MIEC

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Employed/Contract or Locum Tenens Physician Application for Professional Liability Insurance Additional Insured Basis

To be completed by employed/contract/locum tenens physician

1. Name of Employer _____ Policy Number _____

2. Employer's Office Street Address _____ City _____ State _____ Zip _____

3. Your Full Name _____ 4 Date of Birth (mm/dd/yyyy) _____

5. Your E-mail _____ 6. Your License Number (in state where you will practice) _____ State _____

7. A. Exact dates on which you will work for the above-named physician(s): Permanent? ☐ Yes ☐ No

   or From _____ through and including _____ # of days _____

   B. Full-time on above dates? ☐ Yes ☐ No If "No", state number of hours per day _____ # of days/week _____

8. Medical Specialty _____

   ☐ Attachment contains this information

9. A. Medical School _____ Name of School _____ City _____ State _____

   Year Graduated _____ Degree _____

   ☐ Attachment contains this information

   B. Internship _____ Name of Hospital _____ City _____ State _____

   From (mm/yyyy) _____ To (mm/yyyy) _____

   ☐ Attachment contains this information

   C. Residency ☐ Yes ☐ No

   Name of Hospital _____ City _____ State _____

   From (mm/yyyy) _____ To (mm/yyyy) _____ Type _____ Residency completed? ☐ Yes ☐ No

   ☐ Attachment contains this information

   D. Additional Residency

   Name of Hospital _____ City _____ State _____

   From (mm/yyyy) _____ To (mm/yyyy) _____ Type _____ Residency completed? ☐ Yes ☐ No

   ☐ Attachment contains this information

E. Fellowships and Additional Medical Training

Hospital/Facility	City	State	Type of Training	From	To

F. Are you Board certified? ☐ Yes ☐ No Date(s) Certified: _____ From (mm/yyyy) _____ To (mm/yyyy)

Name(s) of American Specialty Board(s): 1) _____

2) _____

G. If eligible, have you taken: the written examination? ☐ Yes ☐ No If yes, result: ☐ Pass ☐ Fail

the oral examination? ☐ Yes ☐ No If yes, result: ☐ Pass ☐ Fail

H. Are you scheduled to take the examinations for certification? ☐ Yes – When? _____ (mm/yyyy)

I. List name(s) of any other Professional or Specialty organizations of which you are a member _____

_____

10. Your current (or most recent) insurance carrier _____ ☐ None

a. Limits of Liability _____ b. Policy Number _____ c. Expiration Date _____

If currently insured, does your carrier cover you for your work with the MIEC insured listed in Question #1? ☐ Yes ☐ No

If yes, provide a copy of your current Certificate of Insurance.

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

If yes, you must complete a claim information form for each (see page 3).

12. Have you ever been charged with or been convicted of a felony? ☐ Yes ☐ No

13. Have you ever been convicted of or entered a "no contest" plea to a crime, other than a traffic violation? ☐ Yes ☐ No

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

15. 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

16. Have you ever been treated for any medical condition, disease or illness that affects your ability to practice medicine? ☐ Yes ☐ No

17. Has any insurance carrier ever declined, canceled, refused to renew, restricted, or rated up your professional liability insurance? ☐ Yes ☐ No

18. Have you ever had any hospital privileges suspended, revoked, restricted, reduced, proctored or modified in any way? ☐ Yes ☐ No

If you have answered "Yes" to any of Questions 12-18, provide full details on separate attachment or in the Additional Comments section.

ADDITIONAL COMMENTS

The undersigned hereby represents that all statements and answers in this application are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my 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

_____ Date

_____ Print Name

_____ Phone Number

_____ Address

CLAIM INFORMATION FORM

☐ Attachment contains this information ☐ None [Please be sure to check here if no claims]

Last Name of Patient/Claimant _____ Gender _____ Age _____

1. Condition and diagnosis of patient prior to treatment and/or surgery:

_____

_____

2. Date(s) and type of treatment and/or surgery rendered by you:

_____

_____

3. Condition of patient subsequent to treatment and/or surgery by you:

_____

_____

4. Nature of allegation:

_____

5. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? _____

6. Names of other doctors and hospital, if any, involved:

_____

_____

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

_____

_____

Name of insurance carrier defending you _____ Name of attorney defending you _____

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

PRINT ADDITIONAL COPIES AS NEEDED.

For All Applications:
When indicating "**Attachment contains this information**" be certain to send all your attachments. You can send in attachments and/or printed applications by:

1. **Mail** – [Print PRE-PAID Mailing Label]
2. **Fax** – **(510) 318-6700**
3. **E-mail** – Underwriting@MIEC.com

(DETACH ALONG DOTTED LINE)

Pre-Paid Mailing Label

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 739 OAKLAND CA

POSTAGE WILL BE PAID BY ADDRESSEE

MEDICAL INSURANCE EXCHANGE
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OAKLAND CA 94609-9930

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