MIEC

Medical Insurance Exchange of California
Medical Underwriters of California
management company

Non-Physician Healthcare Provider
Application for Professional Liability Insurance
Additional Insured Basis

1. Name of Policyholder _____ 2. Policy Number _____

3. Number of Hours Per Week Worked for Above Policyholder _____ 4. Desired Effective Date of Coverage _____

5. Your Full Name _____ 6. Date of Birth (mm/dd/yyyy) _____

7. Your E-mail _____

8. Type of association: ☐ W2 Employee ☐ 1099 Independent Contractor ☐ Other (Specify) _____

Professional Designation:

☐ Aesthetician
☐ Certified Nurse Midwife
☐ Marriage, Family Therapist/Counselor
☐ Physical Therapist
☐ Other _____
☐ Podiatrist
☐ Psychologist
☐ Scrub Nurse/Technician
☐ Social Worker

☐ Attachment contains this information

9. School Attended _____ From _____ To _____

☐ Attachment contains this information

10. Additional Training _____ From _____ To _____

11. Have you taken the exams for certification or licensure? ☐ Yes ☐ No

Oral examination? ☐ Yes ☐ No Date of Exam _____ ☐ Pass ☐ Fail

Written examination? ☐ Yes ☐ No Date of Exam _____ ☐ Pass ☐ Fail

Licensure Number _____

☐ Attachment contains this information

12. Describe previous practice (Name of employer/solo practice) _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

13. Do you have professional liability insurance? ☐ Yes ☐ No If yes:

Name of Carrier _____ Policy Number _____ Expiration Date _____

Limits of Liability _____

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.

14. Have you ever been involved in a malpractice claim/suit? ☐ Yes ☐ No

If yes, you must complete a Claim Information Form for each. See page 4.

15. Have you **ever** been charged with or been convicted of a felony? ☐ Yes ☐ No
16. Have you **ever** been convicted of or entered a "no contest" plea to a crime, other than a traffic violation? ☐ Yes ☐ No
17. Have you **ever** been investigated by any state or federal regulatory body? ☐ Yes ☐ No
18. Has any governmental agency **ever** suspended, revoked, restricted, placed you on probation, or taken any other action against your license? ☐ Yes ☐ No
19. Have you **ever** been diagnosed as having or been treated for alcoholism or narcotics addiction? ☐ Yes ☐ No
20. Are you being treated for any medical condition, disease or illness that affects your ability to provide care or treatment? ☐ Yes ☐ No
21. Has any insurance carrier **ever** declined, canceled, refused to renew, restricted, or surcharged your professional insurance? ☐ Yes ☐ No
22. What type of patients will you treat? _____
23. What procedures will you perform? _____
24. What therapies, lab work, and diagnostic studies can you order? _____
25. Describe the physician's supervisory responsibilities. _____
26. If not in the office, will the supervising physician be telephonically or electronically available to you? ☐ Yes ☐ No

    If yes, please describe: _____
27. Under what circumstances will the supervising physician examine your patients? _____
28. How often will the physician review your charts? _____

Note: SUBMIT
1) Curriculum vitae (CV)
2) Copy of license
3) Copy of individual insurance, if applicable

If you have answered "Yes" to any of Questions 15-21, provide full details on separate attachment or in the Additional Comments section.

ADDITIONAL COMMENTS

The undersigned hereby represents that the above statements and answers 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

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.