MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

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

Application for Employee Professional Liability Insurance Coverage
Allied Healthcare Providers

("Allied Healthcare Providers" do not include nurse anesthetists, nurse practitioners, physician assistants or nurse midwives)

Please note the following:
1. All questions on the application must be answered. Additional requested information must be returned with the application.
2. Only employees of MLMIC insured physicians / physician groups are eligible for coverage.
3. You must designate an "employer" as provided for in question 3 of this application.
4. In the case of multiple employments, only one premium bill will be issued.
5. Policies are issued for limits of $1,000,000 Each Person, $3,000,000 Total.
6. Insurance coverage is provided on an "Occurrence" basis only. A minimum premium per policy applies, regardless of policy term.
7. This application does not apply to the physician extenders shown above. A different application is required for their coverage.

1. Name of applicant _____
Last First Middle

Home Address _____
Number and Street City State Zip Code

Social Security Number _____ Date of Birth _____/_____/_____
Month Day Year

Telephone Numbers _____ E-mail address _____
Home Cell FAX

Complete title of your medical professional designation _____

2. All applications are subject to prior approval. If acceptable, coverage can be provided no earlier than the day following the postmark on the envelope containing the completed and signed application. On what date do you wish the insurance to be effective?

12:01 AM E.S.T. on _____
Month Day Year

3. Name of primary employer: (Note: This is the person or entity that you designate to act as your agent for the payment of premiums, to request changes in the policy, including cancellation thereof, and to receive dividends and any return premiums when available).

_____

Would you like your policy issued with the same anniversary date as your employer and/or associated practice? ☐ Yes ☐ No

Employer's mailing address _____

Billing address (if different from above) _____

Office phone _____ FAX _____ E-mail address _____

Employer practices as: ☐ Individual Practitioner ☐ Partnership ☐ Professional Corporation ☐ Other:_____(specify)

MLMIC policy number for employer _____ Tax identification number of employer _____

Name/specialty of supervising physician _____
Name Specialty Phone Number

Provide the following information for additional MLMIC insured employers you have. Attach additional information sheets if necessary:

Name of employer _____

Employer's Address _____

Contact person and phone number _____

Coverage is provided only for your professional services while acting within the scope of your duties for your Primary Employer. Should insurance coverage be issued, it is an absolute condition of the insurance policy that MLMIC Insurance Company is the insurer of your Primary Employer and that such insurance remain in full force and effect for the full term of your policy. All policies will be mailed to the primary employer's address. **Should your Primary Employer's policy be cancelled, your policy will no longer provide you with coverage as of that date.**

4. Applicant is employed and licensed or certified in the capacity of:

- ☐ Audiologist
- ☐ Cytotechnologist
- ☐ Dietician / Nutritionist
- ☐ Emergency Medical Technician
- ☐ Licensed Practical Nurse
- ☐ Medical Laboratory Technician
- ☐ Medical Services Technician
- ☐ MRI Technician
- ☐ Nuclear Medical Technician
- ☐ Occupational Therapist
- ☐ Occupational Therapist Assistant
- ☐ Ophthalmic Assistant
- ☐ Optician
- ☐ Optometrist
- ☐ Phlebotomist
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physical Therapist Assistant
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Registered Nurse
- ☐ Respiratory Therapy Technician
- ☐ Respiratory Therapist
- ☐ Speech Therapist
- ☐ Social Worker
- ☐ Surgical Technician
- ☐ Ultrasound Technician
- ☐ X-Ray Technician
- ☐ X-Ray Therapist
- ☐ Other (complete title of your medical professional designation) _____

5. Applicant's professional training (attach additional information sheets if necessary)

Name of school, hospital, etc.	FROM (mm / dd / yy)	TO (mm /dd / yy)	Type of training	Date of completion

6. Is applicant licensed, registered or certified under the laws of the State of New York? ☐ Yes ☐ No
If "Yes", list professional designation, license or registry number and date secured (enclose copy with application).

_____

If applicant is certified or registered by a professional organization, provide full name, certification or registration number and corresponding date.

_____

7. Applicant is a member in good standing of the following professional organizations:

Name of organizations

8. Name of applicant's present or immediate past professional liability insurance company. Note: If previous coverage is claims-made, Extended Reporting Endorsement coverage must be purchased for that policy to avoid gaps in coverage for future claims.

Name of insurance company	Policy number	Effective date	Expiration date

9. Has any insurance company ever cancelled or declined to renew professional liability insurance for the applicant? ☐ Yes ☐ No
If "Yes", explain _____

10. Have you ever had a malpractice claim or suit (closed or pending) made against you? ☐ Yes ☐ No
If "Yes", on a separate sheet, state present status of each claim or suit including name of patient, dates, description of treatment and amount of settlement if applicable.

Producer Information

You may choose to submit your application directly to MLMIC or through a producer you identify below:

Agency Name and Contact Person: _____

Address of Agency: _____

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 #95 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 violation. "

_____ _____

Personal Signature of Applicant Date Signed

I understand that any insurance issued to the applicant is contingent upon the applicant's employer also being insured by MLMIC

_____ _____

Personal / Authorized Signature of Employer / Supervising Physician Date Signed