MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

P.O. Box 1287, Latham, NY 12110
(800) ASK-MLMIC | MLMIC.com
New York City | Long Island | Colonie | Syracuse | Buffalo

Application for Employee Professional Liability Insurance Coverage

Extender Healthcare Providers

("Extender Healthcare Provider" means Nurse Anesthetists, Nurse Practitioners, Physician Assistants or Midwives)

Please note the following:

1. All questions on the application must be answered. Additional requested information must be returned with the application.
2. Only employees of MLMIC insured physicians / physician groups are eligible for coverage.
3. You must designate a Policy Administrator. This is the person or entity that you designate to act as your agent for the payment of premiums, request changes to the policy, including cancellation thereof, and any return premiums when available. You may designate yourself as the Policy Administrator. You must complete the Policy Administrator Designation form provided by the Company to make this designation.
4. Policies are issued at limits of $1,000,000 Each Person, $3,000,000 Total.
5. Insurance coverage is provided on an "Occurrence" basis only.

1. Name of applicant _____
   Last First Middle

   Home Address _____

   Birth date (month, day, year) _____ Social Security Number _____

   Home Phone _____FAX number _____E-mail address _____

   Complete title of your medical professional designation _____

2. All applications are subject to prior approval. If acceptable, coverage can be provided no earlier than the day following our receipt of the signed application. On what date do you wish the insurance to be effective?

   12:01 A.M. E.S.T. on _____
   Month Day Year

3. EMPLOYER for which this application is being submitted_____

   Would you like your policy issued with the same anniversary date as your Employer and/or associated practice? ☐ Yes ☐ No

   Employer's mailing address _____

   Practice address_____

   Contact person_____

   Office/Contact Phone _____FAX _____E-Mail Address _____

   Tax identification number of employer _____

   Employer practices as ☐ Individual Practitioner ☐ Partnership ☐ Professional Corporation ☐ Other

   Name / specialty of supervising physician_____
   Name Specialty

4. Are you currently insured by MLMIC for other employment? ____Yes ____ No

   If yes, name of employer _____

5. Is the employer for which you are submitting this application , #3 above, going to replace (_____Yes _____No) or be in addition to your current employer, #4 above (_____Yes _____No) ?

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s) scheduled in the policy. Should insurance coverage be issued, **it is an absolute condition of the insurance policy that MLMIC Insurance Company is the insurer of your employer(s)** and that such insurance remain in full force and effect for the full term of your policy.

6. Applicant is employed and licensed in the capacity of:

- ☐ Certified Registered Nurse Anesthetist
- ☐ Registered Physician Assistant
- ☐ Specialist Assistant
- ☐ Certified Nurse Midwife
- ☐ Midwife
- ☐ Certified Nurse Practitioner
- ☐ Other (complete title of your medical professional designation) _____

7. Is applicant licensed, registered or certified under the laws of the State of New York? _____ Yes _____ No

If "Yes", list professional designation, license or registry number and date secured. Please enclose copy with application.

_____

8. Applicant's professional training (attach additional information sheets if necessary):

Name of school, hospital, etc.	FROM (Mo. /Day/ Yr.)	TO (Mo. /Day/ Yr.)	Type of training	Date of completion

9. Applicant is a member in good standing with the following professional organizations:

Name	Certificate / Registry Number	Date

10. Name of applicant's present or immediate past professional liability insurance company:

Name of insurance company	Effective date	Expiration date	Type of Coverage - claims made or occurrence	Policy number

NOTE: If you are currently covered under a claims made policy, Extended Reporting Endorsement coverage must be purchased for that policy to avoid gaps in coverage for future claims.

11. Has any insurance company ever cancelled or declined to renew professional liability insurance for the applicant?

- ☐ Yes – Name of insurance carrier _____
- ☐ No

If "Yes", explain _____

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

☐ Yes – Name of state _____
☐ No

If "Yes", explain _____

13. Have you ever had a malpractice claim or suit (closed or pending) made against you?

☐ Yes – Number of claims _____
☐ No

If "Yes", on a separate sheet, state the name of the insurance carrier handling each claim, present status of each claim or suit including name of the patient, dates, description of your treatment and amount of settlement if applicable.

Supplemental Legal Defense Costs Coverage

Would you like to apply for Legal Defense Costs Coverage for Administrative Actions and/or Medicare/Medicaid Fraud and/or Abuse?
____☐ Yes ___☐_No

Producer Information

You may choose to submit your application directly to MLMIC or through a producer you identify below:

Agency Name and Contact Person: _____

Address of Agency: _____

YOUR SIGNATURE IS REQUIRED FOLLOWING BOTH THE "INSURANCE REGULATION" AND "RELEASE OF INFORMATION" STATEMENTS.

Release of Information

I hereby authorize MLMIC Insurance Company and its affiliates to obtain all information from any insurance company, credentialing data source, or other party with respect to me, my professional credentials, or my medical practice, which would include any claim, lawsuit, or event pertaining to professional acts or omissions that have been asserted against me or my medical practice, partnership, or professional corporation. I expressly release and discharge from liability any party providing or receiving such information. I consent to the use of my information by MLMIC Insurance Company and its affiliates in their business of insurance. I further authorize that a copy of this signed release be accepted with the same authority as the original.

_____ _____

Personal Signature of Applicant Date Signed

New York State Insurance 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 violation."

_____ _____

Personal Signature of Applicant Date Signed

Special Notice: The attached Supplemental Application including appropriate Certification must be completed. It will become part of the submitted application.

SUPPLEMENTAL APPLICATION

Name of Applicant _____

Name of Supervising/Collaborating Physician _____

Reference Number of Supervising/Collaborating Physician _____

CERTIFICATION REQUIRED FOR NURSE ANESTHETIST

The following certification must be signed by the applicant's Primary Employer / Supervising Physician before insurance can be effected for a Certified Registered Nurse Anesthetist.

I hereby certify that I am the supervising physician of the applicant and that the administration of anesthesia by the applicant will be supervised as follows:

1. No more than a total of three (3) Nurse Anesthetists will be employed by any one (1) Anesthesiologist.
2. Each patient will be seen by an M.D. or D.O. Anesthesiologist before anesthesia is administered.
3. The Nurse Anesthetist will act only under the supervision of an M.D. or D.O. Anesthesiologist and will not work independently. Such supervision will require the physical availability of the M.D. or D.O Anesthesiologist for immediate diagnosis and treatment of exceptional situations.
4. When anesthesia is administered by a Nurse Anesthetist, the hospital chart will clearly reflect this fact.
5. Except in an unusual situation, a single Anesthesiologist shall not simultaneously supervise more than three (3) Nurse Anesthetists. The supervising physician shall not be personally engaged in administering another anesthetic at the time he / she is providing such management.

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

_____ _____

Personal / Authorized Signature of Employer / Supervising Physician | Date Signed

CERTIFICATION REQUIRED FOR PHYSICIAN ASSISTANT

The primary employer / supervising physician must submit a letter describing the exact duties including procedures performed and supervision involved with the applicant. This letter must be on the letterhead stationery of the employer and signed by the supervising physician. After review of this information and review of the applicant, MLMIC will advise the applicant of acceptability for insurance with the Company.

I hereby certify that I am the supervising physician / employer of the applicant and that the provision of medical services by the applicant will be supervised as follows:

1. No more than four (4) Registered Physician Assistants will be supervised by any one (1) physician
2. A Registered Physician Assistant may provide medical services when such acts and duties assigned to him / her are appropriate to their education, training and experience and within the ordinary practice of the supervising physician and employer.
3. Supervision shall be continuous and it shall not require the physical presence of the supervising physician at the time(s) and place(s) outlined in the attached letter. A clearly designated supervising physician must always be available.

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

_____ _____

Personal / Authorized Signature of Employer / Supervising Physician | Date Signed

CERTIFICATION REQUIRED FOR NURSE PRACTITIONER

The primary employer /collaborating physician must submit a letter describing the exact duties and collaboration involved with the applicant. This letter must be on the letterhead stationery of the employer and signed by the collaborating physician. After review of this information and review of the applicant, MLMIC will advise the applicant of acceptability for insurance with the Company.

I hereby certify that I am the collaborating physician /employer of the Applicant and that the provision of professional services by the Applicant will be as follows:

Guideline "A"

1. A physician will not collaborate with more than four (4) Certified Nurse Practitioners who are not located on the same physical premises.
2. A Certified Nurse Practitioner may perform medical services within a specialty area of practice in collaboration with a licensed physician in the same employment who is qualified to collaborate in the specialty involved. The physician and the Certified Nurse Practitioner must maintain documentation of a collaborative relationship as required by law.
3. Collaboration shall be continuous and it requires the physical presence of the collaborating physician at the time and place where such services are performed.

I understand that insurance, if issued to the applicant, will be in reliance on these requirements.

Personal / Authorized Signature of Employer / Collaborating Physician

Date Signed

Guideline "B"

1. A physician will not collaborate with more than four (4) Certified Nurse Practitioners who are not located on the same physical premises.
2. A Certified Nurse Practitioner may perform medical services within a specialty area of practice in collaboration with a licensed physician in the same employment who is qualified to collaborate in the specialty involved. The physician and the Certified Nurse Practitioner must maintain documentation of a collaborative relationship as required by law.
3. Collaboration shall be continuous and it requires the physical presence of the collaborating physician at the time and place where such services are performed except when the Certified Nurse Practitioner is making house calls.

I understand that insurance, if issued to the applicant, will be in reliance on these requirements.

Personal / Authorized Signature of Employer / Collaborating Physician

Date Signed

Guideline "C"

1. A physician will not collaborate with more than four (4) Certified Nurse Practitioners who are not located on the same physical premises.
2. A Certified Nurse Practitioner may perform medical services within a specialty area of practice in collaboration with a licensed physician in the same employment who is qualified to collaborate in the specialty involved. The physician and the Certified Nurse Practitioner must maintain documentation of a collaborative relationship as required by law.
3. Collaboration shall be continuous and it shall not require the physical presence of the collaborating physician at the time and place outlined in the attached letter.

I understand that insurance, if issued to the applicant, will be in reliance on these requirements.

Personal / Authorized Signature of Employer / Collaborating Physician

Date Signed

CERTIFICATION REQUIRED FOR MIDWIFE

The primary employer / collaborating physician must submit a letter describing the exact duties and collaboration involved with the applicant. This letter must be on the letterhead stationery of the primary employer and signed by the collaborating physician. After review of this information and review of the applicant, MLMIC will advise the applicant of acceptability for insurance with the Company.

I hereby certify that I am the collaborating physician / employer of the Applicant and that the provision of professional services by the Applicant will be as follows:

1. No more than a total of two (2) midwives will be employed by any one (1) physician
2. The collaborating physician and the midwife must be in an employment relationship and maintain documentation of a collaborative relationship that is readily available upon request; and
3. Collaboration shall be continuous; however, it shall not require the physical presence of the collaborating physician at the time and place as outlined in the attached letter.

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

Personal / Authorized Signature of Employer / Collaborating Physician

Date Signed

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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 MLMIC 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").

_____
_____
_____

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").

_____
_____
_____

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 MLMIC 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

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Policy Administrator – Designation and/or Change Form

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. 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

*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 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. Your Policy Administrator may also elect to receive and access policy forms and notifications electronically.

NOTICE:

The election of Policy Administrator 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. MLMIC Insurance Company is not a party to any agreement between you and your Policy Administrator.
5. 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*: _____ Taxpayer Identification Number (TIN): _____

Contact Name: _____ E-mail Address: _____

Would you like your policy issued with the same anniversary date as the Policy Administrator? ☐ Yes ☐ No

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)