

Application for Excess Professional Liability Insurance

To secure this coverage under Section 18:

- Your primary insurance must be with MLMIC with limits of \$1.3 million / 3.9 Million
- You must have an active affiliation with a New York State general hospital, where you render emergency medical services from time to time.
- You must have completed a NYS approved risk management course within the last two years.

A direct pay option may be available, if the requirements of Section 18 are not met.

1. Name of Applicant: _____
2. MLMIC Reference Number/Primary Policy Number: _____
3. Desired Excess Coverage Effective Date: _____
4. Primary Hospital Affiliation: _____
 No current hospital affiliation
5. Name of Previous Section 18 Excess Insurance Carrier and Dates of Coverage: _____

6. Risk management course completed: Yes, Date completed: _____
 No, Date scheduled to complete: _____

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? _____

Completion of this form does not bind coverage.

Authorization Statement:

I hereby grant authority to the hospital listed on this application to terminate, on my behalf, the excess liability insurance policy to be written from this application. In the event this excess professional liability insurance is terminated for any reason, I hereby assign all refunds of premium to the payor of such premium.

Certificate of Insurance:

I hereby grant authority for MLMIC Insurance Company to provide a Certificate of Insurance to the Primary Affiliated Hospital as stated above when the excess liability insurance policy is issued.

New York State Insurance 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)

Email address

Telephone Number

Fax Number

Excess new business apps can be returned via email to excess@mlmic.com or fax at 518-786-2660.



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: _____

Policy Number: _____ 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)