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East Meadow, NY 11554  
516.794.7200

## Application For Physicians' And Surgeons' Professional Liability Insurance

www.mlmic.com

### Important Notice

If you elect the claims made form of insurance, please be aware no coverage will be extended for any incidents, occurrences, or alleged wrongful acts which took place prior to the Retroactive Date stated in the policy. Coverage is only provided for incidents that occur on or after the Retroactive Date stated in the policy and which are reported to the Company while the policy is in effect or within 60 days following termination of insurance, unless additional reporting period coverage is purchased, which would provide an unlimited time period to report covered Claims.

During the first several years, claims made premiums are lower than occurrence premiums, but then they increase substantially, independent of overall rate level increases, until the claims made risk reaches maturity. For further information regarding coverage, please read our brochure about coverage forms.

**All applications are subject to prior approval. If your application is approved, coverage can be provided no earlier than the day following the postmark on the envelope containing the completed and signed application.**

### General Information

**1. Name:**

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Last First Middle Month Day Year

**2. Mailing Address:**

\_\_\_\_\_ City/County State Zip Code

**3a. Principal Office Address:**

\_\_\_\_\_ City/County State Zip Code

**3b. Additional Office Address:**

\_\_\_\_\_ City/County State Zip Code

**4. Home Address:**

\_\_\_\_\_ City/County State Zip Code

**5. If you practice in more than one county or state, list the corresponding percentages of patient hours expended in each:**

County/State	County/State	County/State	County/State
%	%	%	%

**6. Social Security Number:**

\_\_\_\_\_

**Telephone Numbers:**

Office \_\_\_\_\_ Home \_\_\_\_\_

**7. Fax Number:**

\_\_\_\_\_

**8. E-mail Address:**

\_\_\_\_\_

**9. On what date do you wish the insurance to be effective?  
12:01 A.M Standard Time on:**

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**10. Do you wish to have your policy issued on a**  **Claims Made or an**  **Occurrence Basis?**

**Legislation has been enacted regarding physicians who qualify and elect to obtain \$1 / \$3 million of excess coverage without charge. Those physicians must have primary limits of \$1,300,000 / \$3,900,000.**

THE LIMITS OF LIABILITY THE POLICY WILL PROVIDE ARE (Check One):

Each Person \$1,000,000 / Annual Aggregate \$3,000,000.

Each Person \$1,300,000 / Annual Aggregate \$3,900,000.

LOWER LIMITS OF LIABILITY ARE AVAILABLE UPON WRITTEN REQUEST.

IF ANY ANSWER TO QUESTIONS 11 – 16 IS "YES", PLEASE PROVIDE COMPLETE DETAILS ON A SEPARATE SHEET.

**11. Have you ever been convicted of a criminal offense other than a motor vehicle violation?**

Yes  No

**12. Have you ever had your hospital privileges or privileges at any other institution or managed care organization revoked, suspended, or restricted, or have you been placed on probation in any state?**

Yes  No

**13. Have you had your medical license or narcotics license revoked, suspended, restricted, or voluntarily surrendered in any state?**

Yes  No

**14. Have you been treated or hospitalized for any drug, chemical, neurological, alcohol, or mental-related problem?**

Yes  No

**15. Has any insurance company ever canceled, refused to renew, restricted coverage, or offered professional liability insurance to you with a deductible, or at higher than regular rates?**

Yes  No

**16. Have you ever practiced without insurance?**

Yes  No

**17a.** Have you ever had professional liability insurance?

Yes  No

If Yes, provide the following information with respect to all past insurance coverage. Use separate sheet if necessary.

_____ Name of Insurance Company	_____ Name of Insurance Company
_____ Policy Number	_____ Policy Number
_____ Dates of Coverage	_____ Dates of Coverage
_____ Limits of Liability	_____ Limits of Liability
_____ Type of Coverage (Occurrence or Claims Made)	_____ Type of Coverage (Occurrence or Claims Made)

**The following question must be completed by all applicants who were covered on a claims made basis by their prior carrier:**

**17b.** If you are applying for either claims made or occurrence coverage, do you intend to purchase Extended Reporting Period Endorsement ("Tail") from your prior carrier?

Yes  No

*(PLEASE NOTE: Your basic coverage with MLMIC may only provide protection for incidents that both occur and are reported on or after the effective date of your coverage. Applicants who are presently covered on a claims made basis by a New York State admitted carrier, who do not intend to purchase "Tail" coverage, may obtain Prior Acts ("Nose") coverage by providing the information requested in the following section.)*

## Request for Prior Acts ("Nose") Coverage

This section should only be completed if you meet the following requirements:

- You are presently covered on a claims made basis.
- You are not purchasing "Tail" coverage from your prior carrier.
- You are applying for claims made coverage with MLMIC.
- There is no coverage lapse between the cancellation date of your current claims made policy and the effective date of your MLMIC coverage.

**1.** For what period of time are you requesting "Nose" coverage:

From (Mo/Day/Yr) \_\_\_\_\_ To (Mo/Day/Yr) \_\_\_\_\_

**2.** A copy of the policy (or policies), including all endorsements in effect during the period for which you are requesting "Nose" coverage, must accompany your application. If this information is not included, it will delay the processing of your application.

**3.** Were you in solo private practice during the entire period for which you are seeking "Nose" coverage?

Yes  No

If No, please provide us with the following information concerning the doctors with whom you were affiliated:

_____ Name of Physician(s), Surgeon(s), and/or Association(s)
_____ Relationship (Employee, Independent Contractor, Fellow Shareholder, Co-Partner, etc.)
_____ Date of Affiliation (From/To)
_____ Name of Physician(s), Surgeon(s), and/or Association(s)
_____ Relationship (Employee, Independent Contractor, Fellow Shareholder, Co-Partner, etc.)
_____ Date of Affiliation (From/To)

## Education Information

**1. Medical School Attended:**

_____ Name	_____ Name
_____ City/State/Country	_____ City/State/Country
_____ Year Graduated	_____ Degree
_____ Year Graduated	_____ Degree

**2. Internship:**

_____ Name of Hospital	_____ Name of Hospital
_____ City/State/Country	_____ City/State/Country
_____ Area of Specialization	_____ Area of Specialization
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)

**3. Residency:**

_____ Name of Hospital	_____ Name of Hospital
_____ City/State/Country	_____ City/State/Country
_____ Area of Specialization	_____ Area of Specialization
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)

**4. Fellowship:**

_____ Name of Hospital	_____ Name of Hospital
_____ City/State/Country	_____ City/State/Country
_____ Area of Specialization	_____ Area of Specialization
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)

**5. Other Training:**

_____ Name of Hospital	_____ Name of Hospital
_____ City/State/Country	_____ City/State/Country
_____ Area of Specialization	_____ Area of Specialization
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)
_____ From (Mo/Day/Yr)	_____ To (Mo/Day/Yr)

## Practice Information

**1a.** Current hospital staff appointments, including any for which you are applying:

_____ Name of Hospital	_____ Name of Hospital
_____ Name of Hospital	_____ Name of Hospital

**1b. If certificates of insurance are required, indicate to whom certificates should be sent and mailing address:**

**2.** Are you board certified?  Yes  No

If Yes, name each American specialty board:

_____ Board	_____ Board
_____ Date Certified	_____ Date Certified

3. In which states are you currently licensed? Attach a copy of New York State License or, if applicable, Limited License or Limited Permit.

State	Date Licensed	License or Permit No.
State	Date Licensed	License or Permit No.

4. List locations where you have practiced to date. (Attach separate sheet, if necessary, or Curriculum Vitae):

City/State/Country	City/State/Country		
From (Mo/Day/Yr)	To (Mo/Day/Yr)	From (Mo/Day/Yr)	To (Mo/Day/Yr)
Hospital Affiliations	Hospital Affiliations		
City/State/Country	City/State/Country		
From	To	From	To
Hospital Affiliations	Hospital Affiliations		

5. Are you a fellow of any American specialty college?

Yes  No

If Yes, give name of each:

6. Professional society memberships:

National	County
State	Other

7. As of the effective date of this insurance, will you be practicing as (please answer all questions):

a. A solo private practitioner?

Yes  No

b. An employee of a partnership, professional corporation, group, or physician / surgeon?

Yes  No

c. A full-time or part-time hospital employee?

Yes  No

If yes, please provide name of hospital and hours worked per week.

Name of Hospital	Hours per Week
------------------	----------------

d. A full-time or part-time employee of a managed care facility (HMO, PPO, etc.)?

Yes  No

If Yes, please provide name of facility and hours worked per week.

Name of Facility	Hours per Week
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e. An independent contractor?

Yes  No

If Yes, with whom are you under contract?

f. A chief, director, or department head of a hospital?

Yes  No

8. Do you practice as a partner or employee of a partnership, or as a shareholder or employee of a professional service corporation or similar entity?

Yes  No

If Yes, please provide names of entities:

A separate application is required for entity coverage if desired. Please contact the company for information. An additional premium applies for entity coverage.

9. Do you individually employ other physicians or surgeons?

Yes  No

If Yes, give name, medical specialty, and insurance carrier for each:

Name	Name
Medical Specialty	Medical Specialty
Insurance Carrier	Insurance Carrier

(Please note that you are not covered for your liability arising out of the acts or omissions of employed physicians unless they are also insured against liability under a valid and collectible professional liability policy.)

10. Do you employ any registered physician assistant, nurse practitioner, nurse midwife, nurse anesthetist, nurse, laboratory technician, x-ray technician, or similar personnel? (Attach separate sheet if necessary)

Yes  No

If Yes, give name, profession, and license and / or registry number of each.

Name	Profession and License / Registry No.
Name	Profession and License / Registry No.
Name	Profession and License / Registry No.
Name	Profession and License / Registry No.

(Please note that you will not be covered for your liability arising out of the acts or omissions of registered physician assistants, registered surgical assistants, certified registered nurse anesthetists, certified nurse midwives, or certified nurse practitioners, who are employed by you, unless those persons are also insured against liability under a valid and collectible professional liability policy.)

If you require applications or additional information regarding insurance for your employees, please contact the underwriting department of the Company.

11. Have you signed or will you sign any contract or agreement to assume the liability of others?

Yes  No

(Please note that the coverage afforded for the liability of others which you have assumed under a contract or agreement is limited. See policy exclusion.)

12. Do you own or operate any hospital, sanitarium, dispensary, clinic with bed and board facilities, laboratory, or other business enterprise?

Yes  No

*(Please note that you will not be covered for your liability as the owner, director, trustee, proprietor, superintendent, or officer of any hospital, sanitarium, dispensary, clinic, laboratory, or any other business enterprise.)*

## Underwriting and Rating Information

**All applicants must answer all parts of questions 1 through 5.**

IF YOU ANSWER YES TO ANY OF THE ASTERISKED (\*) QUESTIONS, YOU MUST SPECIFY TRAINING ON A SEPARATE SHEET AND/OR ENCLOSE CERTIFICATION FOR EACH.

1. In what specialty classification do you wish your policy issued? (See rate schedule for specialty descriptions.)

Classification

2. Indicate the number of practice hours per week:\_\_\_\_\_ (include hours involved in all professional activities as a physician or surgeon).

3. Do you perform:

\*a. Liposuction?

Yes  No

IF YES, LIST PROCEDURES PERFORMED:

\*b. Organ transplants (excluding corneal)?

Yes  No

\*c. Hair implants?

Yes  No

d. Do you practice **alternative medicine**?

Yes  No

IF YES, DESCRIBE:

\*e. Endoscopy?

Yes  No

IF YES, LIST PROCEDURES PERFORMED:

\*f. Laparoscopy for tubal sterilization?

Yes  No

\*g. Laparoscopy for **other** than tubal sterilization?

Yes  No

IF YES, LIST PROCEDURES PERFORMED:

h. Plastic surgery solely for improving the patient's appearance?

Yes  No

i. Radiological studies using chemical substances?

Yes  No

j. Laser Surgery?

Yes  No

IF YES, LIST PROCEDURES PERFORMED:

4. Do you provide:

a. Prenatal care?

Yes  No

b. Home obstetrical deliveries?

Yes  No

c. Vaginal deliveries following a Cesarean Section (VBAC)?

Yes  No

5. Do you perform abortions?

Yes  No

a. Is the procedure limited to suction curettage through the 12th week of pregnancy?

Yes  No

b. Specify other types of abortion procedures used:

c. Are abortions performed in (check where appropriate):

an office  a hospital  a clinic

6. Do you perform acupuncture?

Yes  No

If Yes, provide permit number:

Permit Number

7. Do you perform procedures for the purpose of pain management?

Yes  No

If Yes, \_\_\_\_\_ % of practice.

If Yes, please describe, in detail on a separate sheet, the procedures performed and your training in pain management.

8. Do you perform colon and rectal surgery?

Yes  No

If Yes:

a. Do you limit surgery to the rectum, anal canal, and perineal area?

Yes  No

b. Is any of your surgery performed by the abdominal approach?

Yes  No

9. If you are an **obstetrician/gynecologist**, do you limit your practice to gynecological surgery?

Yes  No

10. If you are an **internist**:

a. Do you perform cardiac catheterization? (Swan-Ganz is not considered cardiac catheterization.)

Yes  No

b. Do you limit your practice to allergy?

Yes  No

c. Do you perform endoscopic retrograde cholangiopancreatography (ERCP)?

Yes  No

d. If applicable, list subspecialties in Internal Medicine:

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11. If you are a **neurologist or psychiatrist**:

a. Do you perform, supervise, or direct the performance of myelography or angiography?

Yes  No

b. Do you perform electroshock therapy?

Yes  No

12. If you are a **radiologist**:

a. Do you practice radiological therapy?

Yes  No

If Yes, do you limit your practice to radiation therapy only?

Yes  No

b. Do you practice or plan to practice interventional radiology?

Yes  No

13. If you are a **specialty or general surgeon**, please indicate the type of surgery that you perform or will perform and the corresponding percentage:

a. Vascular Surgery?

If Yes \_\_\_\_\_ %  No

b. Thoracic Surgery (cardiac)?

If Yes \_\_\_\_\_ %  No

c. Thoracic Surgery (non-cardiac)?

If Yes \_\_\_\_\_ %  No

d. Bariatric Surgery?

If Yes \_\_\_\_\_ %  No

e. General Surgery?

If Yes \_\_\_\_\_ %  No

f. Other, If Yes  list type and percentage  No

\_\_\_\_\_ %  
Type %  
g. Do you perform office surgery?  Yes  No  
IF YES, LIST PROCEDURES PERFORMED:

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14. If you are a **dermatologist**, do you perform:

a. Dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using phenol, or Mohs' microsurgery?

Yes  No

b. Other Dermatological surgery?

Yes  No

If Yes, specify types of procedures:

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c. Cosmetic surgery?

Yes  No

If Yes, specify procedures and training:

d. Do you practice **dermatopathology**?

Yes  No

15. If you are an **anesthesiologist**:

a. Do you administer anesthesia outside of a hospital setting?

Yes  No

If Yes, state where and type of anesthesia administered:

Where \_\_\_\_\_ Type of Anesthesia \_\_\_\_\_

What is the distance to the nearest hospital? \_\_\_\_\_

What equipment is available in the event of an emergency?

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b. Estimate the average number of hours per week that you administer anesthesia: \_\_\_\_\_

Hours Per Week

16. If you are an **otolaryngologist**, do you wish to apply for cosmetic plastic surgery limited to the field of otolaryngology?

Yes  No

17. Please answer **regardless of specialty**. Do you perform:

Deep and superficial x-ray therapy and/or isotope teletherapy?

Yes  No

If Yes, provide the following information:

a. Preceptorship training:

\_\_\_\_\_ Location of Training

\_\_\_\_\_ Name of Doctor Who Directed Training

\_\_\_\_\_ Period of Training From To

\_\_\_\_\_ Period of Training From To

b. Number of year's experience in giving x-ray treatments: \_\_\_\_\_

18. Are you practicing as an **emergency medicine physician**?

Yes  No

If Yes, list hours worked per week: \_\_\_\_\_

Hours Per Week

Please attach copies of documentation denoting current certification in both ACLS and ATLS or evidence of current board certification.

19. Have you successfully completed a risk management course approved by the New York State Insurance Department to obtain a 5% premium discount?

Yes  No

If Yes, provide a letter from your prior insurance carrier indicating successful completion of the course and the expiration date of your discount.

**20. FOR ALL MEDICAL SPECIALTIES, FAMILY/GENERAL PRACTICE, AND EMERGENCY MEDICINE CLASSIFICATIONS (THIS DOES NOT APPLY TO ANY SURGICAL CLASSIFICATIONS):** You must answer all of the questions listed. Indicate how many of the following procedures you anticipate performing during the next 12 months (include both office and hospital practice). If you do not perform a procedure answer "no".

*Please Note: A physician will not qualify for a family/general practice category, if he/she performs open orthopedic procedures or intraabdominal surgery or certain other major surgery.*

a. Deliveries:

Normal as described below\*  Complicated

Yes # \_\_\_\_\_  No  Yes # \_\_\_\_\_  No

\*Normal deliveries are defined as follows: (a) normal spontaneous deliveries, (b) the use of outlet forceps or vacuum delivery, (c) episiotomy, (d) repair of cervical tear in emergency situations, (e) the use of Pitocin as an inductive or augmentative agent, provided the physician examines the patient and consults with a qualified obstetrician prior to its use and the physician is physically present until the patient has been stabilized for a minimum of 30 minutes after the Pitocin is administered and thereafter is readily available to attend to the patient; and (f) performance of vaginal delivery following Cesarean Section (VBAC), provided there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is readily available for consultation and treatment of the patient if necessary. NORMAL DELIVERY DOES NOT INCLUDE THE DELIVERY OF KNOWN BREECH PRESENTATIONS OR MULTIPLE GESTATIONS

b. Hemorrhoidectomies

Yes  No # \_\_\_\_\_

c. Pilonidal cystectomies

Yes  No # \_\_\_\_\_

d. Open reductions of fractures

Yes  No # \_\_\_\_\_

e. Closed reduction of fractures

Yes  No # \_\_\_\_\_

f. Excision of superficial growths

Yes  No # \_\_\_\_\_

Of these, what percentage are referred for pathological evaluation?

Percentage

g. Diagnostic D & C's

Yes  No # \_\_\_\_\_

h. Appendectomies

Yes  No # \_\_\_\_\_

i. Herniorrhaphies

Yes  No # \_\_\_\_\_

j. T & A's

Yes  No # \_\_\_\_\_

k. Abortions (suction curettage through 12th week of pregnancy)

Yes  No # \_\_\_\_\_

Other abortions:

Type Number

Type Number

l. Vasectomies

Yes  No # \_\_\_\_\_

m. Varicose vein surgery

Yes  No # \_\_\_\_\_

n. Will you act as surgical assistant?

Yes  No # \_\_\_\_\_

o. Will other doctors refer patients to you for major surgery?

Yes  No # \_\_\_\_\_

p. Will you provide prenatal care?

Yes  No # \_\_\_\_\_

If Yes, is prenatal care limited to uncomplicated pregnancies as described below?\*

Yes  No # \_\_\_\_\_

*\*Prenatal care for uncomplicated pregnancies will not include: the care of patients with high risk conditions, such as hypertension and diabetes, or pregnancies with known breech presentations or multiple gestations, unless there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is readily available for consultation and treatment of the patient if necessary.*

q. Other major procedures (specify type and number):

Type/Number Type/Number

Type/Number Type/Number

Type/Number Type/Number

r. Other minor procedures (specify type and number):

Type/Number Type/Number

Type/Number Type/Number

Type/Number Type/Number

## Claim/Suit Information

If additional space is required for claims or suits, describe on your business stationery using the following format:

**Have you ever had a malpractice claim or suit (closed or pending) asserted against you?**

Yes  No

If Yes, how many?

Number of Claims or Suits

**If yes, please secure a copy of the National Practitioner Data Bank report and forward a copy of this report to MLMIC.**

For each claim or suit, describe as follows:

**a.** Name of claimant or plaintiff:

**b.** Dates of treatment:

**c.** Factual description of care and treatment (use a separate sheet, if necessary):

**d.** State allegations of malpractice:

**e.** Location of treatment:

County

State

**f.** Names of other doctors involved:

**g.** Name of hospital(s) involved:

**h.** Name of insurance company defending you:

**i.** Status of claim or suit:

Pending  Closed

**j.** If the case was closed, was the final disposition:

A verdict against you?

Yes  No

If Yes, list amount of award:

\$ \_\_\_\_\_

A verdict against a co-defendant?

Yes  No

If Yes, list amount of award:

\$ \_\_\_\_\_

A settlement prior to, or during, trial?

Yes  No

If Yes, list settlement amount:

\$ \_\_\_\_\_

Of this sum, what was paid on your behalf?

\$ \_\_\_\_\_

Amount Paid

A verdict against the plaintiff in your favor?

Yes  No

Dismissed or Discontinued:

Yes  No

## Event/Incident Information

If answering Yes to the following, please provide details including names, dates, and description of treatment on your business stationery and attach it to this application.

**1.** Are you aware of any event(s) or incident(s) that may or will result in a claim against you?

Yes  No

If Yes, how many?: \_\_\_\_\_

Number

**2.** Have any of these events or incidents been reported to your prior insurance carrier(s)?

Yes  No

**Note: Your signature is required following both the Release of Information and Insurance Department Regulation statements which appear below:**

**New York State Insurance Department Regulation Declares That:**

**Release of Information**

I hereby authorize Medical Liability Mutual Insurance Company to obtain full information from any insurance company or from any person with respect to me or my medical practice, including but not limited to, any claim or suit or incident pertaining to professional acts or omissions asserted against me and/or my partnership or professional corporation. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

Date Signed \_\_\_\_\_ Personal Signature of Applicant \_\_\_\_\_

Date Signed \_\_\_\_\_ Personal Signature of Applicant \_\_\_\_\_

If coverage is approved, please indicate payment plan desired:  
 Annual                       Quarterly

As a service to you, the insured, your policy allows you to designate a Policy Administrator, that is, someone other than yourself to make changes and pay premiums when due. To make such a designation, you must complete and return the enclosed MLMIC form, “Policy Administrator — Designation &/or Change.”

Do you wish to designate a Policy Administrator, other than yourself?  
 Yes                               No

If Yes, whom? \_\_\_\_\_  
**(Please complete and return the enclosed MLMIC form, “Policy Administrator - Designation &/or Change.”)**

**THIS SECTION FOR COMPANY USE ONLY – NOT TO BE COMPLETED BY APPLICANT**

EFFECTIVE DATE			EXPIRATION DATE			PREMIUM RATING			COUNTY		TYPE PRAC	RATING BASIS
MO	DAY	YR	MO	DAY	YR	CLASS	SPEC	TERR	RISK	SOCTY		
												%
LIMITS OF LIABILITY						ENDORSEMENTS TO BE ATTACHED AT ISSUE						BASIC COVERAGE PREMIUM \$ _____
EACH PERSON			AGGREGATE			CODE	LIMITING END		OTHER:			OTHER:
\$ _____			\$ _____				NO.					\$ _____
GROUP BILLING NAME												<b>TOTAL POLICY PREMIUM \$ _____</b>
GROUP I.D. N.O.						CHECKED BY:			DATE:			



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**APPLICATION FOR LEGAL DEFENSE COSTS COVERAGE**  
(Coverage for Administrative Actions & Medicare/Medicaid Fraud and/or Abuse)

**No legal defense cost coverage will be provided if you do not return this form to MLMIC**

**Section I – General Information**

Name of Applicant: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

License Number: \_\_\_\_\_

MLMIC Policy Number (if any): \_\_\_\_\_

Limits Requested (check one):

- I do not want to purchase this coverage.
- I wish to purchase \$25,000 maximum limit per policy period per insured person for an annual premium of \$300.
- I wish to purchase \$100,000 maximum limit per policy period per insured person for an annual premium of \$800.

If you are on a multi-risk policy, all insureds on the same policy MUST have the same limit or reject the coverage. Defense cost coverage is not available to professional entities.

**Section II – Statement of Facts Declared By The Applicant**

I, \_\_\_\_\_ represent the following to Medical Liability Mutual Insurance Company (MLMIC):

1. I have not had any administrative action by a governmental body organized for the purpose of maintaining standards of conduct and competence such as the Office of Professional Medical Conduct (OPMC) brought against me at any time except as follows: (provide a description of each administrative action, dates for each administrative action, dollar value for each administrative action and final resolution of each administrative action including “closed with no payment”). If none state “None”. Use additional sheet of paper if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. I have not had any Governmental Proceeding alleging a violation by me of Medicare or Medicaid guidelines arising out of the presentation of a Medicare or Medicaid Claim to a governmental health benefit payor or program for medical services or to items providing or prescribed brought against me at any time except as follows: (provide a description of each Governmental Proceeding, dates for each Governmental Proceeding, dollar value for each Governmental Proceeding and final resolution of each Governmental Proceeding including “closed with no payment”). If none state “None”. Use additional sheet of paper if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. I am not aware of any threatened or pending complaint, investigation or any other action or activity associated with such administrative action or Governmental Proceeding except as follows: (provide details or state "None").

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4. I am not aware of any event, circumstance, incident or fact inclusive of any request for records or threat thereof, which may lead to an administrative action or Governmental Proceeding against me except as follows: (provide details or state "None").

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5. I understand and agree that should a claim or investigation arise from a fact or circumstance of which I had prior knowledge, or reasonably should have had prior knowledge, coverage will not apply to such claim or investigation.

I make these statements with full knowledge that Medical Liability Mutual Insurance Company relies on this representation in its decision to provide defense costs coverage for which I am applying. Furthermore, I understand this Application does not confer any obligation on the part of MLMIC to write this coverage at the \$25,000 or \$100,000 limit.

**New York State Insurance Department Regulation #95 declares that:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

\_\_\_\_\_  
Personal signature of applicant

\_\_\_\_\_  
Date



**Policy Administrator – Designation &/or Change**

You are your own Policy Administrator, unless you designate another party. As a service to you, the insured, your policy allows you to designate a Policy Administrator other than yourself. Please take time to read and understand the authority granted by such a designation.

If you designate a Policy Administrator, that party will be displayed on the Declarations Page or Endorsement.

[www.mlmic.com](http://www.mlmic.com)

Policy Administrator means the person or organization designated in the Declarations Page. Designation as a Policy Administrator confers no coverage.

The Policy Administrator is the agent of all Insureds herein for the paying of Premium, requesting changes in the policy, including cancellation thereof and for receiving dividends and any return Premiums when due. By designating a Policy Administrator each Insured gives us permission to release information about each such Insured, your practice or any other information that we may have to such Policy Administrator.

**NOTICE:**

The election of Policy Administrator (PA) can only be changed by the Insured. However, the current PA, other than the Insured, may rescind their status, allowing the PA role to revert to the Insured or their new designee.

1. The Insured can notify us to change the Policy Administrator by written notice. When such a change is requested we will send notification of the request, including the date of the change, to the individual parties. Once the change in Policy Administrator is made, all rights will be given to the new Policy Administrator as of the effective date of the change.

2. Either the Policy Administrator or the Insured may elect to change or terminate coverage.

3. All cancellation, non-renewals and extended reporting endorsement notices will be sent to both the current Policy Administrator and the Insured at the address shown in the policy. The address of the Policy Administrator becomes the address to which all legal notices will be sent.

4. Dividends, if declared, will be credited to the policy and Policy Administrator on record as of the date declared by the Board of Directors.

5. Medical Liability Mutual Insurance Company is not a party to any agreement between you and your Policy Administrator.

6. By signing this form, the Policy Administrator, indicated below, accepts their role and agrees to notify us in writing in the event they decide not to continue in this capacity.

Print Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of this designation: \_\_\_\_\_

Policy Administrator: \_\_\_\_\_ TIN Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_

Billing Address (if different): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**In Witness Whereof, I sign my name:**

Signature of MLMIC Insured: \_\_\_\_\_ Dated: \_\_\_\_\_

Signature of Policy Administrator (PA): \_\_\_\_\_ Dated: \_\_\_\_\_

(If an organization – signature of authorized party & title.)