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

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") from 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 physicians 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 physician(s) with whom you practiced and the period of your association. (Attach additional pages as needed.)

Entity	Physician(s)	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

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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 regarding a potential incident, claim, or lawsuit? ☐ 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, 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.

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 800.352.0402.