UNDERWRITING REQUIREMENTS

Checklist for Business Enterprise Submission

Business Enterprise Application

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

Physician Applications & Supplements

- ☐ Application for Medical Professional Liability Reporting Policy – All physicians who are members of the group will need to complete an individual physician application.

Additional Insured Applications

- ☐ MICA additional insured application for healthcare provider (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 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

Business Enterprise Application for Medical Professional Liability Reporting Policy

Any changes (i.e. deletion/addition of physicians or paramedicals, change in legal status of group, etc.) to this group practice must be reported to MICA immediately. Failure to do so may jeopardize your coverage.

Name of Group: _____ Date Current Group Established: _____

Name of any DBA's and/or Trade Names: _____

Type of Group: ☐ Corporation ☐ Partnership ☐ Other Taxpayer ID Number _____

Prior Names of Group: _____

Prior Names of any DBA's and/or Trade Names: _____

Mailing Address: _____
Street Number Suite # City | State | Zip Code

Business Manager|Contact Person: _____ Office Ph: _____ (Area Code) FAX #: _____ (Area Code)

E-Mail Address: _____ Do You have a Website? ☐ Yes ☐ No

If yes, please indicate your website address: _____

Professional Office Premises (List All Locations)

_____
Street Number Suite # City | State | Zip Code

_____
Street Number Suite # City | State | Zip Code

Please Describe Your Operation: _____

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

Physician Employees

1.	Shareholders or Partners	Employed Physicians	Independent Contractors

Non-Physician Employees

2.

	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					

3. 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 is charged for these individuals and additional information may be required.

4. Do you own, operate, or have any legal affiliation with any of the following?
   - ☐ Birthing center
   - ☐ Freestanding surgical facility
   - ☐ Laboratory
   - ☐ Medi-Spa
   - ☐ Pharmacy
   - ☐ Surgical suite within office
   - ☐ Urgent care clinic
   - ☐ X-ray or imaging facility

5. 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 1? ☐ Yes ☐ No
6. What percentage of your physicians are board certified? _____

7. Has your group ever been involved in a malpractice Claim,** lawsuit, incident or occurrence? ☐ 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.

   **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.

8. 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 before the Retroactive Date.

   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.

   If yes to #8 above, please complete the following questions:

9. 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 #9 above.

10. At all times from the date noted in question #9, have you been continuously insured under a claims-made type of policy? ☐ Yes ☐ No

    If "No", please explain. _____

11. 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

12. 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

13. 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

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

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

16. 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

17. 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

Please attach a copy of your organizational chart with this application.

Application For Reporting Policy of Medical Professional Liability Insurance

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 therefore, 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 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 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. 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.

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

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

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

Policyholder's Name **(please print)**:
Policy Number:
Billing Email Address:

◯ **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.

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

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

Enroll in AutoPay via the payment portal accessible through the MICA website. Please contact MICA Customer Service at 602.808.2111 or help@mica-insurance.com for instructions.

SIGNATURE: _____ **DATE:** _____

NOTE: To ensure proper completion of the Payment Plan Selection form, please submit the original form with your initial application to micauw@mica-insurance.com or mail to:

MICA
2602 E Thomas Road
Phoenix, AZ 85016-8202

*If you wish to change your payment plan at renewal, you must complete this form and return it to MICA***.**

Note to New Business applicants: If this form isn't returned with your application, your payment plan will be set to Quarterly.