MMIC

7701 France Avenue South, Suite 500
Minneapolis, MN 55435–5288
800–328–5532 • Fax 952–838–6808
MMICGroup.com

Physicians And Surgeons Professional Liability
Renewal Application

A. Applicant Information

Name of Applicant (First, Middle, Last): ☐ MD ☐ DO ☐ Other Specify Other:		MMIC Policy Number:
Applicant's Business Address (Street, City, State, Zip Code):		County:
Business Phone:	Fax:	E-mail:
Website:		
Applicant's Home Address (Street, City, State, Zip Code):		
Home Phone:	Fax:	E-mail:
Mailing/Billing Address: ☐ Home ☐ Business ☐ Other (specify) Other:		Business Manager / Contact Person:
Telephone:	Fax:	E-mail:

Type of Practice: ☐ Individual ☐ Intern/Resident ☐ Fellowship ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Other (Specify):

Are you currently enrolled in a Patient's Compensation Fund (PCF)? ☐ Yes ☐ No
If yes, answer the following question and indicate the fund name.

Have you, at all times subsequent to your retroactive date, been continually qualified/covered by the state fund? ☐ Yes ☐ No

☐ Kansas Healthcare Stabilization Fund ☐ Nebraska Excess Liability Fund ☐ Wisconsin Patients' Compensation Fund
☐ Indiana Patients' Compensation Fund ☐ Other (specify):

Are you a member of a network, alliance or IPA? ☐ Yes ☐ No If yes, indicate the name:

B. Practice Information

1. If you are employed, indicate the name of your employer:
2. If you are an independent contractor, name each entity with which you have contracted healthcare services:

3. List each professional corporation, association, partnership or other healthcare related entity in which you have an ownership:

Name	Description of Interest	% of Practice

Complete one Healthcare Corporate Application for each organization listed above, if coverage is desired.

4. If you, as an individual, employ or contract physicians or surgeons, complete the following:

Employee or Contractor Name	Specialty*	Category* (1 through 5) (see question D1)	Procedures Performed* (see question D4)	Policy # (if insured by MMIC)	Limit of Liability

*Not necessary to complete if insured by MMIC.

5. If you, as an individual, employ or contract other medical professionals, complete the following:

Type	Number	Employment	Current Insurer	MMIC Policy # (if applicable)
Physician/Surgeon Assistants		☐ Employee ☐ Contractor		
Nurse Anesthetists		☐ Employee ☐ Contractor		
Nurse Midwives		☐ Employee ☐ Contractor		
Nurse Practitioners		☐ Employee ☐ Contractor		
Perfusionists		☐ Employee ☐ Contractor		
Podiatrists		☐ Employee ☐ Contractor		
Dentists		☐ Employee ☐ Contractor		
RNs/LPNs/LVNs		☐ Employee ☐ Contractor		
Other (describe):		☐ Employee ☐ Contractor		

C. Specialty / Work Experience

1. What is your medical specialty? What is your medical sub-specialty?

2. Are you certified by an approved specialty board? ☐ Yes ☐ No If yes, certifying board name(s): _____

Date(s) of initial certification: _____ Date(s) of recertification: _____

3. If you are not certified, are you board eligible? ☐ Yes ☐ No If yes, date eligibility expires:

4. List each state where you are licensed to practice, license number and the percentage of patients seen in each state:

State	License Number	% of Patients

5. Indicate the name and location of all facilities, including nonhospital facilities, where you hold staff or courtesy privileges:

Name/Location	Name/Location

6. List all places where you have practiced your profession during the past 5 years:

Facility/Practice	Dates (month/year to month/year)
	to
	to
	to
	to
	to

7. Has there been any change in your practice or specialty during the past five years? ☐ Yes ☐ No
If yes, describe changes:

D. Classification

1. Indicate each of the following that you perform. Check each box that applies.

☐ **Category 1** No surgical procedures performed other than incision of boils and superficial abscess, suturing of skin and superficial fascia or circumcision.
☐ **Category 2** Assist in surgery on your own patients and/or perform minor surgical procedures.
☐ **Category 3** Obstetrical procedures and/or prenatal care beyond the first trimester not including c-sections.
☐ **Category 4** All other types of surgery and operations performed under general or regional anesthesia.
Number of surgeries performed annually: ____
☐ **Category 5** Administration of anesthesia (other than local)

2. Do you perform obstetrical procedures? ☐ Yes ☐ No If yes, answer the following questions:
Average number of deliveries you perform annually: Number of c-sections: Number of VBACs:

3. Indicate the percentage of time devoted to the following medical and/or surgical activities: (Total should equal 100%)

Percentage (Non-Surgical)	Percentage (Non-Surgical)	Percentage (Surgical)
Administrative Medicine	Nephrology	Abdominal
Aerospace Medicine	Neurology	Bariatric
Allergy	Nuclear Medicine	Cardiac
Anesthesiology	Nutrition	Cardiovascular
Broncho-Esophagology	Obstetrics/Pre-Natal Care	Colon & Rectal
Cardiovascular Disease	Occupational Medicine	Dermatology
Dermatology	Oncology	Endocrinology
Diabetes	Ophthalmology	Foot and Ankle
Emergency Medicine	Orthopedics	Gastroenterology
Endocrinology	Otology	General
Family Practice/General Practice	Otorhinolaryngology	Geriatrics
Fetal and Maternal Medicine	Pain Management*	Gynecology
Forensic Medicine	Pathology	Hand
Gastroenterology	Pediatrics	Head & Neck
General Preventive Medicine	Pharmacology-Clinical	Laryngology
Genetic Counseling	Physiatry	Neonatal
Geriatrics	Physical Medicine/Rehabilitation	Nephrology
Gynecology	Psychiatry	Neurosurgery
Hematology	Psychoanalysis	Obstetrics
Hospitalist	Psychosomatic Medicine	Obstetrics-Gynecology
Hypnosis	Public Health	Ophthalmology
Infectious Diseases	Pulmonary Diseases	Orthopedic excluding Spinal Surgery
Intensive Care Medicine	Radiology	Orthopedic including Spinal Surgery
Internal Medicine	Rheumatology	Otorhinolaryngology
Laryngology	Rhinology	Plastic
Legal Medicine	Sports Medicine	Plastic-Otorhinolaryngology
Neonatology	Weight Reduction/Control*	Thoracic
Neoplastic Diseases	Other*	Traumatic
		Urological
		Vascular
		Other*

*Describe in Comments section.

4. Please check the following medical procedures you perform:

- ☐ Autologous Fat Injection
- ☐ Angiography
- ☐ Arteriography
- ☐ Botox Injections
- ☐ Catheterization – arterial, cardiac, or diagnostic, other than:
  - a. Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.
  - b. Urethral catheterization
  - c. Umbilical cord catheterization for diagnostic purposes or for monitoring blood gasses in newborns receiving oxygen.
- ☐ Chelation therapy
- ☐ Closed fracture reduction – other than fingers or toes
- ☐ Colonoscopy
- ☐ Cryosurgery – other than use on benign or premalignant dermatological lesions
- ☐ Conscious sedation
- ☐ D & C performed under local anesthesia
- ☐ Discograms
- ☐ ECT (describe): ____
- ☐ Epidurals
- ☐ ERCP (Endoscopic Retrograde Cholangiopancreatography)
- ☐ Lasers (describe)
- ☐ Laparoscopy
- ☐ Lymphangiography
- ☐ Liposuction
- ☐ Pneumoencephalography
- ☐ Pneumatic or mechanical esophageal dilation (not with buogie or olive)
- ☐ Needle biopsy (describe)
- ☐ Myelography
- ☐ Radiation therapy
- ☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae
- ☐ Vasectomies
- ☐ Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation (describe)

☐ **NONE OF THE ABOVE**

E. Underwriting Questions

Explain any "yes" answers to the following questions in the Comments section.

1.	Do you staff an emergency room for purposes other than to maintain hospital privileges? If yes, include hospital name, location, number of hours per month and relationship in your explanation.	☐ Yes ☐ No
2.	Do you practice in or staff an urgi-center or similar minor emergency clinic?	☐ Yes ☐ No

3.	Do you perform surgery or obstetrical procedures at a location other than a licensed hospital? If yes, include location and distance (travel time) to the nearest hospital in your explanation.	☐ Yes ☐ No
4.	Are you employed full time by the Federal Government or are you in the military service?	☐ Yes ☐ No
5.	Are you engaged in any "moonlighting" activities? If yes, indicate the number of hours per month:	☐ Yes ☐ No
6.	Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities?	☐ Yes ☐ No
7.	Do you own or operate a surgi-center, emergency service facility, minor emergency care facility, laboratory, or other outpatient facility? If so, please complete a Healthcare Facilities Application.	☐ Yes ☐ No
8.	Do you render patients unconscious for treatment in your office or other nonhospital facility?	☐ Yes ☐ No
9.	Do you provide professional services on behalf of a professional sporting team? If yes, include name of team, percentage of practice and relationship in your explanation.	☐ Yes ☐ No
10.	Are you employed or contracted by any facility as a medical director or similar role? If yes, include name of facility in your explanation.	☐ Yes ☐ No
11.	Do you perform utilization review services for a fee for others?	☐ Yes ☐ No
12.	Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges or has probation been invoked?	☐ Yes ☐ No
13.	Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation been invoked?	☐ Yes ☐ No
14.	Are you aware of any complaint or investigation with respect to your license to practice, your BNDD/DEA license, your privileges or participation at or with any hospital or other medical facility?	☐ Yes ☐ No
15.	Has any hospital, medical association, medical society or medical board, HMO, licensing authority or peer review organization notified you of its intention to consider imposing any such change of status, penalties, privileges, participation, certification or membership?	☐ Yes ☐ No
16.	Have you ever been denied a medical license or been denied certification by a specialty board?	☐ Yes ☐ No
17.	Have you ever been treated for alcoholism, narcotics addiction or mental illness? If yes, please attach a letter outlining dates of treatment, results of treatment and current status. This letter should be from your treating physician or institution.	☐ Yes ☐ No
18.	Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program?	☐ Yes ☐ No
19.	Do you provide any diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed under question C4? If yes, include states, type of service and annual number of encounters in your explanation.	☐ Yes ☐ No
20.	Do you work part-time? If yes, indicate number of hours worked per week providing patient care, hospitals rounds, administrative duties, phone calls and teaching:	☐ Yes ☐ No
21.	Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? If yes, include proof of coverage, location, and name of entity providing coverage.	☐ Yes ☐ No
22.	Do you use an electronic healthcare records (EHR) system? If yes, please complete the EHR Supplemental Application.	☐ Yes ☐ No

F. Claim Information

1. Are you aware of any claims, suits or potential claims that have **not** been reported to MMIC? ☐ Yes ☐ No
   If yes, provide a brief description of each claim(s) in the Comments section and answer the following:
   Will claim(s) be reported to MMIC Claim Department? ☐ Yes ☐ No
   If no, explain (e.g. is this claim covered by a different insurance carrier?):

G. Comments

Section & Question	Explanation

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another person files an application for insurance 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 subjects the person to criminal and civil penalties.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If this policy is issued on a claims-made basis, the policy will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: I authorize access by and release to MMIC Insurance, Inc. of any and all information pertaining to underwriting and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: MMIC Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of MMIC Insurance, Inc. to discuss any such information within its committees and boards and to communicate conclusions relating thereto Applicant and administrative or executive personnel of his or her employer or prospective employer.

I hereby certify the foregoing information is true and correct.

Signature of Applicant

Date