MLMIC Insurance Company
a Berkshire Hathaway company

Professional Liability Insurance Application

Advanced Practice Provider

(Nurse Anesthetists, Nurse Practitioners, Physician Assistants, and Midwives)

Return the application to
apply@mlmic.com
or fax (212) 576-9877

Please note the following:

- All questions on the application must be answered. Additional requested information must be returned with the application.
- Only employees of MLMIC insured physicians / physician groups are eligible for coverage.
- A Policy Administrator must be designated. This is the person or entity that you designate to act as your agent for the payment of premiums, request changes to the policy, including cancellation thereof, and any return premiums when available. You may designate yourself as the Policy Administrator. You must complete the Policy Administrator Designation form provided by the Company to make this designation.
- Policies are issued at limits of $1,000,000 Each Person / $3,000,000 Total.
- Insurance coverage is provided on an "Occurrence" basis.
- All applications are subject to prior approval. If acceptable, coverage can be provided no earlier than the day following our receipt of the signed application.

---

1. Name: _____
   Last First Middle

   Home Address_____

   Birth date: _____ License # _____ DEA # (if applicable) _____
   Month/Day/Year

   Phone # _____ E-mail address _____

2. Requested effective date: _____12:01 A.M. E.S.T.
   Month/Day/Year

3. You are employed and licensed in the capacity of:

   ☐ Certified Nurse Practitioner
   ☐ Certified Registered Nurse Anesthetist
   ☐ Certified Nurse Midwife
   ☐ Other (Complete title of your medical professional designation) _____

   ☐ Registered Physician Assistant
   ☐ Registered Specialist Assistant
   ☐ Certified Midwife

   3a. For Nurse Practitioners only, is the presence of your collaborating physician required at the time and place where your professional services are performed?

   ☐ Not Required

   ☐ Required

P O Box 1287, Latham, NY 12110 | (800) ASK-MLMIC | MLMIC.com

4. Professional training (attach additional information sheets if necessary):

Name of school, hospital, etc	From (mm/dd/yy)	To (mm/dd/yy)	Type of Training

5. Name and Specialty of Collaborating/Supervising Physician:

_____

6. Is your practice limited to a certain specialty area(s)? ☐ Yes ☐ No

If Yes, please list _____

If No, please explain _____

7. Average hours per week working: _____

8. EMPLOYER for which this application is being submitted _____

9. If you are insured with MLMIC for other employment, will you continue that employment? ☐ Yes ☐ No

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

10. Do you provide any services via Telemedicine? ☐ Yes ☐ No

If Yes, what percentage of your total services are provided via telemedicine? _____

11. Present or immediate past professional liability insurance company:

Name of insurance company	Effective date	Expiration date	Type of Coverage Claims-Made or Occurrence	Policy Number

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

12. Has any insurance company ever cancelled or declined to renew your professional liability insurance?
☐ Yes ☐ No

If Yes, Name of insurance company _____
Please explain _____

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

If Yes, Name of State _____
Please Explain _____

14. Have you ever had a malpractice claim or suit (closed or pending) made against you?
☐ Yes ☐ No

If Yes, Number of Claims _____
Please provide a copy of the claim experience report, a description of your treatment and amount paid on your behalf, if applicable.

Supplemental Legal Defense Costs Coverage
Would you like to apply for Legal Defense Costs Coverage for Administrative Actions and/or Medicare/Medicaid Fraud and/or Abuse?
☐ Yes ☐ No

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

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

New York State Insurance Regulation 95 declares that:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation."

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.

_____ _____
Signature of Applicant Date Signed

P O Box 1287, Latham, NY 12110 | (800) ASK-MLMIC | MLMIC.com

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

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

Application for Legal Defense Costs Coverage
(Coverage for Administrative Actions & Medicare/Medicaid Fraud and/or Abuse)

No legal defense cost coverage will be provided if you do not return this form to MLMIC

Section I – General Information

Name of Applicant: _____

Mailing Address: _____

Phone Number: _____ Effective Date: _____

License Number: _____

MLMIC Policy Number (if any): _____

Limits Requested (check one):

☐ I do not want to purchase this coverage.

☐ I wish to purchase $25,000 maximum limit per policy period per insured person for an annual premium of $300.

☐ I wish to purchase $100,000 maximum limit per policy period per insured person for an annual premium of $800.

If you are on a multi-risk policy, all insureds on the same policy MUST have the same limit or reject the coverage. Defense cost coverage is not available to professional entities.

Section II – Statement of Facts Declared By The Applicant

I, _____ represent the following to MLMIC Insurance Company (MLMIC):

1. I have not had any administrative action by a governmental body organized for the purpose of maintaining standards of conduct and competence such as the Office of Professional Medical Conduct (OPMC) brought against me at any time except as follows: (provide a description of each administrative action, dates for each administrative action, dollar value for each administrative action and final resolution of each administrative action including "closed with no payment"). If none state "None". Use additional sheet of paper if necessary.

   _____
   _____
   _____

2. I have not had any Governmental Proceeding alleging a violation by me of Medicare or Medicaid guidelines arising out of the presentation of a Medicare or Medicaid Claim to a governmental health benefit payor or program for medical services or to items providing or prescribed brought against me at any time except as follows: (provide a description of each Governmental Proceeding, dates for each Governmental Proceeding, dollar value for each Governmental Proceeding and final resolution of each Governmental Proceeding including "closed with no payment"). If none state "None". Use additional sheet of paper if necessary.

   _____
   _____
   _____

3. I am not aware of any threatened or pending complaint, investigation or any other action or activity associated with such administrative action or Governmental Proceeding except as follows: (provide details or state "None").

_____
_____
_____

4. I am not aware of any event, circumstance, incident or fact inclusive of any request for records or threat thereof, which may lead to an administrative action or Governmental Proceeding against me except as follows: (provide details or state "None").

_____
_____
_____

5. I understand and agree that should a claim or investigation arise from a fact or circumstance of which I had prior knowledge, or reasonably should have had prior knowledge, coverage will not apply to such claim or investigation.

I make these statements with full knowledge that MLMIC Insurance Company relies on this representation in its decision to provide defense costs coverage for which I am applying. Furthermore, I understand this Application does not confer any obligation on the part of MLMIC to write this coverage at the $25,000 or $100,000 limit.

New York State Insurance Department Regulation #95 declares that*:*
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____
Personal signature of applicant Date

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

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

Policy Administrator – Designation and/or Change Form

You are your own Policy Administrator, unless you designate another party. As a service to you, the insured, your policy allows you to designate a Policy Administrator. Please take time to read and understand the authority granted by such a designation.

If you designate a Policy Administrator, that party will be displayed on the Declarations Page or Endorsement.

www.mlmic.com

*Policy Administrator means the person or organization designated in the Declarations Page. Designation as a Policy Administrator confers no coverage.

The Policy Administrator is the agent of all Insureds herein for the paying of Premium, requesting changes in the policy, including cancellation thereof and for and any return Premiums when due. By designating a Policy Administrator each Insured gives us permission to release information about each such Insured, your practice or any other information that we may have to such Policy Administrator. Your Policy Administrator may also elect to receive and access policy forms and notifications electronically.

NOTICE:

The election of Policy Administrator can only be changed by the Insured. However, the current PA, other than the Insured, may rescind their status, allowing the PA role to revert to the Insured or their new designee.

1. The Insured can notify us to change the Policy Administrator by written notice. When such a change is requested we will send notification of the request, including the date of the change, to the individual parties. Once the change in Policy Administrator is made, all rights will be given to the new Policy Administrator as of the effective date of the change.
2. Either the Policy Administrator or the Insured may elect to change or terminate coverage.
3. All cancellation, non-renewals and extended reporting endorsement notices will be sent to both the current Policy Administrator and the Insured at the address shown in the policy. The address of the Policy Administrator becomes the address to which all legal notices will be sent.
4. MLMIC Insurance Company is not a party to any agreement between you and your Policy Administrator.
5. By signing this form, the Policy Administrator, indicated below, accepts their role and agrees to notify us in writing in the event they decide not to continue in this capacity

Print Name of Insured: _____

NYS License No.: _____ Effective Date of this designation: ____/____/____

Policy Administrator*: _____ Taxpayer Identification Number (TIN): _____

Contact Name: _____ E-mail Address: _____

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

Address: _____

Billing Address (if different): _____

Phone Number: _____ Fax Number: _____

In Witness Whereof, I sign my name:

Signature of MLMIC Insured: _____ Dated ____/____/____

Signature of Policy Administrator (PA) _____ Dated ____/____/____
(if an organization – signature of authorized party & title)