer (EFT).

☐ **Quarterly**: Four payments of 25% each.

☐ Process my payments by Electronic Funds Transfer (EFT). **Please complete and return Part B.**

☐ I'll make my payments by check, credit card or by eCheck, not by Electronic Funds Transfer (EFT).

☐ **Monthly**: Initial payment of 20%, then eight monthly payments of 10% each.

All payments must be made by Electronic Funds Transfer (EFT). Please complete and return Part B.

SIGNATURE: _____ **DATE:** _____

NOTE: To ensure proper completion of the Payment Plan Selection/Electronic Funds Transfer (EFT) Authorization forms, please mail the original forms with your initial application to:

MICA
2602 E Thomas Road
Phoenix, AZ 85016-8202

Renewal policies issued by MICA will be processed based on the payment plan previously selected. If you wish to change your payment plan at renewal, you must complete this form and return it to MICA, or send via email to **billing @mica-insurance.com.**

Note to New Business applicants: If this form isn't returned with your application, your policy will be issued at the Quarterly Payment Plan without EFT.

FOR MICA USE ONLY: ☐ PART B TO FINANCE & ACCOUNTING

Electronic Funds Transfer (EFT) Authorization

Electronic Funds Transfer (EFT) Authorization, Part B

Part B. EFT Authorization (EFT is required for the monthly payment plan. EFT is optional for other payment plans)

Policyholder's Name **(please print):**	
Policy Number: TBD	Name of Bank/Credit Union*:
Home Phone:	Account/Member Number:
Work Phone:	Bank Routing Number (9 digits):

PLEASE ATTACH VOIDED CHECK HERE

(not a deposit slip)

***NOTE:** Not all Credit Unions offer EFT services. Confirm with your Credit Union that this service is available before submitting this form.

Terms of Agreement

1. I authorize my Bank or Credit Union to honor MICA's electronic funds transfer request for my insurance premium on any new, renewal or replacement policy.
2. I understand that MICA will send written notice if changes occur in my EFT deduction date or amount. I understand that my monthly Bank or Credit Union statement will serve as my payment record.
3. I understand that any changes I make to my policy that change my premium amount may not be immediately reflected in my EFT deductions. **I understand that I must allow at least eight business days prior to the deduction date for changes to be reflected in my EFT deduction.**
4. **I understand that I can stop this EFT deduction by contacting MICA at least eight business days prior to the deduction date.**
5. I understand that if I select the monthly payment plan and later stop this EFT deduction, I must select another payment plan. I understand that if I fail to inform MICA of an alternative payment selection, my account will automatically revert to a quarterly payment plan.
6. I understand that the policyholder's name on this authorization form and the name on the voided check being provided must match. I also understand that MICA cannot guarantee that a EFT deduction will be made if the names do not match and that it is my responsibility to make arrangements with my financial institution to process this request.
7. I understand that if I change financial institutions or close my checking account, I must complete a new authorization form and attach a new voided check in order to continue my EFT deductions. Financial institution changes must be received by MICA at least eight business days prior to the deduction date.
8. I understand that if there are insufficient funds in my account on the deduction date, MICA will make a second EFT deduction attempt. I understand that any fees charged by my financial institution associated with the second deduction attempt are my responsibility and will not be paid or reimbursed by MICA. If three insufficient funds occur during the current policy term, the EFT pay plan option will be rescinded.

SIGNATURE: _____ **DATE:** _____