2 Park Avenue
New York, NY 10016
Tel: 212-576-9800

8 British American Blvd.
Latham, NY 12110
Tel: 518-786-2700

2 Clinton Square
Syracuse, NY 13202
Tel:315-428-1188

90 Merrick Avenue
East Meadow, NY 11554
Tel: 516-794-7200

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, to request changes in the policy, including cancellation thereof, and to receive dividends 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 for limits of $1,000,000 Each Person, $3,000,000 Total.
5. Insurance coverage is provided on an “Occurrence” basis.

1. Name of applicant ____
   Last First Middle

   Home Mailing address ____

   Birthdate (month, day, year) ______________________ Social Security Number ______________________

   Home phone ______________ FAX number ______________ E-mail address ______________Cell phone ______________

   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 the postmark on the envelope containing the completed and signed application. On what date do you wish the insurance to be effective?

   12:01 AM E.S.T. on ____
   Month Day Year

3. PRIMARY EMPLOYER ____

   Employer’s mailing address ____

   Contact person: ____

   Office phone ____________________ FAX ____________________ E-mail address ____________________

   Tax identification number of employer ____

   Employer practices as: __ Individual Practitioner __ Partnership __ Professional Corporation ______________ Other: (specify)

   MLMIC policy number for employer ____

   Name/specialty of supervising physician ____
   Name Specialty Phone

ADDITIONAL EMPLOYERS (if applicable):

Provide the following information for **additional** MLMIC insured employers you may have. Attach additional information sheets if necessary:

Name of employer ____

Employer's address ____

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 Medical Liability Mutual 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.

4. 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) ______________________________

5. 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 (enclose copy with application).

   ____

6. 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

7. Applicant is a member in good standing of the following professional organizations:

Name of organizations

If applicant is certified or registered by a professional organization, provide full name, certification or registration number and corresponding date.

____

____

8. Name of applicant's present or immediate past professional liability insurance company. Note: Coverage is provided on an occurrence basis. 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.

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

9. Has any insurance company ever cancelled, declined to offer or declined to renew your professional liability insurance coverage?

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

If "Yes", explain ______________________________

10. 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 ______________________________

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

- ☐ Yes
- ☐ No

If "Yes", on a separate sheet, state name of insurance carrier, status of each claim or suit including name of patient, date(s) of treatment, description of treatment and amount of settlement if applicable.

Special Notice: The attached supplemental application must be completed and will become a part of this application.

THE APPLICANT'S SIGNATURE IS REQUIRED FOLLOWING THE "RELEASE OF INFORMATION" and "INSURANCE DEPARTMENT REGULATION" STATEMENTS.

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, suit or incident pertaining to professional acts or omissions asserted against me. 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.

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 violation."

______________________________ ______________________________

Personal Signature of Applicant Date Signed

SUPPLEMENTAL APPLICATIONS

Name of applicant ____

Name of supervising physician ____

Reference number of supervising physician(s) ____

CERTIFICATE REQUIRED FOR NURSE ANESTHETISTS

The following certificate 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 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 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 unusual situations, 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 the insurance, if issued to the Applicant, will be in reliance on these requirements.

____ ____________________

Personal / Authorized Signature of Employer / Supervising Physician Date Signed

CERTIFICATE REQUIRED FOR PHYSICIAN ASSISTANTS

The primary employer / supervising physician must submit a letter describing the exact duties and supervision involved with the applicant. This letter must be on the letterhead stationery of the primary employer and signed by the supervising physician.

After review of this information and review of the application, 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 administration of professional services by the Applicant will be supervised as follows:

1. No more than a total of two (2) Registered Physician Assistants will be employed by any one (1) physician (Note: physicians may employ different types of extenders but no more than a total of two (2) in any combination);
2. A Registered Physician Assistant may perform medical services when such acts and duties assigned to him / her are within the scope of practice of the supervising physician.
3. Supervision shall be continuous, however, it shall not require the physical presence of the supervising physician at the time and places 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 / Supervising Physician Date Signed

CERTIFICATE REQUIRED FOR NURSE PRACTITIONERS

The primary employer / supervising physician must submit a letter describing the exact duties and supervision involved with the applicant. This letter must be on the letterhead stationery of the primary employer and signed by the supervising physician.

After review of this information and review of the application, 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 administration of professional services by the Applicant will be supervised as follows:

Guideline "A"

1. No more than a total of two (2) Certified Nurse Practitioners will be employed by any one (1) physician (Note: physicians may employ different types of extenders but no more than a total of two (2) in any combination);
2. A Certified Nurse Practitioner may perform medical services when such acts and duties assigned to him / her are within the scope of practice of the supervising physician. With respect to a Certified Nurse Practitioner, these services must be performed in accordance with the written practice agreement executed by the Nurse Practitioner and the employing physician and the written practice protocol filed with the Department of Education. (Note: attach copy of both to the application);
3. Supervision shall be continuous and it requires the **physical presence** of the supervising 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 / Supervising Physician
Date Signed

Guideline "B"

1. No more than a total of two (2) Certified Nurse Practitioners will be employed by any one (1) physician (Note: physicians may employ different types of extenders but no more than a total of two (2) in any combination;
2. A Certified Nurse Practitioner may perform medical services when such acts and duties assigned to him / her are within the scope of practice of the supervising physician. With respect to a Certified Nurse Practitioner, these services must be performed in accordance with the written practice agreement executed by the Nurse Practitioner and the employing physician and the written practice protocol filed with the Department of Education. (Note: attach copy of both to the application);
3. Supervision shall be continuous, and it requires the **physical presence** of the supervising 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 / Supervising Physician Date Signed

Guideline "C"

1. No more than a total of two (2) Certified Nurse Practitioners will be employed by any one (1) physician (Note: physicians may employ different types of extenders but no more than a total of two (2) in any combination);
2. A Certified Nurse Practitioner may perform medical services when such acts and duties assigned to him / her are within the scope of practice of the supervising physician. With respect to a Certified Nurse Practitioner, these services must be performed in accordance with the written practice agreement executed by the Nurse Practitioner and the employing physician and the written practice protocol filed with the Department of Education. (Note: attach copy of both to the application);
3. Supervision shall be continuous, however, it shall not require the physical presence of the supervising 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 / Supervising Physician Date Signed

CERTIFICATE REQUIRED FOR MIDWIVES

The primary employer / supervising physician must submit a letter describing the exact duties and supervision involved with the applicant. This letter must be on the letterhead stationery of the employer and signed by the supervising physician.

Acknowledgement of Supervision Requirements by Supervising Physician:

The following certificate must be signed by the applicant's employer / supervising physician before insurance can be effected for a midwife applicant:

1. No more than a total of two (2) midwives will be employed by one (1) physician (Note: physicians may employ different types of extenders but no more than two (2) in any combination);
2. A midwife may perform medical services when such acts and duties assigned to him / her are within the scope of the practice of the supervising physician; and
3. Supervision shall be continuous, however, it shall not require the physical presence of the supervising 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 / Supervising Physician Date Signed

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Extender Application Addendum for Prior Acts Coverage (this will be produced as a separate document)

Request for Prior Acts ("NOSE") Coverage:

This section should only be completed if you meet all of the following criteria:

- You are presently covered on a claims made basis;
- Extended Reporting Endorsement ("Tail") coverage is not available to you from your prior carrier;
- There is no coverage lapse between the cancellation date of your current claims made policy and the requested effective date of your MLMIC coverage

A. Time period (month/day/year) requested for Prior Acts coverage? From:: __________ To: __________
B. A copy of the policy (or policies), including all endorsements in effect during the period for which you are requesting Prior Acts coverage must accompany your application. If this information is not included, it will delay processing of your application.

2 Park Avenue
New York, NY 10016
Tel: 212-576-9800

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Latham, NY 12110
Tel: 518-786-2700

2 Clinton Square
Syracuse, NY 13202
Tel: 315-428-1188

90 Merrick Avenue
East Meadow, NY 11554
Tel: 516-794-7200

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”).

____
____
____

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

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

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.)