

Application for Employee Professional Liability Insurance Coverage Allied Healthcare Providers

(“Allied Healthcare Providers” do not include nurse anesthetists, nurse practitioners, physician assistants or nurse 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 an “employer” as provided for in question 3 of this application.
4. In the case of multiple employments, only one premium bill will be issued.
5. Policies are issued for limits of \$1,000,000 Each Person, \$3,000,000 Total.
6. Insurance coverage is provided on an “Occurrence” basis only. A minimum premium per policy applies, regardless of policy term.
7. This application does not apply to the physician extenders shown above. A different application is required for their coverage.

1. Name of applicant _____
Last First Middle

Home Address _____
Number and Street City State Zip Code

Social Security Number _____ Date of Birth _____ / _____ / _____
Month Day Year

Telephone Numbers _____ E-mail address _____
Home Cell FAX

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. Name of primary employer: (Note: 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).

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

Employer’s mailing address _____

Billing address (if different from above) _____

Office phone _____ FAX _____ E-mail address _____

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

MLMIC policy number for employer _____ Tax identification number of employer _____

Name/specialty of supervising physician _____
Name Specialty Phone Number

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

Name of employer _____

Employer’s Address _____

Contact person and phone number _____

Coverage is provided only for your professional services while acting within the scope of your duties for your Primary Employer. Should insurance coverage be issued, it is an absolute condition of the insurance policy that MLMIC Insurance Company is the insurer of your Primary Employer and that such insurance remain in full force and effect for the full term of your policy. All policies will be mailed to the primary employer’s address. **Should your Primary Employer’s policy be cancelled, your policy will no longer provide you with coverage as of that date.**

4. Applicant is employed and licensed or certified in the capacity of:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Nuclear Medical Technician | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Cytotechnologist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Physical Therapist Assistant | <input type="checkbox"/> Surgical Technician |
| <input type="checkbox"/> Dietician / Nutritionist | <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Ultrasound Technician |
| <input type="checkbox"/> Emergency Medical Technician | <input type="checkbox"/> Ophthalmic Assistant | <input type="checkbox"/> Psychologist | <input type="checkbox"/> X-Ray Technician |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Optician | <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> X-Ray Therapist |
| <input type="checkbox"/> Medical Laboratory Technician | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Respiratory Therapy Technician | <input type="checkbox"/> Other (complete title of your medical professional designation) |
| <input type="checkbox"/> Medical Services Technician | <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Respiratory Therapist | _____ |
| <input type="checkbox"/> MRI Technician | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Speech Therapist | _____ |

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

Name of school, hospital, etc.	FROM (mm / dd / yy)	TO (mm /dd / yy)	Type of training	Date of completion

6. 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).

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

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

Name of organizations

8. Name of applicant's present or immediate past professional liability insurance company. Note: If previous coverage is claims-made, Extended Reporting Endorsement coverage must be purchased for that policy to avoid gaps in coverage for future claims.

Name of insurance company	Policy number	Effective date	Expiration date

9. Has any insurance company ever cancelled or declined to renew professional liability insurance for the applicant? Yes No
If "Yes", explain _____

10. Have you ever had a malpractice claim or suit (closed or pending) made against you? Yes No
If "Yes", on a separate sheet, state present status of each claim or suit including name of patient, dates, description of treatment and amount of settlement if applicable.

<p>Producer Information</p> <p>You may choose to submit your application directly to MLMIC or through a producer you identify below:</p> <p>Agency Name and Contact Person: _____</p> <p>Address of Agency: _____</p>
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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, 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

I understand that any insurance issued to the applicant is contingent upon the applicant's employer also being insured by MLMIC

Personal / Authorized Signature of Employer / Supervising Physician

Date Signed