mpie
michigan professional insurance exchange

# MEDICAL PROFESSIONAL LIABILITY INSURANCE PHYSICIAN APPLICATION

**Please fill out the application in its entirety and Fax to: (616) 741-1980**

**Please allow 10 business days for application processing and policy issuance.**
**If you have not received within 10 business days, please contact Underwriting at (616) 202-2288 option #2.**

## COMPLETION CHECKLIST

***Before submitting the application, please review and complete this checklist. Missing information will result in the return of your application.***

- ☐ Must provide evidence of 10 years of continuous coverage (renewal certificate, declaration page, tail)
- ☐ An insurer-produced summary of your prior claims experience (loss run or claims history) for the past ten years. We must have a loss run from every one of your previous insurers.
- ☐ Include current Curriculum Vitae (CV)
- ☐ License & DEA numbers (attach copies)
- ☐ Social Security Number
- ☐ Email Address
- ☐ Read & understand Subscriber Agreement: Pages 8 & 9
- ☐ Sign and date these pages on the application: Pages 9 & 10

333 Bridge St NW, Suite 810
Grand Rapids, MI 49504
(616) 741-1490 P
www.mpie.org

# APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

## APPLICANT INFORMATION

Applicant's name: (First, Middle Initial, Last Name) ☐ MD ☐ DO

Social Security Number: Date of Birth (MM/DD/YYYY): ☐ Male ☐ Female

Home address:

| Cellular Number: | Pager: | Email: |
|---|---|---|

Hospital/Office Name where you will be working (if applicable please include DBA name):

Principal office address: County:

Office telephone: Office fax:

Practice Manager/Primary Contact Name:

Telephone: Email:

Secondary office address, if any:

Billing and/or Mailing address (if different than Principal Office Address):

## COVERAGE INFORMATION

Type of coverage required:

- ☐ Claims-made: Covers incidents that take place and are reported during the policy period, which begins with the retroactive date. *(Claims-made coverage is only available to physicians currently insured under a claims-made policy)*
  If claims-made coverage is selected, give date when you began your claims-made coverage: _____ (retro date).
  (*Without prior acts coverage, retro date is your requested effective date*)
- ☐ Modified Claims Made: Claims Made policy with tail premium included.
- ☐ Occurrence-basis: Covers incidents that take place during the policy period regardless of when reported as a claim.
- ☐ Moonlighting Only
- ☐ Locum Tenans (substitute)

If your current insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer? ☐Yes ☐ No ☐ N/a
If Yes, attach a copy of the reporting endorsement.
If No, please explain_____

**Requested effective date of insurance:**

Limits of liability requested (Occurrence/Aggregate):

| | | |
|---|---|---|
| ☐ $200,000/800,000 | ☐$300,000/1.2M | ☐ $400,000/1.6M |
| ☐ $500,000/2M | ☐ $1M/4M | ☐ $2M/4M |

Please check the appropriate box(es) and state the complete name of any medical professional corporation to which you belong.

**Name:** _____ **Tax ID#:** _____

☐ Partnership ☐ Association ☐ Corporation ☐ Wholly Owned Corporation or

☐ Joint Venture by which you are employed or to which you belong, if any:

Do you request that the Company's Partnership or Professional Corporation listed above to be endorsed to your policy as an additional insured? ☐ Yes ☐ No

**Please Note:** No charge is made for this coverage if all individual physicians who are practicing in the partnership or professional corporation are continuously insured by MPIE. If this endorsement is used, the partnership or professional corporation will be insured in accordance with the policy, declarations, and endorsement, only for its liability for your acts or omissions as an individual physician.

Do you request for an additional 9% of your total premium to purchase an endorsement that will provide coverage for Advanced Practice Provider, which we classify as Physician Assistant, Nurse Practitioner, Certified Nurse Midwife & Certified Registered Nurse Anesthetist. ☐ Yes ☐ No

## LICENSE INFORMATION

Are you a U.S. Citizen? ☐ Yes ☐ No
If no, please describe your current status, including your intentions regarding future citizenship: _____
_____

| **Michigan Permanent License Identification Number (attach copy):** | **DEA Number (attach copy):** |
|---|---|
| | |

Board Certified: ☐ Yes ☐ No Medical Specialty: _____

☐ American Board ☐ American Collage ☐ American College of Osteopathic Medicine

If No, when are you Board eligible? _____
If eligible for over 5 Years, but not certified, please explain: _____

Have you ever failed a Board Exam? ☐ Yes ☐ No
If Yes, which Board exam and how many times on each part? ☐ Oral _____ ☐ Written _____

## EDUCATION INFORMATION
**● Copy of CV is required ●**

Medical School: City, State & Country

Graduation Date:

If you are a foreign medical graduate, have you ever failed the ECFMG examination? ☐ Yes ☐ No If Yes, how many times _____
**Please attach ECFMG certificate.**

| | | |
|---|---|---|
| Internship served at: | Specialty: | Month/Year Completed: |
| Residency served at: | Specialty: | Month/Year Completed: |
| Fellowship served at: | Specialty: | Month/Year Completed: |

| | | | |
|---|---|---|---|
| Number of years in practice at current location: | | | |
| List previous practice locations and dates since residency: | | | |
| Name: | | City/State: | |
| Dates at Location: | | Type of Practice: | |
| Name: | | City/State: | |
| Dates at Location: | | Type of Practice: | |
| Name: | | City/State: | |
| Dates at Location: | | Type of Practice: | |
| List all locations of where you will be practicing at (example: nursing homes, urgent care clinics, surgery centers) | | | |
| Name: | City/State | Type of Practice | |
| | | | |
| | | | |
| | | | |
| List all hospitals at which you have staff privileges: | | | |
| Name: | City/State: | Type of Privileges: | % of Admissions: |
| | | | |
| | | | |
| | | | |

**PROFESSIONAL LIABILITY HISTORY**

**PLEASE NOTE:**
**If you answered yes to any of the questions below, please provide complete details regarding the event including documentation of recovery/reinstatement actions and resolution on a separate sheet.**

| | |
|---|---|
| Have you ever had your membership in any professional society or association refused, suspended, revoked or ever received any criticism or reprimand from any professional society? | ☐ Yes ☐ No |
| Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended or revoked? | ☐ Yes ☐ No |
| Has any hospital ever restricted, reduced or suspended your privileges or invoked probation? | ☐ Yes ☐ No |
| Have you ever been subject to a state licensing investigation? | ☐ Yes ☐ No |
| Have you ever been sanctioned or terminated from the Medicare or Medicaid program or any other non-governmental Health Plan? | ☐ Yes ☐ No |
| Have you had your license to prescribe or dispense narcotics refused, suspended or revoked? | ☐ Yes ☐ No |
| Have you been treated for alcoholism, narcotics addiction or mental illness within the past year? | ☐ Yes ☐ No |
| Have you ever been convicted of a crime other than traffic offenses? | ☐ Yes ☐ No |
| Have you ever been refused board certification? | ☐ Yes ☐ No |
| Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge, issued on any other special terms, or had renewal refused? | ☐ Yes ☐ No |

| | |
|---|---|
| Have you had any malpractice claim(s)/suit(s) for alleged malpractice brought against you within the past ten years? | ☐ Yes ☐ No<br>If yes, how many _____?<br>Please provide details on supplemental claim form attached. |
| Have you ever been involved in a claim whereby a settlement was paid on behalf of the hospital under a self-insured plan and not necessarily for you as a named defendant? | ☐ Yes ☐ No<br>If yes, how many _____?<br>Please provide details on supplemental claim form attached. |
| Other than the claims/suits indicated above, are you aware of any circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim/suit would be without merit? | ☐ Yes ☐ No<br>Please provide details on supplemental claim form attached. |
| Are you doing clinical research? | ☐ Yes ☐ No<br>If yes, please explain: |
| Do you practice any forms of alternative medicine (e.g.: Ayurvedic, Chiropractic, Chinese Holistic, Homeopathic or Naturopathic)? | ☐ Yes ☐ No<br>If yes, please list: |
| Do you agree to the terms and conditions of the Provider Loss Prevention Program stated in section 7 of the subscriber agreement? | ☐ Yes ☐ No<br>If NO, please explain: |
| Do you work in an emergency room for other than your own patients? | ☐ Yes ☐ No<br>If yes, how many hours per week? |
| Do you render patients unconscious for treatment in your office or other non-hospital facility? | ☐ Yes ☐ No<br>If yes, please explain: |
| Do you hold any positions as Director or Trustee of any licensed medical institution? | ☐ Yes ☐ No<br>If yes, please specify: |
| Have you signed a contract that requires specific limits of liability? | ☐ Yes ☐ No<br>If yes, please specify: |
| Does your practice include treating patients located in states other than Michigan, including treatment through remote technology? | ☐ Yes ☐ No<br>If yes, identify which states: |
| Do you use medical service, such as remote radiology interpretation, located outside of the state of Michigan in the treatment of patients? | ☐ Yes ☐ No<br>If yes, identify which states: |

| MEDICAL PROCEDURES |
|---|
| **Average number of hours seeing patients per week:** |
| Any Anesthesia procedures in Office other than local. ☐ Yes ☐ No If Yes, please explain: |
| Select one of the following Surgery types as applicable:<br>☐ No Surgery - Includes incision of boils and superficial abscess, or suturing of skin or superficial fascia.<br>☐ Minor Surgery - Includes obstetrical procedures not constituting major surgery, or assisting in major surgery on your own patients. Tonsillectomies and adenoidectomies are considered minor surgery; cesarean sections are considered *major surgery*. If assisting on own patients, indicate average time per month: _____<br>☐ Major Surgery - Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length of the circumstances of the operation presents a distinct hazard to life. It also includes:<br>☐ Removal of tumors, open bone fractures, the removal of any gland or organ, plastic surgery, and any operation done using general anesthesia.<br>☐ Assisting in Major Surgery - On the patients of others. If assisting, indicate the percentage of total practice spent assisting: _____%. |

## PROCEDURES PERFORMED

**Please indicate the total number of procedures you perform annually below:**

Abortions
Acupuncture
Amniocentesis
Anesthesia-general, spinal,epidural or caudal
Angiography/Angioplasty or lymph angiography
Arteriography
Bariatric Procedures
Biopsy, Percutaneous or diagnostic study of organs or structures other than skin or superfacial fascia
Breast implants and/or reduction
Bronchoscopy
Catheterization other than proctoscopy or sigmoidoscopy
- o Right Heart
- o Left Heart
- o Arterial
- o Urinary

Deliveries: Vaginal
Chelation therapy
Cholecystectomy
Circumcision
Colonoscopy
Cryosurgery
Cystoscopy Procedure
D & C's
Deliveries: Cesarean
Deliveries: VBAC
Dermatological procedures:
- o Botox injection
- o Chemical Peels
- o Dermabrasion
- o Sclerotherapy
- o Surface veins
- o Deep Veins
- o Dermal Fillers (such as collagen)
- o Hair Transplant
- o Laser Hair Removal
- o Laser Skin Resurfacing
- o Mesotherapy
- o Mircrodermabrasion
- o MOHS Surgery
- o Tattoo Removal
- o Thread Lifts

Discograms
Electromyography
Endoscopic Retrograde Cholangiopancreatomography (ERCP)
Endoscopy other than proctoscopy or sigmoidoscopy
Fluoroscopy
Fracture reductions-closed
Fracture reductions-open
Hair transplants
Hemorrhiodectomy- Internal or External
Herniorrhaphy
Hysterectomy
Intravenous Pyelogram (IVP)
Laparoscopy
Laser surgery
Liposuction
Lumbar puncture
Myelography
Obstetrics, considered to be major surgery, (including Cesarean sections)
Obstetrics, not considered to be major surgery
Ophthalmology
Orthopedic – Major surgery
- o Spines
- o No Spines

Pain management
Plastic surgery-cosmetic or reconstructive
Pre-natal care
Radial keratotomy (Lasik surgery)
Radiation oncology
Radiopaque dye injections
Silicone injections
Surgery-assisting in major surgical procedures on other than your own patients
Surgery-pedicle screws for spinal surgery
Surgery-major, other than tonsillectomies, adenoidectomies and hemorrhoidectomies
Surgery-minor, other than the or suturing of skin and superficial fascia
Surgery-total joint procedure
Thoracentesis
Tonsillectomies/adenoidectomies
Total joint replacement
Tubal ligations
Vasectomy
Venography

Other:

Non-procedural Physicians:
☐ Behavioral Medicine
☐ Hospitalist
☐ Occupational Medicine
☐ Urgent Care
☐ Other: _____

**SUPPLEMENTAL CLAIM FORM**

| | |
|---|---|
| Patient Name: | |
| Patient Age: | Patient Sex: ☐ Male ☐ Female |
| Date of Incident: | |
| Claim Allegations: | |
| Claim Status ☐ Open<br>☐ Closed If Closed: ☐ Arbitration ☐ Dismissed ☐ Judgement for Defendant ☐ Judgment for Plaintiff ☐ Mediation | |
| Settlement Date & Amount: | |
| Insurance Company: | |
| Defense Attorney: | |

| | |
|---|---|
| Patient Name: | |
| Patient Age: | Patient Sex: ☐ Male ☐ Female |
| Date of Incident: | |
| Claim Allegations: | |
| Claim Status ☐ Open<br>☐ Closed If Closed: ☐ Arbitration ☐ Dismissed ☐ Judgement for Defendant ☐ Judgment for Plaintiff ☐ Mediation | |
| Settlement Date & Amount: | |
| Insurance Company: | |
| Defense Attorney: | |

**MICHIGAN PROFESSIONAL INSURANCE EXCHANGE SUBSCRIBER AGREEMENT**

THIS SUBSCRIBER AGREEMENT is made as of the date set forth below by and among the undersigned (the "Subscriber"), MICHIGAN PROFESSIONAL INSURANCE EXCHANGE, a Michigan reciprocal insurance exchange (the "Exchange"), the other Subscribers of the Exchange and MICHIGAN PROFESSIONAL EXCHANGE SERVICES, a Michigan nonprofit corporation, or any successor attorney-in-fact appointed in accordance with the Bylaws of the Exchange (the "Attorney-in-Fact").

RECITALS:

A. The Exchange has been organized as an unincorporated association and will be operated as a reciprocal insurance exchange in accordance with Chapter 72 of the Michigan Insurance Code. The purpose of the Exchange is to provide property, casualty, surety and fidelity insurance to its Subscribers, who will consist of physicians and hospitals meeting the eligibility requirements set forth in the Bylaws of the Exchange.

B. The Subscriber desires to become a Subscriber of the Exchange and to exchange insurance policies with the other Subscribers through the Attorney-in-Fact.

**ACCORDINGLY, THE PARTIES HEREBY AGREE AS FOLLOWS:**

1. ***Application to Become a Subscriber, Bylaws.*** The Subscriber hereby applies to become a Subscriber of the Exchange. The Subscriber has read and agrees to be bound by the terms and conditions of the Bylaws of the Exchange, as amended from time to time (the "Bylaws"), which are incorporated into this Agreement by reference. The Subscriber shall become a Subscriber of the Exchange only if he or she meets the eligibility requirements and underwriting criteria of the Exchange and satisfies the other conditions set forth in the Bylaws.

2. ***Power of Attorney.*** The Subscriber hereby appoints the Attorney-in-Fact as the Subscriber's Attorney-in-Fact with the power to do all things which the Subscriber could do in connection with the business and operations of the Exchange, including, but not limited to, the power to exchange insurance policies among the Subscriber and the other Subscribers of the Exchange and exercise all of the other powers granted to the Attorney-in-Fact under the Michigan Insurance Code, the Bylaws and any Management Agreement between the Exchange and the Attorney-in-Fact (the "Management Agreement"), as amended from time to time. In the event that Michigan Professional Exchange Services ceases to be the Attorney-in-Fact of the Exchange, any successor attorney-in-fact appointed in accordance with the Bylaws shall be substituted as the Attorney-in-Fact, without any further action by the Subscriber. The Attorney-in-Fact shall not have the power to make the Subscriber jointly liable with, or bind the Subscriber for the obligation of, any other subscriber of the Exchange.

3. ***Surplus Notes.*** In accordance with the Bylaws, the board of directors of the Exchange shall have the authority to issue surplus notes to Subscribers of the Exchange and may require the funding of surplus notes by individuals or entities who wish to become Subscribers of the Exchange. The Subscriber understand that any surplus notes issued by the Exchange shall not be a liability or claim against the Exchange or any of its assets, except as provided in the Michigan Insurance code, and shall be repaid only out of the surplus earnings of the Exchange. The repayment of the surplus notes shall not be guaranteed by the Attorney-in-Fact or any Subscriber of the Exchange.

4. ***Other Surplus.*** In accordance with the Bylaws, the Board of Directors of the Exchange shall have the authority to establish surplus accounts and, in its sole discretion, to allocate the net income and losses of the Exchange to such accounts and to reallocate or transfer surplus balances among such accounts. The surplus accounts established by the Board may include Subscriber Savings Accounts as contemplated by Section 832(f) of the Internal Revenue Code. The Subscriber understands that the allocation of net income to his or her Subscriber Savings Account shall cause the recognition of taxable income to the Subscriber based upon the portion of net income allocated to his or her Subscriber Savings Account. Subject to the approval of the Michigan Insurance Bureau, the Subscriber shall be promptly paid the balance of his or her Subscriber Savings Account upon withdrawal from the Exchange. The Subscriber understands that such balance may decrease if the Exchange allocates net losses to the Subscriber Savings Accounts.

5. ***Limitation of Rights.*** The rights and interests of the Subscriber in and to the assets and accounts of the Exchange shall be limited to the rights provided for under any insurance policies issued to the Subscriber, the balance of any surplus notes owing to the Subscriber, and the balance of the Subscriber Savings Account attributable to the Subscriber. Except in the event of the dissolution of the Exchange, the Subscriber shall have no right to or interest in any surplus accounts of the Exchange other than his or her surplus note and Subscriber Savings Account.

6. ***Limitation of Liabilities.*** All insurance policies issued by the Exchange shall be non-assessable. Neither the Exchange nor the Subscriber shall have a claim against any other Subscriber for the payment of claims, losses or expenses under any insurance policy issued by the Exchange. The Subscriber shall not be liable to the Exchange, the Attorney-in-Fact, any other Subscriber or any third party for the payment of claims, losses, debts, expenses or other obligations of the Exchange beyond the amount of the premiums paid by the Subscriber, and the rights and interests of the Subscriber in and to the assets and accounts of the Exchange. The Attorney-in-Fact shall not have the power to make the Subscriber liable beyond the limits set forth in this Paragraph.

7. ***Provider Loss Prevention Program*.** In his or her application for insurance, the Subscriber may agree to adhere to certain loss prevention criteria and guidelines contained in the Provider Loss Prevention Program established by the Exchange. By doing so, the Subscriber may obtain premium credit in accordance with the terms of such Program. If Subscribers are not willing or elect not to participate in the program, the Subscribers will not qualify for the premium credit on their annual premium rate and continued nonparticipation for two consecutive years may result in a surcharge of premium up to 25% or non-renewal. It is the responsibility of the Subscriber to be familiar with the criteria of the plan and to meet said criteria.

8. ***Premiums.*** The premiums charged to the Subscriber and the other Subscribers for the insurance policies issued by the Exchange may vary based upon the underwriting standards filed with and approved by the Michigan Insurance Bureau. The factors to be considered in determining the premiums payable by any Subscriber may include the Subscriber's loss experience, risk exposure, field or fields of specialization, and other factors set forth in such underwriting standards.

9. ***Termination by Exchange.*** This Agreement and any insurance policies issued to the Subscriber may be terminated by the Exchange if the Exchange reasonably determines that the Subscriber no longer meets the underwriting standards filed with and approved by the Michigan Insurance Bureau, or if the Subscriber fails to make timely payment of any premiums due to the Exchange or otherwise defaults in his or her obligations under this Agreement, the Bylaws or any insurance policy. In the event of such termination, the rights of the Subscriber shall be determined in accordance with the Bylaws.

10. ***Termination by Subscriber.*** This Agreement, including the power of attorney granted to the Attorney-in-Fact, shall remain in effect throughout the term of any insurance policies issued by the Exchange to the Subscriber. This Agreement shall terminate when the Subscriber withdraws from the Exchange and all insurance policies issued to the Subscriber by the Exchange are canceled or terminated. Upon such termination, the rights of the Subscriber shall be determined in accordance with the Bylaws.

11. ***Counterparts.*** This Agreement may be signed in any number of counterparts with the same effect as if the signatures of all parties were on one document.

12. ***Binding Effect.*** This Agreement shall not be assigned by the Subscriber or the Attorney-in-Fact except as permitted under the Bylaws. Subject to such limitation, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective personnel representatives, heirs, successors and assigns.

**I hereby certify that the information provided herein is complete, accurate and truthful to the best of my knowledge. I understand that misrepresentations in this application may result in cancellation rescission of coverage.**

Date: _____

_____ _____

(Print Name) (Subscriber Signature)

_____

(Address)

## FRAUD NOTICE

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 subjects such person to criminal and civil penalties, which may include voiding of the policy if allowed by state law.

## AUTHORIZATION

I hereby certify that I have read the above questions and that all statements are true, material and complete. I understand that if the policy is issued this is done in reliance upon these representations; and any policy obtained by fraud, material misrepresentation or omission is void. I agree that a copy of my signature may be relied upon as if it were the original. My signing of this application does not bind the insurance company to sell nor does it bind the applicant to purchase the insurance.

The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application; (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

_____ _____

Signature Date