



a Berkshire Hathaway company

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Syracuse, NY 13202
Tel: 315-428-1188

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East Meadow, NY 11554
Tel: 516-794-7200

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 Home Cell FAX E-mail address
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).

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:

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

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.

Release of Information

I hereby authorize MLMIC Insurance Company to obtain full information from any insurance company or from any person with respect to me or my medical practice, including but not limited to, any claim, suit or incident pertaining to professional acts or omissions asserted against me. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this 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