MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Application for Healthcare Professional Liability Insurance
Mid-Level/Advanced Provider

APPLICATION INSTRUCTIONS AND CHECKLIST

IMPORTANT NOTICE:
You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

INSTRUCTIONS:
Please complete the entire application and indicate not applicable (n/a) where appropriate, then sign and date.

ATTACHMENTS TO PROVIDE WITH APPLICATION:

☐ Copy of current Curriculum Vitae

☐ Certain portions of the application may require information that is already reflected on personal documents such as curriculum vitae, etc. For your convenience, we include the option to indicate "Attachment contains this information" rather than require that you type in all information. When you indicate "Attachment contains this information," you **represent** to MIEC that the information contained in the attachments is true and correct. MIEC is relying upon the information in the attachments to make a determination of whether to issue coverage.

☐ Collaborative or Delegation of Services Agreement

☐ Standardized Procedures or Protocol

☐ Medication Protocols (if dispensing and/or prescribe drugs)

☐ Employment or Independent Contractor Agreement—if applicable

ADDITIONAL COMMENTS:
If you wish to provide detailed responses to any of the questions in the application, please use the "Additional Comments" section on page 4 of the application.

For assistance, you may call our main office at the number below from 8:00 a.m. to 5:00 p.m. PST or E-mail us at the address below. Please include in your E-mail the location of your practice or where you plan to practice including the city, state and zip code.

TEL: 800-227-4527
FAX: (510) 318-6700
E-MAIL: underwriting@miec.com

AGENT INFORMATION (if applicable)**:**

Agent Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

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GENERAL/SPECIALTY INFORMATION/PROFESSIONAL LICENSES — ANSWERS 1-3

1. GENERAL INFORMATION

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ☐Male ☐Female ☐Other

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Mobile Telephone Number _____

Principal Practice Address _____ City _____ State _____ Zip Code _____

County _____ Office Telephone Number _____ Office Fax Number _____

E-mail Address _____ Website Address or ☐N/A

Tax I.D. Name _____ Federal E.I.N. _____ NPI# _____

Secondary Practice Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____

Preferred Contact Person _____ Contact Information _____

Preferred Mailing Address: ☐Home ☐Practice ☐Billing *Please use "Additional Comments" section on Page 4 to list any additional locations.*

2. SPECIALTY INFORMATION Please indicate your specialty:

☐Certified Registered Nurse Anesthetist (CRNA) ☐Certified Nurse Midwife (CNM) ☐Nurse Practitioner

☐Optometrist ☐Physician Assistant ☐Surgical Assistant

☐Other*: _____ *Separate limits may not be available based on specialty

3. PROFESSIONAL LICENSES

Please list all states in which you are currently licensed. Use the "Additional Comments" section on page 4 to list any additional locations

State _____ License # _____ Expiration Date _____ Percent of Practice _____ ☐Active ☐Inactive ☐Pending

State _____ License # _____ Expiration Date _____ Percent of Practice _____ ☐Active ☐Inactive ☐Pending

State _____ License # _____ Expiration Date _____ Percent of Practice _____ ☐Active ☐Inactive ☐Pending

State _____ License # _____ Expiration Date _____ Percent of Practice _____ ☐Active ☐Inactive ☐Pending

B. DEA License Number _____ Date of Issue _____ Expiration Date _____

4. COVERAGE REQUEST / LIMITS

Requested Effective Date (mm/dd/yyyy): _____ Retroactive Date if applicable (mm/dd/yyyy): _____

Type of Limit: ☐ Shared ☐ Separate ***If Shared Limit, please provide the following:***

REQUEST ADDITION TO A CURRENT MIEC POLICY*

_____ _____

Name of Entity/Organization/Physician Policy Number

Relationship ☐ Employee ☐ Independent Contractor ☐ Other: _____

Do you have a collaborative or delegation of services agreement? ☐ Yes ☐ No Physician name: _____

If yes, please attach a copy of the agreement.

Have your limits of liability changed (increased or decreased) in the past five years? ☐ Yes ☐ No

If yes, please indicate your prior limits of liability: _____

If requesting Separate Limits, please provide the following:

☐ Claims-made **WITHOUT** prior acts coverage. Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.

☐ Claims-made **WITH** prior acts coverage. Under this option, the retroactive date will be the same as the retroactive date on your current policy. ***Please provide a copy of your current Declarations page.***

Please indicate the primary limits of liability requested (Limit per claim / annual aggregate):

☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

Do you wish to request excess limits of liability? ☐ Yes ☐ No (additional screening may be required). If Yes, please select an option:

☐ $1,000,000/$1,000,000

*Coverage will be limited to your professional service provided within the course and scope of employment or contract, while under the direction, control and/or supervision, by MIEC physician/entity listed above.

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department

5. SCOPE OF PRACTICE

Average Number of Weekly Hours: _____

Does your practice involve any of the following?

A. Treatment of patients via virtual or telemedicine? ☐ Yes ☐ No If Yes,

1. What percentage of your practice does this comprise? _____
2. What percentage of patients are physically located in the state of your principal licensure/practice location/primary residence? _____

   If not 100%, then
3. What states are your patients treated via telemedicine located in? _____

   Are you licensed in all the states where your patients are physically located? ☐ Yes ☐ No
4. For patients treated via telemedicine, are they ☐ New Patients? ☐ Established Patients? Check all that apply.
5. For patients treated via telemedicine, do you prescribe any controlled substance? ☐ Yes ☐ No

   If Yes, then
6. Do you follow DEA protocols which involves a prior in-person examination? ☐ Yes ☐ No

B. Do you provide care in a nursing home? ☐ Yes ☐ No Name(s) of nursing home(s): _____

_____

C. Do you provide home health care? ☐ Yes ☐ No Name of employer: _____

D. Will you work in an operating room? ☐ Yes ☐ No If yes, in what capacity: ☐ Observe Only ☐ Assist Only ☐ Other: _____

E. Do you or will you work in a labor and delivery room or birthing center? ☐ Yes ☐ No

F. Do you currently have hospital privileges? ☐ Yes ☐ No

HOSPITAL PRIVILEGES/EMPLOYMENT/INSURANCE HISTORY/ADDITIONAL COMMENTS ANSWERS 6-9

6. HOSPITAL PRIVILEGES ☐ *Attachment contains this information*

List all hospitals and ambulatory surgery centers where you currently have privileges or have applications for privileges pending. Indicate type of privileges and restrictions, if any. If you want MIEC to send evidence of coverage (certificate of insurance) to any of these hospitals, please indicate.

Hospital/Facility	City	Send Certificate of Insurance
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

A certificate of your insurance will be sent only if you request it and if MIEC approves your application for insurance. Any additional privileges may be listed on separate attachment or in the Additional Comments section.

7. EMPLOYMENT HISTORY ☐ None

List all locations where you have practiced within the last 5 years. Begin with current location.

Name/Type of practice	City	State	From	To

Any gaps? Please explain: _____

☐ *Attachment contains this information*

8. INSURANCE HISTORY ☐ None

List all professional liability carriers (including current) who have insured you during the last 5 years. Use additional comments on page 5 or separate sheet of paper, if necessary.

Name of Carrier	Limits			Coverage Dates: From	To	Retro Date
		☐ Claims-Made	☐ Occurence			
		☐ Claims-Made	☐ Occurence			
		☐ Claims-Made	☐ Occurence			

☐ *Attachment contains this information*

9. ADDITIONAL COMMENTS ☐ *Attachment contains this information*

10. PROFESSIONAL DISCLOSURE

Use additional comment section to explain any "Yes" response.

A. Have you ever failed any licensing or Board Certification examinations? ☐Yes ☐No

If yes, how many times? _____

B. Have you ever practiced medicine while you were uninsured? ☐Yes ☐No

C. Have you ever been accused of sexual misconduct of any kind? ☐Yes ☐No

D. Has any insurance carrier ever denied, declined, canceled, refused to renew, restricted, or placed a surcharge on the premium of your professional liability insurance? ☐Yes ☐No

E. Have your ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐Yes ☐No

F. Have you ever had any hospital, surgical outpatient or healthcare services plan privileges denied, suspended, revoked, restricted, reduced, not renewed, proctored, or modified in any way? ☐Yes ☐No

G. Has your participation in any governmental or nongovernmental health program (e.g., Medicare, Medicaid, HMO, PPO, or any managed care program ever been suspended, placed on probation, terminated, or limited in any way? ☐Yes ☐No

H. Have you ever been investigated, arrested, indicted, pled guilty to, or been convicted of any misdemeanor or felony other than minor traffic violations not involving any allegation of alcohol or substance use? ☐Yes ☐No

I. Have you ever been investigated by any state or federal regulatory body or specialty society? ☐Yes ☐No

J. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ☐Yes ☐No

K. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your medical license or your narcotics license? ☐Yes ☐No

L. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or other medical review committee? ☐Yes ☐No

M. Have you ever had a patient, or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? ☐Yes ☐No

N. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? If yes, please include a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any agreement you have made with any recovery organization. ☐Yes ☐No

O. Are you aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? ☐Yes ☐No

If yes, please include a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any limitations on your ability to practice the specialty(ies) listed.

P. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? ☐Yes ☐No

Q. Has any physician, patient, or insurance plan ever filed a complaint against you with any medical association/society or foundation, consumer protection agency, Chamber of Commerce, or Better Business Bureau? ☐Yes ☐No

R. Have you ever in any way altered, embellished, deleted, changed, and/or destroyed any records, medical or otherwise, or were allegations made that you did so. ☐Yes ☐No

ADDITIONAL COMMENTS ☐ *Attachment contains this information*

CLAIM INFORMATION FORM

CLAIM INFORMATION FORM ☐ *Attachment contains this information* ☐ None (Please be sure to check here if no claims)

Have you **ever** been involved in a malpractice claim, suit or arbitration proceeding, or have you reported any incidents which resulted in a claim to a former carrier? ☐ Yes ☐ No

If yes, you must complete a claim information form for **each** claim OR submit a current loss run representing the last 10 years of practice

Are you aware of any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have not been reported to your current or prior medical professional liability carrier? ☐ Yes ☐ No

All claims information should be provided. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information.

Last name of Patient/Claimant _____ ☐ Male ☐ Female ☐ Other Age _____

Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon): _____

Allegation: _____

Date of Incident: _____ Location: _____

Insurance carrier(s): _____

Other defendants: _____

Present status: ☐ Open ☐ Closed

Indemnity and expenses reserved: _____

Loss of: $ _____ Expenses paid: $ _____

Date Closed: _____ ☐ Settlement ☐ Judgement

Conditions and diagnosis at time of incident:

_____

_____

Dates and description of professional services rendered:

_____

_____

Condition of patient subsequent to professional services (and dates of follow-up visits, if known):

_____

_____

Explain what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR <u>EACH</u> PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

IMPORTANT

THE FOLLOWING SECTIONS PROVIDE IMPORTANT INFORMATION RELATING TO VARIOUS ASPECTS OF THE INSURANCE YOU ARE APPLYING FOR.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned represents that the statements made in this application and any materials submitted herewith are true and correct, that neither the undersigned nor any of the undersigned's employees, agents, or representatives have withheld or failed to disclose pertinent information, and that all have given careful consideration to the statements and information provided. The undersigned further acknowledges that such statements are material representations and that any policy issued by MIEC is issued in reliance upon the truth and accuracy of such statements.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose limits in this application. The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature _____ Date _____

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MIEC UNDERWRITERS, LLC., to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MIEC UNDERWRITERS, LLC. to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MIEC UNDERWRITERS, LLC. as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MIEC UNDERWRITERS, LLC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MIEC UNDERWRITERS, LLC. and the Board of Governors or its Executive Committee shall be borne by MIEC UNDERWRITERS, LLC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with Section 1399 and 1400 or 1401 or 1401.5 of the Insurance Code of the State of California subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION FOR HOSPITALS/MEDICAL STAFFS/AMBULATORY FACILITIES

As an applicant for initial or continued professional liability insurance coverage from MIEC, I hereby give my consent to MIEC, its agents and representatives, to make inquiries to hospitals, medical staffs, ambulatory facilities, health care service plans or other managed care organizations where I have exercised or applied for clinical privileges or membership.

I grant permission to such hospitals, medical staffs and managed care organizations and their representatives and agents to provide information to MIEC which pertains to those privileges I have exercised and to my fitness and qualifications to exercise such privileges. This includes but is not limited to information relating to the scope of privileges granted, any special limitations imposed on such privileges and any information regarding any disciplinary action taken with respect to such privileges.

I further agree that the organization releasing the information, its representatives, agents and employees shall not incur any liability as a result of furnishing or releasing information pursuant to this authorization, even if such information is incomplete or incorrect.

Signature	Print Name		Date
Address	City	State	Zip

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature	Print Name		Date
Address	City	State	Zip