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

Application for Medical Professional Liability Reporting Policy

Name: _____ LAST _____ FIRST ____ MI _____ PROFESSIONAL DEGREE

Gender: ☐ Male ☐ Female Date of Birth: _____

Office address: _____

_____ CITY | STATE | ZIP

Office phone: _____ Fax #: _____ Website: _____

Cell phone: _____ Email: _____

Medical license: State _____ Lic. # _____ State _____ Lic. # _____

Specialty: _____ Subspecialty: _____

Board Certification: _____ NAME OF BOARD Year Certified/Recertified: _____

Average number of hours worked per week: _____

Coverage Requested

Effective Date: _____ Retroactive Date (if requesting prior acts): _____

Limits of Liability: (check one box)

O $1,000,000/$3,000,000 O $2,000,000/$4,000,000 O $3,000,000/$5,000,000

Additional Information

Within the last 10 years, have you been named in a medical liability claim, lawsuit, incident or occurrence? O Yes O No

If yes, please attach a summary of the claim and current status.

Have you ever had a complaint against you submitted to a state licensing board or entity, regulatory agency or hospital credentialing department? O Yes O No

If yes, please attach a copy of the complaint or a summary providing an explanation.

Please attach the following (all attachments are hereby incorporated by reference into this application and made a part of this application):

- Current valued loss run from all prior carriers for the last 10 years.
- Copy of your Curriculum Vitae.
- A summary of your medical training, history of your medical practice(s) and location(s), and a list of hospitals where you have staff privileges. A copy of a hospital credentialing application or an application used to apply for medical professional liability coverage signed within the past six months is acceptable if it includes this information.

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 by MICA in making decisions.

I agree that all information provided to MICA as part of this application, including attachments or statements, is a part of my application.

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 request for coverage.

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 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 (or any attachment to this 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 certify that the information and all statements provided to MICA are true and complete. All information and all attachments provided to MICA to evaluate my request for coverage shall be considered my application for insurance. 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 (and all attachments hereto) 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, and 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.

SIGNATURE OF APPLICANT _____ DATE _____

NAME _____

Note: You are required to notify MICA immediately of any change to your practice. Failure to do so may jeopardize coverage. Return only fully completed applications to MICA. **If you have 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.**