ISMIE Mutual Insurance Company
The Physician-First Service Insurer

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

Processing Number_____

Application for Partnership/Corporation -or- Clinic Option Professional Liability Insurance

Please choose your desired coverage option either claims-made or occurrence.

Claims-Made Coverage ☐

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations Page, and as defined in the policy."

Occurrence Coverage ☐ (Not Available in Florida)

"An occurrence policy is limited to claims that arise out of professional services rendered during the policy period stated in the Declarations Page and as defined in the policy."

Instructions: It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check **no** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section.**

INDICATE TYPE OF POLICY DESIRED:

A. ☐ PARTNERSHIP/CORPORATION POLICY Traditional entity coverage.

B. ☐ CLINIC OPTION POLICY A coverage alternative for corporations, partnerships or other legal entities with 2 or more physicians. The ISMIE Mutual Clinic Option covers each physician as an additional named insured (with separate limits) on a single policy form, eliminating the need for multiple bills and statements. Only the Clinic Option is available with unique shared aggregate limits of liability **(shared aggregate limits not available in states with a Patient Compensation Fund)**.

1A. Partnership/Corporation or Clinic Name:

1B. Indicate all states of practice where ISMIE Mutual coverage is desired:

2. Desired effective date of coverage (12:01 a.m. Standard Time):

____/____/____
Month Day Year

3. Desired retroactive date for Claims-Made coverage (12:01 a.m. Standard Time): Retroactive date is required to secure prior acts coverage (nose coverage). Only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage

____/____/____
Month Day Year

4. Mailing Address:
Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____ **Telephone: ( ) -** _____

Fax: ( ) - _____ **E-mail Address:** _____

5. Billing Address: **Same as #4** ☐
Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____ **Telephone: ( ) -** _____

Fax: ( ) - _____ **E-mail Address:** _____

Partnership/Corporation/Clinic General Information

6. Name of President/Partner: _____

7. Name of Business Manager/Administrator: _____

8. The legal entity applying for coverage is a:

☐ Partnership
(Submit a copy of the partnership agreement)

☐ Limited Liability Company
(Submit a copy of State Issued Organizational Documents)

☐ Multi-Shareholder Corporation
(Submit a copy of State issued Organizational Documents)

☐ Sole Shareholder of Medical Corporation
(Submit a copy of State Issued Organizational Documents)

☐ Other (Describe)

_____

9. Federal Tax Identification Number: _____

9a. NPI Number: _____

10. Does the Partnership/ Corporation/ Clinic operate under any other names (d.b.a. "doing business as")?

YES____NO____

If Yes, please list all "doing business as" names of the Partnership/Corporation/ Clinic:

1.
2.
3.
4.

11. Previous Insurance Carriers - Last ten years*:

Please indicate in chronological order, most recent first.

***It is necessary that you obtain a current Loss History from each carrier listed above.**

12. Please provide total Group premiums paid, by year, for the last ten years.

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Year	Annual Premium
1. Current Year	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$

13. Have any malpractice claims or suits been brought against your entity within the past five (5) years?

☐ Yes ☐ No

If "Yes", please provide the following:

- Brief description of each claim (Use Claim Information Supplement included in application)
- Reserves on pending claims (both indemnity and expense)
- Payments on any closed claim/suit (both indemnity and expense)
- Complete copies of all office/hospital medical records and summons and complaint.

14. Limits of Liability (Please skip this section if your entity is domiciled in a state with a Patient's Compensation Fund.)

The offering of the following policy limits by ISMIE Mutual should not be deemed to express or imply that any particular policy limit is or is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate limit of coverage.

Please select **one** of the following options available: A, B or C.

A. Limits of Liability: Corporation/ Partnership/Clinic

☐ Yes ☐ No

☐ $1,000,000/$3,000,000 "each person"/ "aggregate" ☐ $2,000,000/$4,000,000 "each person"/ "aggregate"

B. Shared Limits of Liability: Clinic Option Only – <u>Not applicable for Corporation/Partnership</u>

☐ Yes ☐ No

The shared limit option is available for clinic option policyholders who **desire to insure their professional entity on a** shared limit basis under the clinic option policy, which means the entity shares in one limit of liability with one ISMIE insured employed physician when both are named as co-defendants in the same claim. Further details will be provided to applicants interested in this option.

<u>The Shared Limit Option must match the limits of the ISMIE insured physician affiliates, as listed below:</u>

☐ $1 million each person

☐ $2 million each person

15. Profile Questions. Include details to each question in the space provided. If additional space is needed, please utilize the "Remarks Addendum" section.

	YES	NO	
A.	☐	☐	**Has the partnership/corporation/ clinic's professional liability insurance ever been canceled for non-payment of premium?** If "yes," indicate date(s) of such cancellation: **(Not Applicable in Missouri)**_____
B.	☐	☐	**Has the partnership/corporation/ clinic's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms?** (Including but not limited to: restrictive endorsements, surcharged premium, etc.)**(Not Applicable in Missouri)**
C.	☐	☐	**Has the partnership/corporation/ clinic owned and operated, participated in or directed any entrepreneurial medical business?** If "yes," indicate name(s), address(es) and type(s) of business(es):_____ _____ _____
D.	☐	☐	**Does the partnership/corporation/clinic, through its additional named insured physicians, treat or intend to treat any patient by means of therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes," utilize the "Remarks Addendum" on page 17 to identify physician(s) in the clinic who participate in this activity and provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.**
E.	☐	☐	**Does the partnership/corporation/ clinic contract to any governmental facility? If "Yes," please provide a copy of any contract you have executed.**

16. Please provide a detailed narrative of your group's process for credentialing its physician affiliates:

Partnership/Corporation /Clinic Census

17. Please provide census information on physicians who are partners, shareholders, officers, directors, employees or independent contractors. If additional space is required to complete this question, use "Remarks Addendum" section.

Codes: 01-Partner 02-Shareholder 03-Officer 04-Director 05-Employee 06-Independent Contractor

Code	Physician Name	Insurance Carrier	Limits of Liability	Policy Number	Specialty
	1)				
	2)				
	3)				
	4)				
	5)				
	6)				
	7)				
	8)				
	9)				
	10)				
	11)				
	12)				
	13)				
	14)				
	15)				
	16)				
	17)				
	18)				
	19)				
	20)				
	21)				
	22)				
	23)				
	24)				
	25)				
	26)				

18. Allied Health Personnel

Please provide census information on your employed Allied Health Personnel.
Only separate limits are available in states with a Patient Compensation Fund.

Coverage for the following Allied Health Personnel are offered on either a Shared or Separate Limit basis for an additional charge. A separate Non-Physician application is required, and is available on our website- www.ismie.com.

		Total			Total
A .	**Certified Registered Nurse Anesthetist**	____	**E.**	**Physician Assistant**	____
B.	**Certified Clinical Nurse Specialist**	____	**F.**	**Psychologist**	____
C.	**Certified Nurse Practitioner**	____	**G.**	**Other (Specify Below)**	____
D.	**Certified Nurse-Midwife**	____			

Coverage for the following Health Care Professionals is only offered on Separate Limit basis for an additional charge. A separate Individual Physician application is required for Chiropractors and Podiatrists, and a Non-Physician application is required for Dentists, Optometrists and Pharmacists. Applications are available on our website- www.ismie.com.

		Total			Total
H.	**Chiropractor**	____	**K.**	**Podiatrist**	____
I.	**Dentist**	____	**L.**	**Pharmacist**	____
J.	**Optometrist**	____			

Note: Coverage for all Health Care Professionals is limited to the scope of employment and services rendered on behalf of the ISMIE Mutual insured Physician or Corporation. *(Not applicable in the State of Kansas)*

19. Practice Information

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please indicate additional locations on the "Remarks Addendum" section. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa / Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this the group's primary office location? **Yes** ☐ **No** ☐

Distance to Hospital: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? **Yes** ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Name of Office Manager/Administrator (if other than listed in question 7)

_____

_____.

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this the group's primary office location? **Yes** ☐ **No** ☐

Distance to Hospital: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? **Yes** ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Name of Office Manager/Administrator (if other than listed in question 7)

_____

_____.

19. Practice Information (continued)

Facility Codes (Please indicate all that Apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa / Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

C. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ Telephone: _____

Is this the group's primary office location? Yes ☐ No ☐

Distance to Hospital: Miles _____ Minutes _____

Do you own or operate a Pharmacy at this location? Yes ☐ No ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Name of Office Manager/Administrator (if other than listed in question 7)

_____

_____.

D. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ Telephone: _____

Is this the group's primary office location? Yes ☐ No ☐

Distance to Hospital: Miles _____ Minutes _____

Do you own or operate a Pharmacy at this location? Yes ☐ No ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Name of Office Manager/Administrator (if other than listed in question 7)

_____

_____.

20. Do your physicians maintain hospital privileges at one or more facilities? Yes ☐ No ☐
If yes, please complete section A and B (please copy this page for additional hospital locations)
If your physicians do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do your physicians staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

_____

Is this your group's primary hospital location?

Yes ☐ No ☐

Do your physician's teach at this hospital?

Yes ☐ Classroom ☐ Clinical ☐

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do your physicians staff the ER at this hospital other than to maintain hospital privileges?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

_____

Is this your group's primary hospital location?

Yes ☐ No ☐

Do your physician's teach at this hospital?

Yes ☐ Classroom ☐ Clinical ☐

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

21. Does your group have a credentialing process for staff?

A. Physician staff? ☐ Yes ☐ No

B. Non-physician staff? ☐ Yes ☐ No

If "Yes", does your credentialing include the following:	Physicians	Non-physicians
A. Verification of Training?	❑ Yes ❑ No	❑ Yes ❑ No
B. Verification of Appropriate Licensure?	❑ Yes ❑ No	❑ Yes ❑ No
C. Confirmation of Board Certification?	❑ Yes ❑ No	❑ Yes ❑ No
D. Appropriate certification for non-physicians?		❑ Yes ❑ No
E. Evaluation of clinical competence?	❑ Yes ❑ No	❑ Yes ❑ No
F. Evaluation of loss experience?	❑ Yes ❑ No	❑ Yes ❑ No
G. Review of any disciplinary action by a Hospital or Licensing Board?	❑ Yes ❑ No	❑ Yes ❑ No

22. Does your group maintain any kind of accreditation? ❑ Yes ❑ No

-If "Yes, please indicate accrediting organization(s), effective date and term:

_____

_____

23. Does your group maintain medical equipment which requires on-going maintenance? ❑ Yes ❑ No

-If "Yes, describe your maintenance process and procedures:

_____

_____

24. Does your group maintain written practice protocols such as:

A. Delegation of medical treatment to non-physician staff? ❑ Yes ❑ No

B. Office procedures for follow-up on Lab reports/X-rays? ❑ Yes ❑ No

C. Office procedures for missed appointments? ❑ Yes ❑ No

D. Office procedures for referrals? ❑ Yes ❑ No

E. Prescription refill authorization? ❑ Yes ❑ No

F. Medical record retention/HIPAA compliance? ❑ Yes ❑ No

G. Written procedures for resolution of patient complaints? ❑ Yes ❑ No

H. Patient satisfaction surveys? ❑ Yes ❑ No

I. Guidelines for access to care after hours, weekends, holidays? ❑ Yes ❑ No

(copies of practice protocols/documentation may be requested)

25. Does you group have an active Quality Service Committee and/or Medical Director responsible to review unexpected outcomes, monitor quality of care, etc.? ❑ Yes ❑ No

-If "Yes", copies of reports or minutes may be requested

-If "No", describe the process your group utilizes:

_____

_____

26. Does your group, on an annual or more frequent basis, monitor the ratio of Patient Volume to Physician Staff and Non-Physician Staff? ❑ Yes ❑ No

27. Do any of your physicians function as a Hospitalist or Laborist?
If "yes", list physician names below:

_____

_____

-If "No", does your group utilize the services of outside Hospitalists or Laborists? ❑ Yes ❑ No

28. Does your group or any of your physicians have a written contract to provide healthcare services to any professional sports organizations? ❑ Yes ❑ No
If "yes", please provide names of Organization(s) _____
(please include copy of contract)

29. Does your group provide Telemedicine Services? ❑ Yes ❑ No

If "yes", please indicate where the films or other forms of electronic transmissions will be read,

i.e. City / State. _____ .

If these transmissions will originate in another state, please provide a copy of your medical license for that state.

30. Does your group or any of your physicians provide Concierge services? ❑ Yes ❑ No
(Concierge medicine, also known as direct primary care, involves charging patients a fee or retainer in exchange for medical care and treatment)

If "yes", please describe the services provided, hours of availability, etc.

_____

_____

31. Does your group or any of your physicians provide Aesthetic or Spa type services? ❑ Yes ❑ No

32. Does your group employ a full-time Risk Manager? ❑ Yes ❑ No
-If "Yes", provide the individual's name, title and employment date, and provide written job description:
(Please note an application for Risk Manager Premium Discount must be submitted and approved by ISMIE to qualify for any discounts available)

_____

_____

33. Provide an overview of your group's practice by reimbursement type:

Payor	Percent of Practice Total
Medicare	_____
Medicaid	_____
Private Insurance Companies	_____
Private HMO (Managed Care)	_____
Self Pay	_____

34. Does your group support participation in Continuing Medical Education (CME)? -If yes, complete A - D ❑ Yes ❑ No

A. Does your group provide physicians with time away from practice to ensure participation? ❑ Yes ❑ No

B. List the number of days per physician per year: _____ ;
Annual CME hours expected: _____

C. Does your group provide Allied Health Personnel (AHPs) with time away from practice to ensure participation? ❑ Yes ❑ No

D. List the number of days per AHP per year: _____ ;
Annual CME hours expected: _____

Certificate(s) of Insurance

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED.

35. If your insurance request is accepted, as a service to its insureds ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a hospital or other health care institution on your behalf, complete the following:

A. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

B. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

C. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

D. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

ELECTRONIC SIGNATURES ARE PERMISSIBLE IN ILLINOIS PURSUANT TO THE ELECTRONIC COMMERCE SECURITY ACT (5 ILCS 175); AND PURSUANT TO THE UNIFORM ELECTRONIC TRANSACTIONS ACT IN BUSINESS AND COMMERCE CODE CHAPTER 322 IN THE STATE OF TEXAS.

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

Partnership/Corporation or Clinic Name (*please print*)	Signature of President/Partner or Authorized Person	Date

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ALASKA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE TO DELAWARE APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO IDAHO APPLICANTS: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO INDIANA APPLICANTS: A person who knowingly and with intent to defraud and insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: 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 state value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO PUERTO RICO APPLICANTS: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, will be sanctioned for each violation with a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty may be increased to a maximum of five (5) years, if attenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE TO TEXAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative**.** I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Partnership/Corporation or Clinic Name (*please print*)	Signature of President/Partner or Authorized Person	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor offer insurance to the applicant. A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original. PLEASE NOTE: Email transmission of a completed application or other document is unsecure. ISMIE Mutual is not responsible for any disclosure while the information is in transit. Email submissions may be made to underwriting@ismie.com

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

Claim Information Supplement (please print). In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant

_____
Name Age Sex

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ Yes ☐ No If "Yes", state when ____ / ____
Month Year

4. Name of insurance carrier defending you: _____

5. Policy Number. _____
6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____
7. Disposition or current status of claim or suit:

☐ Open - Indicate case value established by carrier $_____

☐ Closed-With no payment made
Date _____

☐ Closed-With payment made.
- Has carrier indicated desire to settle?
Indicate amount of settlement or award:

☐ Yes ☐ No

a. Your policy $ _____ Date _____

b. Total (if additional defendants involved) $ _____

----------NEXT CLAIM----------

1.Patient/Claimant _____
Name Age Sex

2.Date(s) of treatment and/or surgery which led to the allegations against you _____

3.Was suit ever filed? ☐ Yes ☐ No If "Yes", state when ____ / ____
Month Year

4.Name of insurance carrier defending you: _____

5. Policy Number. _____
6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____
7. Disposition or current status of claim or suit:

☐ Open - Indicate case value established by carrier $ _____

☐ Closed-With no payment made
Date _____

☐ Closed-With payment made.
- Has carrier indicated desire to settle?
Indicate amount of settlement or award:

☐ Yes ☐ No

a. Your policy $ _____ Date _____

b. Total (if additional defendants involved) $_____

Remarks Addendum

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED, OR CONTINUE INFORMATION ON YOUR LETTERHEAD. PLEASE WRITE LEGIBLY

Question Number	Remarks

BA-3000-AR (02/23)