



## Application for Medical Professional Liability Reporting Policy

Name: \_\_\_\_\_  
LAST FIRST MI 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

Cell phone: \_\_\_\_\_

Home phone: \_\_\_\_\_ Fax #: \_\_\_\_\_

Home address: \_\_\_\_\_  
CITY | STATE | ZIP

Preferred Mailing Address:  Home  Office Email: \_\_\_\_\_

Do you have a website?  Yes  No Website: \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical license: Primary state \_\_\_\_\_ Lic. # \_\_\_\_\_ Dt. Issued: \_\_\_\_\_ Temp. expiration dt. \_\_\_\_\_

Other States Licensed: \_\_\_\_\_  
LIST STATES, NUMBER AND DATE

Specialty: \_\_\_\_\_ Subspecialty: \_\_\_\_\_

**REQUIRED:** Please describe your **current/proposed practice** and any **anticipated/planned practice** activity (development) over the next several years. \_\_\_\_\_

1. **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.

2. **Limits of Liability:** (check one box)

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

\*Combined per occurrence and aggregate

3. **Do you wish to apply for Prior Acts\* Coverage?**  Yes  No

If "Yes", a separate Prior Acts Application must be submitted.

\* "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.

*Please provide a full and complete explanation to any yes response on this application in writing on your letterhead and return with your completed application. Please reference on this application that additional information is attached. Please attach a copy of your letterhead. Please be certain to sign and date the application on page 6.*

## 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.

1. a. Medical School: \_\_\_\_\_ Year Graduated: \_\_\_\_\_  
NAME OF SCHOOL CITY | STATE
- b. Residency (1): \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_  
NAME OF HOSPITAL CITY | STATE MONTH | YR MONTH | YR  
 Specialty \_\_\_\_\_ Residency Completed?  Yes  No  
 If "no", Please Explain: \_\_\_\_\_
- c. Residency (2): \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
NAME OF HOSPITAL CITY | STATE MONTH | YR MONTH | YR  
 Specialty \_\_\_\_\_ Residency Completed?  Yes  No  
 If "no", Please Explain: \_\_\_\_\_
- d. Add'l. Training(1): \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
NAME OF HOSPITAL OR FACILITY CITY | STATE MONTH | YR MONTH | YR  
 Type of Training: \_\_\_\_\_
- Add'l. Training(2): \_\_\_\_\_ From: \_\_\_\_\_ to \_\_\_\_\_  
NAME OF HOSPITAL OR FACILITY CITY | STATE MONTH | YR MONTH | YR  
 Type of Training: \_\_\_\_\_
- e. Were you ever warned about your performance or placed on any type of probation during your training?  Yes  No
- f. Are you Board Certified?  Yes  No \_\_\_\_\_ Year: \_\_\_\_\_  
NAME OF BOARD
- Have you ever been denied Board certification or recertification?  Yes  No  
 If "yes", please state reason: \_\_\_\_\_

## 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 medical school. Please explain any gaps in your education or professional practice history.

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

2. Please list all hospitals where you have or are applying for staff privileges.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. 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: \_\_\_\_\_  
 Do you have any Physicians or Surgeons in your employ?  Yes  No  
 If "yes", please name: \_\_\_\_\_
- A Member of a Medical Corporation or Partnership - Name of Corporation or Partnership: \_\_\_\_\_
- An Employed Physician - Name of Employer: \_\_\_\_\_

An Independent Contractor - Name of Physician, Corporation or Partnership with whom you contract:

---

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

---

4. a. Do you employ, contract with or supervise any non-physician healthcare providers? ○ Yes ○ No  
 If "yes", please write the number of such persons and their name where appropriate:

|                     | Number | Name  |   | Number | Name  |
|---------------------|--------|-------|---|--------|-------|
| Acupuncturist       | _____  | _____ | Certified Registered Nurse Anesthetist                        | _____  | _____ |
| Neonatology Nurse   | _____  | _____ | Nurse Midwife (Certified)                                     | _____  | _____ |
| Nurse Midwife (Lay) | _____  | _____ | Nurse Practitioner  | _____  | _____ |
| Optometrist         | _____  | _____ | Perfusionist  | _____  | _____ |
| Physician Assistant | _____  | _____ | Psychologist  | _____  | _____ |
| Surgical Assistant  | _____  | _____ | Therapist (behavioral, occupational, physical or respiratory) | _____  | _____ |
| Other               | _____  | _____ |   | _____  | _____ |

b. Do the above individuals carry professional liability insurance? ○ Yes ○ No  
 Please submit a current certificate of insurance or current copy of the declarations page for the individuals who carry their own professional liability coverage.

---

*Due to the exposure represented by the above health care providers, additional premium may be charged for these individuals and additional information may be required.*

---

5. Average/estimated number of hours worked per week: Average # hours \_\_\_\_\_

6. Do you own, operate, or have any legal affiliation with any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Birthing center    | <input type="checkbox"/> Freestanding surgical facility | <input type="checkbox"/> Laboratory                   |
| <input type="checkbox"/> Medi-Spa           | <input type="checkbox"/> Pharmacy                       | <input type="checkbox"/> Surgical suite within office |
| <input type="checkbox"/> Urgent care clinic | <input type="checkbox"/> X-ray or imaging facility      |   |

7. For any healthcare facility noted in the previous question, does the facility provide medical services to individuals who are not patients of any of the physicians listed in question 3? ○ Yes ○ No

8. Are you employed by or under contract to an:      Emergency Department: ○ Yes ○ No  
    Urgent Care Facility: ○ Yes ○ No

9. 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 describe: \_\_\_\_\_  
 Please include a certificate of insurance evidencing coverage.

10. Do you perform any aesthetic and/or cosmetic procedures or employ or contract with anyone that does? ○ Yes ○ No

If "yes", please describe: \_\_\_\_\_

11. Do you use any of the following **in your office practice**: conscious sedation or general anesthesia? ○ Yes ○ No

If "yes", for what procedures, who administers it, and who monitors and recovers the patient?

---

12. a. Do you participate in telemedicine or teleradiology for patients located in the same state as your address of record with MICA? ○ Yes ○ No

If "yes", are you physically located at the address of record while providing telemedicine or teleradiology? ○ Yes ○ No

If "no", please list what state(s) you are in at the time of providing care/reads:  
 \_\_\_\_\_

b. Do you participate in telemedicine or teleradiology for patients located outside of your address of record with MICA? ○ Yes ○ No

If "yes", a) please list what state(s) the patients are located in and (b) please list what state YOU are located in at the time of providing care/reads: \_\_\_\_\_

13. Are you practicing as a hospitalist? If "yes," percentage of time: \_\_\_\_\_  Yes  No  
 For purposes of this question, a hospitalist is defined as a hospital-based physician (excludes specialties of anesthesiology, infectious disease, neonatology, pathology, radiology and emergency medicine) who treats only hospitalized patients.
14. Do you perform bariatric surgery or weight control surgery?  Yes  No
15. Do you provide "concierge" practice services?  Yes  No

### Additional Underwriting Information

1. Do you permit other healthcare providers to use your office space to provide their services?  Yes  No  
 If "yes," please describe the activities: \_\_\_\_\_  
 \_\_\_\_\_
2. Do you practice in any other state? If yes, provide an explanation:  
 \_\_\_\_\_  
 \_\_\_\_\_
3. a. Have you ever been denied privileges by a medical staff, hospital, health care facility, managed care organization, or any other health care entity in any state? If "yes," please provide an explanation on a separate sheet.  Yes  No
- b. Have you ever voluntarily surrendered your privileges or resigned from the medical staff at a hospital, healthcare facility, managed care organization, or any other health care entity in any state while under investigation or to avoid possible disciplinary action? If "yes," please provide an explanation on a separate sheet.  Yes  No
- c. Have you ever been investigated, warned, reprimanded, censured, sanctioned, placed on probation, suspended, other than a temporary suspension for delinquent medical records, or asked to resign by a medical staff, hospital, health care facility, managed care organization, or any other health care entity in any state? If "yes," please provide an explanation on a separate sheet.  Yes  No
- d. Have you ever been the subject of an official or non-official proceeding or hearing brought by a medical staff, hospital, managed care organization, or any other health care entity in any state to modify, restrict, limit, reduce, suspend, non-renew, or revoke your privileges or that could place your exercise of such privileges under supervision, observation, or any other type of review? If "yes," please provide an explanation on a separate sheet.  Yes  No
4. Has any insurance carrier ever declined, surcharged, rated up, restricted, canceled or refused to renew your professional liability insurance?  Yes  No  
 If "yes," give details: \_\_\_\_\_
5. Have you ever been involved in a malpractice Claim,\*\* lawsuit, incident or occurrence?  Yes  No  
 If "yes," complete the claim narrative addendum for each claim, lawsuit, incident, or occurrence.  
 \*\*As defined in the MICA Policy, "Claim" means either a demand received by an Insured for damages or a complaint, lawsuit, demand for arbitration or other legal process served on an Insured. "Occurrence" means an event or series of events resulting in bodily injury, personal injury, or property damage neither intended nor expected from the standpoint of an Insured, which may give rise to a claim.
6. In the course of your career:
- a. Have you ever been convicted of, been charged with, been formally arraigned, or pleaded guilty or no contest to, a crime other than a traffic violation? Exclude only non-DUI related misdemeanor traffic violations. If "yes," please provide an explanation on a separate sheet.  Yes  No
- b. Have you suffered from or been treated for alcohol or substance abuse, disability, mental illness or serious illness/injury? If "yes," please provide an explanation on a separate sheet.  Yes  No
- c. Has your license to practice medicine or permit to prescribe or dispense narcotics or other controlled substances in any state ever been restricted, limited, voluntarily surrendered, suspended, or revoked? If "yes," please provide an explanation on a separate sheet.  Yes  No
- d. Has your application for a license to practice medicine or permit to prescribe or dispense narcotics or other controlled substances in any state ever been denied?  Yes  No  
 If "yes," please provide an explanation on a separate sheet.
- e. Have you ever been investigated, disciplined, censured, reprimanded, fined, or placed under probation or stipulation (either voluntarily or otherwise) by any state licensing entity or board, the Drug Enforcement Administration, or any other governmental or regulatory agency? If "yes," please provide an explanation on a separate sheet.  Yes  No
- f. Have you ever had a complaint against you submitted to any such entity, board, or agency?  Yes  No

If "yes", please provide an explanation on a separate sheet.

- g. Have you ever been notified to respond to or appear before any such entity, board, or agency for a complaint against you? If "yes", please provide an explanation on a separate sheet.  Yes  No
- h. Have you ever received an advisory letter, a letter of concern, a letter of admonition, a letter of reprimand, or a decree of censure from any such entity, board, or agency? If "yes", please provide an explanation on a separate sheet.  Yes  No
- i. Have you ever entered into any voluntary stipulation, order, or similar action with any such entity, board, or agency? If "yes", please provide an explanation on a separate sheet.  Yes  No
- j. Has Medicare/Medicaid ever brought documented charges against you for alleged fraud or inappropriate fees? If "yes", please provide an explanation on a separate sheet.  Yes  No
- k. Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct? If "yes", please provide an explanation on a separate sheet.  Yes  No
- l. Have you ever been subject to disciplinary proceedings or to a review affecting your participation in a foundation, HMO, PPO, IPA, Medicare/Medicaid or similar entity or have you ever been notified of an intent to pursue such action? If "yes", please provide an explanation on a separate sheet.  Yes  No

### 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 malpractice 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, physician counseling and related services.

I consent to MICA obtaining reviews from other physicians if necessary or appropriate to evaluate my application.

I understand that all physicians, 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 physician.

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, 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.**

### 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.

\_\_\_\_\_  
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.

**Additional Insured | Rotator - see page 6.**

**If you are applying as an Additional Insured, please have your group or employer complete the following:**

### **Group or Employer Authorization**

I hereby request the above applicant be added to my policy as (check one):       additional insured     rotator  
(90 days max)

If you are working as a rotator, please provide the number of days to be worked on a monthly basis: \_\_\_\_\_

I understand that such coverage is limited to the language in Section IV. Additional Insureds of the MICA policy and is subject to underwriting approval.

\_\_\_\_\_  
REQUESTED EFFECTIVE DATE

\_\_\_\_\_  
SIGNATURE OF GROUP OR EMPLOYER

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

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.**



## Application for Medical Professional Liability Claims Narrative Addendum

Applicant's Name (please print): \_\_\_\_\_

Please supply the following information for any "yes" response to question #5 in the Additional Underwriting Information section of the Application for Medical Professional Liability 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)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pending          | <input type="checkbox"/> Settled out of Court | <input type="checkbox"/> Found for Plaintiff at Trial |
| <input type="checkbox"/> Summary Judgment | <input type="checkbox"/> Dismissed            | <input type="checkbox"/> 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