MLMIC Insurance Company

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

Professional Entity Application Instructions
and
Eligibility Requirements

PLEASE READ CAREFULLY.

Your policy will not provide separate limits of coverage to your entity for professional services provided or medical incidents. In order for your Professional Entity to have separate limits coverage and for certain employees to share in this limit with the entity, you MUST apply for this coverage. We are enclosing the necessary application for you to complete if you wish to apply for coverage.

Please be advised that each entity applying for this coverage need only return one application regardless of the number of providers in the entity. Only the authorized representative of the entity should complete the application and return it to us. Please coordinate the completion of this application amongst all members of the entity.

In order for a Professional Entity to be eligible for coverage it must meet the following criteria:

- **The Professional Entity must be incorporated in New York State;**
- **Members and employed physicians, surgeons, or physician extenders in the practice must be acceptable based on MLMIC's underwriting standards; and**
- **All members, employed physicians and/or physician extenders must carry individual limits of insurance of at least $1,000,000 each person/ $3,000,000 total limit.**

The premium for your Professional Entity depends on a number of factors. The cost of coverage for a professional entity is based upon a percentage of the total premium of all members and employees who are physicians, surgeons and extenders. Claims made factors would be applied accordingly for claims made coverage.

Please note, all applications are subject to prior approval.

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

Application for Physician/Surgeon Professional Entities Related to a Members Practice – Professional Liability

Please **type** or **print** responses and answer all questions. Coverage will not be considered until this application is complete.

PLEASE NOTE:

- A limit of $1,000,000 each person/ $3,000,000 aggregate is the maximum limit available and unless otherwise requested, is the limit that will be provided if this application is approved.
- The type of coverage available (claims made or occurrence) will be determined based on the information provided in this application.
- **All applications are subject to prior approval. If your application is approved, coverage can be provided no earlier than the day following the postmark on the envelope containing the completed and signed application.**

Requested coverage effective date: _____

1. Legal name of professional entity as it appears on your entity's Articles of Incorporation or Partnership Agreement:

   _____

2. Is this entity known by any other names (DBA's)? ___ Yes ___ No

   If yes, please list: _____

3. Address(es) of entity (street address, city, state, zip code):

   _____

   _____

   Website Address: _____

4. Name and title of entity insurance contact person: _____

   Phone number: _____ Fax Number: _____ E-mail address: _____

5. Type of entity: _____ Professional Corporation _____ Professional Limited Liability Company
   _____ Partnership _____ Professional Limited Liability Partnership

6. Is the Professional Entity incorporated in New York State? ___ Yes ___ No
   (Please note that incorporation in New York State is a requirement for coverage.)

   Date of Incorporation: _____ Taxpayer ID#: _____

7. Check all of the following which describe the medical service classification(s) for this entity:

   ___ Physician office practice or medical group

   ___ New York Article 28 healthcare facility (please describe and also list current professional liability insurance company & limits):

   _____

   _____

   If the facility / entity is a surgery center, what is the average number of surgeries performed per month? _____

If the facility / entity provides services through a outpatient healthcare facility other than a surgery center (e.g. emergency room, urgent care, laboratory, etc.) what is the average number of monthly patient visits? _____

Does the facility / entity provide medical services (e.g. laboratory, imaging, physical therapy, etc.) to individuals who are not patients of any Member of the professional entity? _____ Yes _____ No If yes, please explain:

_____

_____

_____

Independent Contractors:

Please provide the following information for each independent contractor associated with the entity under contract or other agreement (use additional sheets if necessary):

(a) Name of independent contractor: _____

(b) List all medical professional services provided by this independent contractor (e.g. direct patient care, patient care assistance, locum tenens, diagnostic / imaging services, etc.):

_____

_____

(c) List all non-medical professional services provided by this independent contractor (e.g. personnel or administrative services, billing services, maintenance services, vendor / supply services, other operational services, etc.):

_____

_____

(d) List all medical professional services provided by the entity to this independent contractor (e.g. direct patient care, patient care assistance, locum tenens, diagnostic / imaging services, etc.):

_____

_____

(e) List all non-medical professional services provided by the entity to this independent contractor (e.g. personnel or administrative services, billing services, maintenance services, vendor / supply services, other operational services, etc.):

_____

_____

___ other: (please describe any other medical professional services or non-medical professional services provided by this entity to members of the entity or to others):

_____

_____

8. Have there been claims filed against the entity? _____ Yes _____ No
If yes, please submit currently valued loss runs for each claim.

9. Are you aware of any circumstances that could lead to a claim against the entity? _____ Yes _____ No
If yes, please explain:

_____

_____

10. Is this entity engaged in any activity other than the practice of medicine ? ___ Yes ___ No
If yes, please explain:

_____

_____

11. Have you signed or will you sign any contract / agreement to assume the professional liability of others? ___ Yes ___ No
If yes, please identify and explain:

_____

_____

12. Please submit the following information for **physicians and physician extenders** (Registered Physician or Surgical Assistants, Certified Nurse Practitioners, Certified Nurse Midwives or Nurse Anesthetists) who are currently partners, shareholders, employees, or independent contractors of this entity: (Please use page 4 to answer this question.)
    - Name (indicate whether full time – FT or part time – PT)
    - Specialty/type of services rendered
    - License number
    - Role in entity (partner, shareholder, employee, independent contractor and hours worked per week if part time)
    - Current Insurance Company, Policy Number and Limits of Liability
    - Type of Coverage (Claims Made or Occurrence)

13. Please submit a list of other employees showing number of employees by specialty type, e.g. nurses, lab techs, therapists, etc. (Please use page 4 to answer this question)

14. Please submit the following material with this application for coverage:
    - Copy of your letterhead / stationery
    - Articles of Incorporation, Professional Services Corporation Triennial Statement or Partnership Agreement
    - Copies of any alternate name or DBA permits

Important Notice: Claims Made Coverage

If claims made coverage is indicated, please be aware that no coverage will be extended 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.

Note: Your signature is required following the Insurance Department Regulation statements which appear below:

Release of Information:

I hereby authorize MLMIC Insurance Company and its affiliates to obtain all information from any insurance company, credentialing data source, or other party with respect to me, my professional credentials, or my medical practice, which would include any claim, lawsuit, or event pertaining to professional acts or omissions that have been asserted against me or my medical practice, partnership, or professional corporation. I expressly release and discharge from liability any party providing or receiving such information. I consent to the use of my information by MLMIC Insurance Company and its affiliates in their business of insurance. I further authorize that a copy of this signed release be accepted with the same authority as the original.

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.

_____ _____

Date signed Authorized Representative

Questions 12 and 13: Please use this sheet to complete questions 12 and 13. Please attach additional sheets if necessary.

12. Please submit the following information for **physicians and physician extenders who are currently partners, shareholders, employees, or independent contractors of this entity:**

- Name (indicate whether full time – FT or part time – PT)
- Specialty/type of services rendered
- License number
- Role in entity (partner, shareholder, employee, independent contractor)
- Current Insurance Company, Policy Number and Limits of Liability
- Type of Coverage (Claims Made or Occurrence)

Name Full time – FT Part time - PT	Specialty	License Number	Role in Entity	Current Insurance Company	Policy Number	Limits of Liability	Coverage Claims Made or Occurrence

13. Please submit a list of other employees showing number of employees by specialty type, (e.g. nurses, lab techs, therapists)

Specialty Type (nurse, lab tech, therapist, etc.)	Number of Employees