UNDERWRITING REQUIREMENTS

Checklist for Facility Submission

Medical Facility Application

- ☐ Application for Medical Professional Liability Reporting Policy - Please answer each question in the application that is applicable to your specific facility type.
- ☐ Facility Roster - List all healthcare professionals who use this facility
- ☐ 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 Insured Applications

- ☐ MICA additional insured application for healthcare provider (MD, DO, PA, NP, etc.). If you employ any of the following extended role providers and would like to apply for coverage under your policy with shared limits: Acupuncturist, Certified Registered Nurse Anesthetist, Dentist, Neonatal Nurse Practitioner, Nurse Midwife, Nurse Practitioner, Optometrist, Perfusionist, Physician, Physician Assistant, Psychologist, Surgical Assistant, Therapist (behavioral, occupational, physical or respiratory).
- ☐ Certificate of Insurance: if the healthcare provider (PA, NP, etc.) has his or her own insurance

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

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
- ○ $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

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 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

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

MPL-8024b (07|2011)

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.

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: ____________

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