



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

Additional Insured Application for Medical Professional Liability Reporting Policy

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 E-mail: _____

Do you have a website? Yes No Website: _____

Social Security: _____ Date of Birth: _____ State & License #: _____

I wish to have coverage as an additional insured while practicing as:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Neonatal Nurse Practitioner | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Therapist (behavioral, occupational, physical or respiratory) |
| <input type="checkbox"/> Certified Registered Nurse Anesthetist | <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Physician Assistant | |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychologist | |
| | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Surgical Assistant | |

I work as an employee independent contractor

Name of employer: _____

How many hours do you work per quarter? (check one)

- 240 hours per quarter (full time)? 121 to 240 hours per quarter (50% Limited Practice)?
 1 to 120 hours per quarter (75% Limited Practice)?

1. 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? Yes No
 - Suffered from or been treated for alcohol or substance abuse, disability, mental illness or serious illness/injury? Yes No
 - 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
 - Had any professional license/permit or narcotics license investigated, disciplined, reprimanded, suspended, revoked, restricted, placed under probation, rejected, or denied? Yes No
 - 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 provide a brief summary of the medical facts to include a description of your involvement and the name of the insurance carrier defending you.

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 and indicate the name of the insurance carrier providing coverage for these activities. Please include a certificate of insurance evidencing 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 and indicate the name of the insurance carrier providing coverage. Please include a certificate of insurance evidencing coverage.

- 6. Please answer the following questions if you hold staff privileges at any hospital or outpatient facility:
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 hospital at which I have applied for privileges, whether those privileges were granted or not.
2. The regulatory body granting me a license to practice medicine in any State.
3. Any insurance company to which I have applied for medical malpractice coverage, whether such coverage was granted or not.
4. 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. Underwriting matters from my past and present state licensing board.

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

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.

I also certify that I have read the attached "restrictions applying to additional insured coverage."

SIGNATURE OF APPLICANT- ADDITIONAL INSURED SIGNATURE

DATE

NAME

Insured's Authorization

I hereby request the above applicant be added to my policy as (check one) [] an Additional Insured [] Rotator
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.

SIGNATURE OF INSURED (or Officer if Insured is a Group)

REQUESTED EFFECTIVE DATE:

NAME

DATE

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

Restrictions Applying To Additional Insured Coverage

Coverage for Additional Insureds does not provide a separate limit of liability. Additional Insureds are insured within the limit available to the policy to which they are added.

This means that if an Additional Insured and the Named Insured are named in an action involving the same patient, only one occurrence limit of liability is available to cover both. There may be other Additional Insureds on the policy as well. Regardless of the number of persons insured under the policy, no more than one limit of liability is available for each occurrence or person who makes a claim (see Policy Section IV. Additional Insureds).

The policy contains an aggregate amount of coverage. If some or all of an aggregate limit is used up, only the remaining portion is available for future claims made against the policy.

Additional Insureds should check the hospital bylaws, if applicable, to see if that coverage meets their criteria.

The MICA Policy is issued on a Reporting form of modified Claims-Made basis. This means that if the Policy is cancelled, there is no coverage for claims made after the policy ends, unless the Named Insured has purchased an Extended Reporting Endorsement. Additional Insureds have no independent right to purchase this

coverage. Only the Named Insured may make that decision. It is, therefore, important to understand that the Named Insured may, at a future date, elect to cancel their MICA Policy and not purchase Extended Reporting Coverage. If this occurs, neither the Named Insured nor any Additional Insured would have any further coverage for unreported claims and lawsuits.

Coverage provided to an Additional Insured is limited to Section I, Part 1, and Section I, Part 2, Coverages (a) and (b). Any settlements and judgments paid as a result of an Additional Insured's occurrences will apply against the applicable limit of liability of the Named Insured.

These guidelines are meant to point out some of the more important restrictions that apply to an additional insured. There are others. Please read the policy carefully. In addition, the terms under which an additional insured is covered may change in future policies. MICA undertakes no duty to inform an additional insured of such changes. We will notify the Named Insured of changes which occur. It is up to the additional insured to ask the Named Insured to inform them if changes occur. These changes could involve limits of liability, coverage provisions, exclusions, etc.