MLMIC
Medical Liability Mutual Insurance Company

Supplement to Application for Physicians' and Surgeons' Professional Liability Insurance

Completion and Delivery Instructions:

1. Complete all forms online

2. Print file

3. Sign where indicated

4. Submit utilizing one of the following options:

- Fax your application to 212-576-9877
- Scan your application and email to: apply@mlmic.com
- Print and mail a hard copy of your appliaction to **Medical Liability Mutual Insurance Company** at the office address nearest your practice location:

Two Park Avenue
Suite 2500
New York, NY 10016
(212) 576-9670

8 British American Blvd.
Latham, NY 12110
(518) 786-2700

2 Clinton Square
Syracuse, NY 13202
(315) 428-1188

90 Merrick Avenue
East Meadow, NY 11554
(516) 794-7200

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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 that no coverage will be provided 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 "A Closer Look: Claims Made vs. Occurrence", which may be found on our Web site indicated above.

All applications are subject to prior approval. If your application is approved, coverage can be provided no earlier than the day following our receipt of the signed application. Any Supplemental Application(s) that are required may be found on our Web site indicated above.

General Information

1. Name: _____ Date of Birth: ___/___/___
Last, First, Middle — Month Day Year

2. Mailing Address: _____
Number and Street, City/County, State, Zip Code

3a. Principal Office Address: _____
Number and Street, City/County, State, Zip Code

3b. Additional Office Address: _____
Number and Street, City/County, State, Zip Code

4. Home Address: _____
Number and Street, City/County, State, Zip Code

5. List all counties and states where you are currently practicing, and the corresponding percentages of patient hours expended in each:

_____ % _____ %
County, State — County, State

_____ % _____ %
County, State — County, State

6. Social Security Number: _____

7. Telephone Numbers: ___/___/___
Home Office Cell

8. Fax Number: _____

9. E-mail Address: _____

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

___/___/___
Month Day Year

11. On what basis do you wish to have your policy issued?
☐ Claims Made ☐ Occurrence

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

12. LIMITS OF LIABILITY (please select limits desired):
☐ $1,000,000 Each Person/$3,000,000 Total
☐ $1,300,000 Each Person/$3,900,000 Total

IF ANY ANSWER TO QUESTIONS 13-18 IS "YES," PLEASE PROVIDE COMPLETE DETAILS ON A SEPARATE SHEET.

13. Have you ever been convicted of a criminal offense other than a motor vehicle violation?
☐ Yes ☐ No

14. 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

15. Have you had your medical license or narcotics license revoked, suspended, or restricted, or have you voluntarily surrendered your license in any state?
☐ Yes ☐ No

16. Have you been treated or hospitalized for any drug, chemical, neurological, alcohol, or mental related problem?
☐ Yes ☐ No

17. 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 standard rates?
☐ Yes ☐ No

18. Have you ever practiced without insurance or opted not to purchase the Extended Reporting Period Endorsement ("Tail") on a claims made policy?
☐ Yes ☐ No

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 documentation from your prior insurance carrier indicating successful completion and the expiration date of your discount.

20. Have you ever had professional liability insurance?
☐ Yes ☐ No

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

Name of Insurance Company
Name of Insurance Company
Policy Number
Policy Number
Dates of Coverage
Dates of Coverage
Limits of Insurance
Limits of Insurance
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:

21. If you are applying for either claims made or occurrence coverage, do you intend to purchase the Optional 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 on purchasing "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.)

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.

2. 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 (Mo./Day/Yr.) - To (Mo./Day/Yr.)
Name of Physician(s), Surgeon(s), and/or Association(s)
Relationship (Employee, Independent Contractor, Fellow Shareholder, Co-partner, etc.)
Date of Affiliation From (Mo./Day/Yr.) - To (Mo./Day/Yr.)

Education Information

1. Medical school(s) 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

1. List current hospital staff appointments and percentage of patient care at each hospital, including any for which you are applying:

Name of Hospital, %
Name of Hospital, %
Name of Hospital, %
Name of Hospital, %

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

3. Are you board certified?
☐ Yes ☐ No
If Yes, name each American specialty board:

Board | Board

Date Certified | Date Certified

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

State, Date Licensed, License or Permit No.

State, Date Licensed, License or Permit No.

5. List locations where you have practiced to date and attach your current 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 (Mo./Day/Yr.) - To (Mo./Day/Yr.) | From (Mo./Day/Yr.) - To (Mo./Day/Yr.)

Hospital Affiliations | Hospital Affiliations

6. Are you a fellow of any American specialty college?
☐ Yes ☐ No
If Yes, give name of each:

7. List professional society memberships:

National | County

State | Other

8. 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
If Yes, provide legal name:

If you would like to apply for coverage for your Professional Entity, a supplemental application must be completed. An additional premium applies for this coverage.

c. A full-time or part-time hospital employee?
☐ Yes ☐ No
If Yes, please provide name of hospital(s) 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

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
If Yes, name of hospital:

9. Do you or does your professional entity 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 separate valid and collectible professional liability policy with limits of liability of at least the same amount as your limits of liability.)

10. Do you or does your professional entity employ any physician assistants, nurse practitioners, midwives, nurses providing anesthesia services, nurses, laboratory technicians, x-ray technicians, 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 physician's assistants, specialist's assistants, nurses providing anesthesia services, midwives, or 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 or visit our Web site.

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, nursing home, 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, nursing home, laboratory, or any other business enterprise. See policy exclusion.)

13. Do you use an electronic health record system?
☐ Yes ☐ No

If Yes, which software do you use?

When did you begin utilizing this system? _____
Month / Year

14. Do you e-prescribe?
☐ Yes ☐ No

If Yes, which software do you use?

When did you begin e-prescribing? _____
Month / Year

Underwriting and Rating Information

Applicant must answer all parts of each question.

1. What specialty classification most accurately describes your practice? (See rate schedule for specialty descriptions.)

_____
Classification Description

2. Indicate the number of practice hours per week: _____

(Include hours involved in all professional activities as a physician or surgeon.) If the number of practice hours per week is 20 or less the Supplemental Application for Part-Time Practice must be completed.

3. Do you perform liposuction?
☐ Yes ☐ No
If Yes, list procedures performed:

4. Do you, or other members of your staff, perform any of the following cosmetic procedures?

Botox injections	☐ Yes I do	☐ Yes other staff	☐ No
Dermal fillers	☐ Yes I do	☐ Yes other staff	☐ No
Hair transplants/implants	☐ Yes I do	☐ Yes other staff	☐ No
Laser hair removal	☐ Yes I do	☐ Yes other staff	☐ No
Laser procedures	☐ Yes I do	☐ Yes other staff	☐ No

Other (please describe): _____

If Yes, to any of the above, please attach a detailed description of training and certificates of completion for each person performing such procedure(s).

5. Do you perform organ transplants (excluding corneal)?
☐ Yes ☐ No

6. Do you perform endoscopy?
☐ Yes ☐ No
If Yes, list procedures performed:

7. Do you perform laparoscopy:
for tubal sterilization? ☐ Yes ☐ No
for **other** than tubal sterilization? ☐ Yes ☐ No
If Yes, list procedures performed:

8. Do you perform plastic surgery solely for improving the patient's appearance?
☐ Yes ☐ No

9. Do you provide:
a. Prenatal care? ☐ Yes ☐ No
b. Home obstetrical deliveries? ☐ Yes ☐ No
c. Vaginal deliveries following a Cesarean Section (VBAC)? ☐ Yes ☐ No
d. Treatment for spontaneous abortions? ☐ Yes ☐ No
If Yes, through which trimester? _____

10. Do you perform abortions?
☐ Yes ☐ No
If Yes,
a. Medical abortions? ☐ Yes ☐ No
b. Suction curettage? ☐ Yes ☐ No
• Limited to the first 12 weeks of pregnancy? ☐ Yes ☐ No
• Beyond the first 12 weeks of pregnancy? ☐ Yes ☐ No
c. Other, explain: _____

d. Are abortions performed in (check where appropriate):
☐ an office ☐ a hospital ☐ a clinic ☐ other

11. Do you practice alternative medicine?
☐ Yes ☐ No
If Yes, describe:

12. Do you perform acupuncture?
☐ Yes ☐ No
If Yes, provide permit number: _____
Permit Number

13. Do you perform pain management procedures?
☐ Yes ☐ No
If Yes,
a. Percentage of practice: ____ %
b. Please describe procedures and provide evidence of training:

c. Is this for the treatment of chronic pain?
☐ Yes ☐ No
d. Do you have a fellowship in Pain Management?
☐ Yes ☐ No

e. Do you perform nerve blocks/injections? ☐ Yes ☐ No

If Yes, complete the following:

Type			Office	Outpatient Facility	Hospital
Spinal	☐ Yes	☐ No			
Epidural	☐ Yes	☐ No			
Cervical	☐ Yes	☐ No			
Thoracic	☐ Yes	☐ No			
Brachial	☐ Yes	☐ No			
Peripheral	☐ Yes	☐ No			
Sympathetic	☐ Yes	☐ No			

f. Do you perform kyphoplasty?
☐ Yes ☐ No

g. Do you perform any other pain management procedures?
☐ Yes ☐ No

If Yes, please describe procedure(s) and provide evidence of training:

_____

_____

14. Do you practice critical care medicine?
☐ Yes ☐ No
If Yes,
a. What percentage of your practice is dedicated to critical care medicine? _____ %

b. Do you have specialty training in critical care medicine?
☐ Yes ☐ No

15. Are you practicing as an **emergency medicine physician?**
☐ Yes ☐ No

If Yes, please attach copies of documentation denoting current certification in both ACLS and ATLS or evidence of current board certification in emergency medicine.

16. If you are an obstetrician/gynecologist, do you limit your practice to gynecological surgery?
☐ Yes ☐ No

17. If you are an **internist:**
a. Do you perform cardiac catheterization? (Swan-Ganz is not considered cardiac catheterization.)
☐ Yes ☐ No

b. Do you perform permanent pacemaker/defibrillator placement?
☐ Yes ☐ No

c. Do you limit your practice to allergy?
☐ Yes ☐ No

d. Do you perform endoscopic retrograde cholangiopancreatography (ERCP)?
☐ Yes ☐ No

e. If applicable, list subspecialties in internal medicine:

_____

_____

18. If you are a **neurologist** or **psychiatrist:**
a. Do you perform, supervise, or direct the performance of myelography and/or angiography?
☐ Yes ☐ No

b. Do you perform electroshock therapy?
☐ Yes ☐ No

If Yes, submit evidence of training.

19. If you are a **radiologist:**
a. Do you practice radiation oncology?
☐ Yes ☐ No

If Yes, do you limit your practice to radiation oncology only?
☐ Yes ☐ No
b. Do you practice or do you plan to practice interventional radiology?
☐ Yes ☐ No

20. If you are a **specialty or general surgeon**, please indicate the type of surgery that you perform or will perform and the corresponding percentage of practice for each:
a. General Surgery? ☐ Yes, _____ % ☐ No

Type: _____

b. Vascular Surgery? ☐ Yes, _____ % ☐ No

c. Thoracic Surgery (cardiac)? ☐ Yes, _____ % ☐ No

d. Thoracic Surgery (non-cardiac)? ☐ Yes, _____ % ☐ No

e. Bariatric Surgery? ☐ Yes, _____ % ☐ No

If Yes, Supplemental Bariatric Application must be completed.

f. Other? ☐ Yes, _____ % ☐ No

Type: _____

g. Do you perform office surgery?
☐ Yes ☐ No

If Yes, list procedures performed:

_____

_____

21. 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

22. 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 surgery:

_____

_____

c. Cosmetic surgery?
☐ Yes ☐ No

If Yes, specify procedures and training:

_____

d. Do you practice dermatopathology?
☐ Yes ☐ No

If Yes, is it limited to your own patients?
☐ Yes ☐ No

23. If you are an **anesthesiologist:**
Do you administer anesthesia outside of a hospital setting?
☐ Yes ☐ No

If Yes, state where and type of anesthesia administered:

Where _____ Type of Anesthesia _____

Where _____ Type of Anesthesia _____

Where _____ Type of Anesthesia _____

What is the distance to the nearest hospital? _____

What equipment is available in the event of an emergency?

24. If you are an **otolaryngologist**, do you wish to apply for coverage for cosmetic plastic surgery?
☐ Yes ☐ No

If Yes, is cosmetic plastic surgery limited to the field of otolaryngology?
☐ Yes ☐ No

If you are performing cosmetic plastic surgery procedures outside the field of otolaryngology, provide a list of the procedures and evidence of training.

25. 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 Physician Who Directed Training _____

Period of Training, From (Mo./Day/Yr.) - To (Mo./Day/Yr.) _____

b. Number of years of experience in x-ray treatments: _____

26. FOR ALL NON-SURGICAL SPECIALTIES (This does not apply to any surgical classifications). You must answer all of the questions listed.

PLEASE NOTE: A physician will not qualify for a family/general practice category if he/she performs open orthopedic procedures or intra-abdominal surgery or certain other major surgery.

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".

a. Deliveries:
Normal deliveries* as described below ☐ Yes #_____ ☐ No
Complicated deliveries ☐ Yes #_____ ☐ No
b. Hemorrhoidectomies ☐ Yes #_____ ☐ No
c. Pilonidal cystectomies ☐ Yes #_____ ☐ No
d. Open reduction of fractures ☐ Yes #_____ ☐ No
e. Closed reduction of fractures ☐ Yes #_____ ☐ No
f. Excision of superficial growths ☐ Yes #_____ ☐ No
If Yes, what percentage is referred for pathological evaluation?_____%
g. Diagnostic D&Cs ☐ Yes #_____ ☐ No
h. Appendectomies ☐ Yes #_____ ☐ No
i. Herniorrhaphies ☐ Yes #_____ ☐ No
j. T&As ☐ Yes #_____ ☐ No
k. Vasectomies ☐ Yes #_____ ☐ No
l. Varicose vein surgery ☐ Yes #_____ ☐ No
If Yes, indicate type: _____
m. Will you act as a surgical assistant? ☐ Yes #_____ ☐ No
n. Will you provide prenatal care? ☐ Yes #_____ ☐ No
If Yes, is prenatal care limited to uncomplicated pregnancies** as described below? ☐ Yes #_____ ☐ No

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

Type / Number _____ Type / Number _____

Type / Number _____ Type / Number _____

Type / Number _____ Type / Number _____

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

Type / Number _____ Type / Number _____

Type / Number _____ Type / Number _____

*Normal deliveries are defined as follows: (1) normal spontaneous deliveries, (2) the use of outlet forceps or vacuum delivery, (3) episiotomy, (4) repair of cervical tear in emergency situations, (5) the pharmacological or surgical induction or augmentation of labor, 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 induction or augmentation is administered and thereafter is readily available to attend to the patient and if a Cesarean Section is indicated then the physician must contact a qualified obstetrician who must be available within 30 minutes of the determination of the need to perform a Cesarean delivery, and (6) performance of vaginal delivery following Cesarean Section (VBAC), provided there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is "immediately available" for consultation and treatment of the patient. "Immediately available" means physically present at the location of the delivery and the qualified obstetrician with Cesarean privileges with whom you consulted cannot be performing a surgical procedure or delivering another patient during this time. NORMAL DELIVERY DOES NOT INCLUDE THE DELIVERY OF KNOWN BREECH PRESENTATIONS OR MULTIPLE GESTATIONS.

**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 presentation or multiple gestation, unless there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is available for consultation and treatment of the patient.

Claim/Suit Information

COMPLETE IN FULL – providing incomplete information will delay the underwriting review of your application.

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

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

☐ Yes # _____ ☐ No

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

For each claim or suit, describe as follows:

a. Name of claimant or plaintiff:

_____

b. Dates of treatment:

_____

c. Complete and detailed description of your involvement in the care and treatment:

_____

_____

_____

_____

d. State allegations of malpractice:

_____

_____

_____

_____

e. Location of treatment:

_____
County, State

f. Name of other physician(s) involved:

_____

_____

_____

g. Name of hospital(s) involved:

_____

_____

h. Name of insurance company defending you:

_____

i. Date claim or suit was reported to the above company: ____/____/____
Month Day Year

j. Status of the claim or suit:
☐ Pending ☐ Closed Date closed: ____/____/____
Month Day Year

k. 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?
$ _____

A verdict against the plaintiff in your favor?
☐ Yes ☐ No

Dismissed or discontinued:
☐ Yes ☐ No

Event / Incident Information

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,

a. List patient name(s): _____

_____

_____

b. Provide details including names, dates, and description of treatment on your letterhead stationery and attach it to this application.

c. Have any of these events or incidents been reported to your prior insurance carrier(s)?
☐ Yes ☐ No

ADD ADDITIONAL CLAIMS

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

If Yes, please complete and return the supplemental application for Legal Defense Costs coverage. An additional premium applies to this coverage.

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

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.

_____ ____/____/____

Personal Signature of Applicant Date Signed (MM/DD/YY)

New York State Insurance Department Regulation 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 Signed (MM/DD/YY)

Policy Administrator Designation

As a service to you, the policy allows you to designate a Policy Administrator, that is, a party other than yourself whom you authorize to make changes and pay premiums when due. To make such a designation you must complete a separate form titled: Policy Administrator - Designation and/or Change.

Do you wish to designate a Policy Administrator other than yourself?

☐ Yes ☐ No

If Yes, whom? _____

Please complete and return the Policy Administrator - Designation and/or Change form.

MLMIC
Medical Liability Mutual Insurance Company

Two Park Avenue
Suite 2500
New York, NY 10016
(212) 576-9670

2 Clinton Square
Syracuse, NY 13202
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8 British American Blvd.
Latham, NY 12110
(518) 786-2700

90 Merrick Avenue
East Meadow, NY 11554
(516) 794-7200

Application for Legal Defense Costs Coverage

(Coverage for Administrative Actions & Medicare/Medicaid Fraud and/or Abuse)

www.MLMIC.com

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): Use a separate sheet.

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.

_____

_____

_____

NAME _____ **DATE** 01/26/2016

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 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 Signed (MM/DD/YY)

MLMIC
Medical Liability Mutual Insurance Company

Two Park Avenue
Suite 2500
New York, NY 10016
(212) 576-9670

2 Clinton Square
Syracuse, NY 13202
(315) 428-1188

8 British American Blvd.
Latham, NY 12110
(518) 786-2700

90 Merrick Avenue
East Meadow, NY 11554
(516) 794-7200

Policy Administrator – Designation and/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

*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-renewal 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*: _____ Taxpayer Identification Number (TIN): _____

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 and title.)

NAME _____ **DATE** 01/26/2016

IMPORTANT NOTICE:
In accordance with state legislation, all physicians' and surgeons' policies may be written on either an occurrence or a claims made basis.

Medical Liability Mutual Insurance Company

2014 Rating Classifications

Physicians and Surgeons professional liability insurance policies issued by MLMIC bear the most appropriate of the following descriptions:

Premium Class 1

- Neurosurgery

Premium Class 2

- General Surgery, including bariatric surgery

Premium Class 3

- Obstetrics and Gynecology

Premium Class 4

- General Surgery, excluding bariatric surgery

Premium Class 5

- Orthopedic Surgery

Premium Class 6

- Cardiac Surgery
- Vascular Surgery

Premium Class 7

- Gynecology only
  Does not provide coverage for prenatal care; obstetrical deliveries of any kind (except for assistance at Cesarean Section); induced abortions (except for those in the first trimester); or treatment of spontaneous abortions (except for those in the first trimester).
- Otolaryngology, including otolaryngological cosmetic plastic surgery
- Plastic and Reconstructive Surgery

Premium Class 8

- Colon and Rectal Surgery and/or Proctology
- Urology, including major surgery

Premium Class 9

- Emergency Medicine

Premium Class 10

- Computerized Tomography
- Diagnostic Radiology only
- Diagnostic Radiology and Radiation Oncology

Premium Class 11

- Neurology and/or Psychiatry, including the supervision, direction, or performance of myelography and/or angiography
- Obstetrics and Gynecology, Uncomplicated Obstetrics and Limited Surgery
  See description under Family/General Practice and Limited Major Surgery.
- Otolaryngology, excluding cosmetic plastic surgery

Premium Class 12

- Obstetrics and Gynecology, Uncomplicated Obstetrics and Minor Surgery
  See description under Family/General Practice and Minor Surgery.

Premium Class 13

- Internal Medicine, including cardiac catheterization

Premium Class 14

- Gynecology Only, including minor surgery
  Does not provide coverage for prenatal care; obstetrical deliveries of any kind (except for assistance at Cesarean Sections); treatment of spontaneous abortions (except for those in the first trimester); any intra-abdominal surgery or any orthopedic procedures and any major surgery, including but not limited to T&As, vasectomies, herniorrhaphies, hemorrhoidectomies, pilonidal cystectomies, and the administration of general or spinal anesthesia. The surgical procedures covered in this classification include: closed reduction of fractures; excision of superficial growths; diagnostic D&Cs; abortions through the 12th week of pregnancy; and assistance at major surgery.
- Otolaryngology, with surgery limited to minor procedures
  Does not include tonsillectomy and adenoidectomy.
- Occupational Medicine and Minor Surgery
  See description under Family/General Practice and Minor Surgery.

Premium Class 15

- Neurology, excluding the supervision, direction, or performance of myelography and/or angiography

Premium Class 16

- Dermatology, including dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using Phenol, Mohs microsurgery, and all procedures listed

Class 22, Dermatology

- Internal Medicine, excluding cardiac catheterization
  But including cardiology, gastroenterology, rheumatology, pulmonary disease, endocrinology, and medical oncology.
- Radiation Oncology only
- Urology, including minor surgery

NAME _____ **DATE** 01/26/2016

Premium Class 17

- Ophthalmology, including major surgery

Premium Class 18

- Anesthesiology

Premium Class 19

- Occupational Medicine, excluding surgery
  See description under Family/General Practice, Exclusive of Surgery.

Premium Class 20

- Pathology and/or Hematology

Premium Class 21

- Ophthalmology, with surgery limited to minor procedures
- Pediatrics, not to include tonsillectomy and adenoidectomy, other major surgery, or general or spinal anesthesia

Premium Class 22

- Dermatology, excluding dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using Phenol, Mohs microsurgery, but including the use of laser, face peels with agents other than Phenol, collagen injections, and sclerotherapy
- Physical Medicine and Rehabilitation, including pain medicine

Premium Class 23

- Allergy, including pediatric allergy
- Dermatology, excluding the use of laser, dermabrasion, hair transplants, micro-lipo injections, liposuction, face peels using Phenol, Mohs microsurgery, but including face peels with agents other than Phenol, collagen injections, and sclerotherapy
- Ophthalmology, excluding surgery
- Physical Medicine and Rehabilitation, excluding pain medicine; Preventive Medicine; Public Health
- Psychiatry, excluding the supervision, direction, or performance of myelography and/or angiography

Family/General Practice Classifications

Premium Class 19

- Family/General Practice, exclusive of surgery
  General medicine, medical diagnostic procedures, and excisional and punch biopsy; minor surgery limited to incision of boils and superficial abscesses and suturing of skin and superficial fascia; splinting or casting of non-displaced fractures; fulguration of growths; and circumcision of the newborn.

Premium Class 14

- Family/General Practice and Minor Surgery
  Family/General Practice as described under Premium Class 19; closed reductions of fractures, circumcision, excision of superficial growths, and assistance at major surgery. Coverage for Obstetrics is limited to: diagnostic D&Cs, treatment of spontaneous abortions through the 12th week of pregnancy, induced abortions through the 12th week of pregnancy, prenatal care for uncomplicated pregnancies, and normal deliveries. 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 available for consultation and treatment of the patient. 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 pharmacological or surgical induction or augmentation of labor, 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 induction or augmentation is administered and thereafter is readily available to attend to the patient, and if a Cesarean Section is indicated then the physician must contact a qualified obstetrician who must be available within 30 minutes of the determination of the need to perform a Cesarean delivery; and (f) performance of vaginal delivery following a Cesarean Section (VBAC) provided there is antepartum consultation with a qualified obstetrician and a qualified obstetrician is "immediately available" for consultation and treatment of the patient. "Immediately available" means physically present at the location of the delivery and the qualified obstetrician with Cesarean privileges with whom you consulted cannot be performing a surgical procedure or delivering another patient during this time. NORMAL DELIVERY DOES NOT INCLUDE THE DELIVERY OF KNOWN BREECH PRESENTATIONS OR MULTIPLE GESTATIONS.

Premium Class 11

- Family/General Practice and Limited Major Surgery
  Family/General Practice as described under Premium Class 19 and 14; referred or non-referred major surgery limited to tonsillectomy and adenoidectomy, herniorrhaphy, hemorrhoidectomy; and pilonidal cystectomy.

A physician will not qualify for a Family/General Practice classification if he/she (1) performs open orthopedic procedures or any intra-abdominal surgery including hysterectomies or (2) in the opinion of the Physician Underwriting Committee, represents a risk similar to that of a specialist.

NOTE: FOR CLASSIFICATION PURPOSES, TONSILLECTOMY AND ADENOIDECTOMY AND ABORTIONS (OTHER THAN TREATMENT OF SPONTANEOUS ABORTIONS AND INDUCED ABORTIONS THROUGH THE 12TH WEEK OF PREGNANCY) ARE CONSIDERED MAJOR SURGERY.

Claim/Suit Information

COMPLETE IN FULL – providing incomplete information will delay the underwriting review of your application.

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

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

☐ Yes # _____ ☐ No

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

For each claim or suit, describe as follows:

a. Name of claimant or plaintiff:

_____

b. Dates of treatment:

_____

c. Complete and detailed description of your involvement in the care and treatment:

_____

_____

_____

_____

d. State allegations of malpractice:

_____

_____

_____

_____

e. Location of treatment:

_____
County, State

f. Name of other physician(s) involved:

_____

_____

_____

g. Name of hospital(s) involved:

_____

_____

h. Name of insurance company defending you:

_____

i. Date claim or suit was reported to the above company: ____/____/____
Month Day Year

j. Status of the claim or suit:
☐ Pending ☐ Closed Date closed: ____/____/____
Month Day Year

k. 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?:
$ _____

A verdict against the plaintiff in your favor?
☐ Yes ☐ No

Dismissed or discontinued:
☐ Yes ☐ No

Event / Incident Information

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,

a. List patient name(s): _____

_____

_____

b. Provide details including names, dates, and description of treatment on your letterhead stationery and attach it to this application.

c. Have any of these events or incidents been reported to your prior insurance carrier(s)?
☐ Yes ☐ No

BACK ADD ADDITIONAL CLAIMS

Claim/Suit Information

COMPLETE IN FULL – providing incomplete information will delay the underwriting review of your application.

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

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

☐ Yes # _____ ☐ No

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

For each claim or suit, describe as follows:

a. Name of claimant or plaintiff:

_____

b. Dates of treatment:

_____

c. Complete and detailed description of your involvement in the care and treatment:

_____

_____

_____

_____

d. State allegations of malpractice:

_____

_____

_____

_____

e. Location of treatment:

_____
County, State

f. Name of other physician(s) involved:

_____

_____

_____

g. Name of hospital(s) involved:

_____

_____

h. Name of insurance company defending you:

_____

i. Date claim or suit was reported to the above company: ____/____/____
Month Day Year

j. Status of the claim or suit:
☐ Pending ☐ Closed Date closed: ____/____/____
Month Day Year

k. 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?:
$ _____

A verdict against the plaintiff in your favor?
☐ Yes ☐ No

Dismissed or discontinued:
☐ Yes ☐ No

Event / Incident Information

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,

a. List patient name(s): _____

_____

_____

b. Provide details including names, dates, and description of treatment on your letterhead stationery and attach it to this application.

c. Have any of these events or incidents been reported to your prior insurance carrier(s)?
☐ Yes ☐ No

BACK

Additional Information / Continue Responses

Please Type Question and Question # Here		*Please Type Corresponding Answer Here*
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		

HOME ADD ADDITIONAL INFO

Additional Information / Continue Responses

Please Type Question and Question # Here		*Please Type Corresponding Answer Here*
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		
Question Number:		

HOME