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a Berkshire Hathaway company

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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
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Application for Physicians' and Surgeons' Professional Liability Insurance

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:

_____ %	_____ %
<small>County, State</small>	<small>County, State</small>
_____ %	_____ %
<small>County, State</small>	<small>County, State</small>

6. Social Security Number: _____

7. Telephone Numbers: _____
Home

8. Fax Number: _____
Office

9. E-mail Address: _____
Cell

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.)

NAME _____ DATE _____

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

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.

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.

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: _____

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 MLMIC 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)



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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): 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.

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 Signed (MM/DD/YY)



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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.

*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 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. 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: _____

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.)

IMPORTANT NOTICE:

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

MLMIC Insurance Company

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

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

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

Yes No

Additional Information / Continue Responses

Please Type Question and Question # Here

Please Type Corresponding Answer Here

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Additional Information / Continue Responses

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