MACM | Medical Assurance Company of Mississippi

404 West Parkway Place
Ridgeland, Mississippi 39157
Office 601.605.4882 • 800.325.4172
Claims 601.605.8878 • 800.362.2912
Fax 601.605.8849
www.macm.net

APPLICATION FOR PROFESSIONAL LIABILITY
PHYSICIANS

Please use the checklist below to assist you with this process.

- ☐ Recently generated 10-Year Claims History from your insurance company(ies).

  Residents/Fellows should contact the Risk Management Department at the training program for a letter attesting to your claims history.

- ☐ Attach a **current** Curriculum Vitae.
- ☐ Use Claim Information Form at the end of the application to give details of each claim. You may copy the form for multiple claims.
- ☐ Most recent professional liability insurance Certificate of Insurance.

Please email application and supporting documents to:

underwriting@macm.net

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Application for Professional Liability Insurance
Physicians

Please type or print legibly throughout this application. Please be advised that it may take up to 30 days to process and consider your application. If you need additional room for explanation of any question herein, please use page 15 of this application. **Questions left unanswered and/or without requested explanation will delay processing of your application.**

Personal Information:

Full Name of Applicant: | Date of Birth | Place of Birth | Gender

Principal Mississippi Office Address:

Street | City | County | Zip

Mississippi Mailing Address (if different from above):

Street | City | County | Zip

Business Phone No:

Applicant's E-Mail Address:

Applicant's Cell Phone:

Office Manager/Contact Person:

Contact Person's Office Phone No.:

Contact Person's E-mail address:

Contact Person's Cell Phone:

Website (if applicable):

Permanent Residence Address:

Street | City | County | Zip

Previous Professional Liability Information:

	YES	NO
1. Have you ever made application to, or been insured by, Medical Assurance Company of Mississippi?	☐	☐
2. Have you been insured by a professional liability carrier in the past, or are you currently insured by another company? (Including Residency/Internship/Fellowship Years)	☐	☐

If question 2 is "Yes", please list all current and prior professional liability carriers.
Please include claims history reports from all carriers for the past 10 years. Please use page 15 to list additional carriers.

NAME OF INSURANCE COMPANY	Dates covered MM/DD/YY to MM/DD/YY	# of Pending Claims	# of Closed Claims	Total # of Claims

	YES	NO
3. If your current professional liability policy is written on the "Claims Made" form, have you or will you purchase a "Reporting Endorsement" (tail-end coverage) from your current carrier?	☐	☐
4. Do you desire MACM to consider providing Prior Acts coverage? If yes, include complete copy of current policy.	☐	☐

Effective Date, Licensure and Specialty Information:

5. Date you would like your coverage with MACM to begin:

6. Permanent Mississippi License Number:

7. Social Security Number:

8. What is the practice specialty for which you are applying for coverage?

	YES	NO
A. Do you limit your practice to the above specialty?	☐	☐
B. Please list any subspecialties.		
C. Prior to the effective date in Question 5 above, have you (or will you have) completed a residency training in the specialty(ies) for which you are applying?	☐	☐
9. Are you Board Certified in the specialty indicated in Question 8 above? If "Yes", please attach a copy of your Board Certificate.	☐	☐
10. Are you Board Certified in the specialty indicated in Question 8B above? If "Yes", please attach a copy of your Board Certificate.	☐	☐

11. If not currently Board Certified in Question 8 and/or Question 8B above, please explain why.

Education and Training:

Please provide the following COMPLETE chronological data (Provide a detailed explanation of any gaps in time.)

12. From what medical school did you graduate?

Year: Degree: City / State:

13. Other medical schools attended and dates.

14. Post graduate years (including internships/residency/fellowship.) (Provide a detailed explanation of any gaps in time.)

NAME	LOCATION	SPECIALTY TRAINING	DATES (Month / Year)			
			From:		To:	
			From:		To:	
			From:		To:	
			From:		To:	
			From:		To:	
			From:		To:	

Prior Practice History:

15. Where have you practiced since completion of your Post Graduate Medical Education? Provide a detailed explanation of any gaps in time.

FACILITY NAME	CITY and STATE	DATES (Month / Year)			
		From:		To:	
		From:		To:	
		From:		To:	
		From:		To:	
		From:		To:	

Current Practice Information:

16. Give the name and location of **EVERY** hospital, clinic, surgical facility, nursing home, rehabilitation facility, hospice, prison, healthcare facility, or medical practice for which you are asking MACM to provide insurance coverage to you. COVERAGE WILL ONLY BE PROVIDED FOR THOSE LOCATIONS LISTED. **Check "Yes" or "No" to indicate if you desire confirmation of coverage to be sent. If not checked, confirmation will not be sent.**

FACILITY NAME	CITY and STATE	Send Confirmation? Yes	No

	YES	NO
17. Will you be in Private Practice? (Including joining a private practice group.)		
18. Will you be employed full-time or part-time (faculty) by the University of Mississippi Medical Center?		
19. Will you be employed full-time or part-time by the Federal Government? If "Yes", explain, give location.		
20. Will you be employed full-time or part-time by the MS State Board of Health, MS State Board of Mental Health, MS State Hospital (Whitfield), a State College, Jail, or any other State Agency? If "Yes", give name of facility.		
21. Will you be employed full-time or part-time by a County or Local Government Owned Hospital? If "Yes", give name of hospital and provide contract.		
22. Will you be an independent contractor with any State or Federal Government agency or entity? If yes, give facility name and provide contract.		
23. Will you be employed full-time or part-time by a Private Hospital or employed by a clinic which is owned by a Private Hospital? If "Yes", give name of hospital.		
24. Will you be a Hospitalist? If "Yes", give name of hospital. Indicate age range of patients you will see.		
25. Will you be in full-time Post Graduate training? If "Yes", where?		
26. Will you be engaged in, or are you planning to engage in, any medical professional services (such as moonlighting activities) outside of or on behalf of anyone other than your employer or primary practice?		
A. If "Yes", do you desire coverage for those services?		
B. If "Yes" to questions 26 and 26A, describe these services.		

27. How many hours per week do you anticipate working?

Current Practice Information (continued):

IMPORTANT NOTE:

If you are not certain of the answer to any part of Question 28, you should consult with your attorney to determine the correct answer.

28. Please indicate how your medical practice is legally organized. Check One.

☐ Solo Practitioner ☐ Limited Partnership ☐ Limited Liability Company

☐ Corporation ☐ General Partnership ☐ Other (Please explain)

A. Please provide the **EXACT LEGAL NAME** of your business entity

B. Please provide the full name of each physician associated with your practice as a partner, stockholder, member, employee or independent contractor and indicate your business relationship with each. If additional space is needed, use page 15.

PHYSICIAN NAME	BUSINESS RELATIONSHIP	PHYSICIAN NAME	BUSINESS RELATIONSHIP

C. If any Non-Physician owns any part of your medical practice, please provide the name(s) of that person or entity and indicate percentage of ownership.

NAME	BUS. RELATIONSHIP	%	NAME	BUS. RELATIONSHIP	%

D. Please indicate any physician(s) whom you employ or whom you pay to cover your practice (not including partners, associates, or other physicians with whom you have a reciprocating coverage agreement, whether written or understood.)

PHYSICIAN NAME	MEDICAL SPECIALTY	BUSINESS RELATIONSHIP

	YES	NO
29. A. Do you wish to purchase Vicarious Liability Coverage for any physician listed in Question 28D above? If "Yes", list name(s).	☐	☐
B. Do you wish to purchase Vicarious Liability Coverage for any physician NOT listed in Question 28D above? If "Yes", give name(s).	☐	☐

Vicarious Liability Coverage provides professional liability coverage to an insured for the professional acts and services rendered on the insured's behalf by another physician, if that physician has valid collectible, individual medical professional liability insurance and a permanent license to practice medicine in the State of Mississippi. The Limits of Coverage provided will not exceed the limits of the other physician's liability insurance. The premium for Vicarious Liability coverage is 10% of the applicable mature premium.

30. If you have a contract with any hospital or other organization which provides healthcare, do you wish to purchase Contractual Liability coverage?	☐	☐

Contractual Liability coverage covers you for professional liability assumed in the subject contract. Without this coverage, you have no coverage for any liability you have assumed by contract. If you answered Q30 "Yes", YOU MUST ATTACH A COPY OF THE CURRENT APPLICABLE CONTRACT(S), including all revisions, endorsements, etc., thereto. You may delete any financial details from the contract copy. The premium for Contractual Liability is 10% of the applicable mature premium of the insured physician.

31. Do you want any other entities named as Additional Interest on your professional liability policy? If "Yes", list the entities below and furnish a copy of the contract or agreement regarding such coverage.	☐	☐

Entity Name:

Entity Name:

Current Practice Information (continued).

32. LIMITS OF COVERAGE: Please indicate the amount of coverage desired. (Per Claim/Annual Aggregate)
MACM guidelines prohibit raising limits except at policy renewal. Therefore, give careful consideration to the limits you request.

☐ $1 Million / $3 Million ☐ $3 Million / $5 Million

☐ $2 Million / $3 Million ☐ $5 Million / $7 Million

33. ADDITIONAL COVERAGE: ANSWER THIS SECTION ONLY IF YOU WISH TO PURCHASE COVERAGE FOR THE FOLLOWING:

	YES	NO
A. Professional Premises Liability. Total square feet of your professional premises. _____ sq. ft. Location. _____	☐	☐
B. Non-Physician Health Care Professional Employees as ADDITIONAL INSUREDS. (Employees have separate Limits of Coverage.) Limits of Coverage will be $1,000,000 per claim / $3,000,000 annual aggregate. *Please mark desired number of each in "C" below.*	☐	☐

C. Note position and quantity below for Additional Insured coverage.

Position	MACM Use Only	Quantity	Position	MACM Use Only	Quantity	Position	MACM Use Only	Quantity
Nurse Anesthetist	31		Physician Assistant	73		Clinical Psychologist	63	
Nurse Practitioner	34		Optometrist	72		Medical Physicist	93	
Acute Care Nurse Practitioner	92		Perfusionist	35		Radiation Therapist	32	
Nurse Midwife with deliveries	74		Pharm D	69		Radiologist Assistant	91	
Nurse Midwife NO deliveries	54		Podiatrist	71		Pathologist Assistant	80	

D. Please give the name and position of each ancillary personnel you have indicated above. If you need additional space, please use page 15. Please make certain that the number of personnel/positions matches to the names given.

Name:	Position:	Name:	Position:
Name:	Position:	Name:	Position:
Name:	Position:	Name:	Position:

Employed ancillary personnel for the following positions will automatically be covered as **Non-Extender Employees, thereby sharing the limits of the Named Insured.** You will **not** need to notify MACM of these personnel changes throughout the year. If you are a physician within a group which has a corporate policy with MACM, these employed ancillary personnel will have coverage through the corporate policy. If you are a solo practitioner, these employed ancillary personnel will have coverage through your individual policy.

Aesthetician
Alcohol and Drug Counselor
Allergy Tech
Anesthesia Tech
Angiography Tech
Athletic Trainer
Audiologist
Bone Density Tech
Cast Tech
Certified First Assistant
Cytotechnologist
Dietician
Echo Tech
EEG Tech
EKG Tech
ENT Tech
Exercise Physiologist
GI Tech
Histotechnologist
Lab Tech
Laser Tech
Licensed Clinical Social Worker
Licensed Prof. Counselor
Medical Assistant
Medical Tech
Non-Licensed Counselor
Nuclear Medicine Tech
Nurse
Occupational Health Tech
Occupational Therapist
Occupational Therapy Assistant
Operating Room Tech
Ophthalmic Assistant
Ophthalmic Surgical Tech
Optician
Orthopedic Tech
Orthoptist
Pathology Tech
Phlebotomist
Physical Therapist
Physical Therapy Asst.
Physiotherapist
Psychometrist
Radiology Tech
Respiratory Tech
Respiratory Therapist
Skin Care Specialist
Speech Pathologist
Surgical Assistant

Medical / Legal Information:

Please answer "Yes" or "No" to each of the following questions. "Yes" answers must be explained in the space provided. If additional space is needed, please use page 15.	**YES**	**NO**
34. Has your license to practice medicine or your DEA permit **EVER** been denied, revoked, suspended, or in any other way limited, either voluntarily or involuntarily, or are you under investigation? If "Yes", please explain.	☐	☐
35. Have you **EVER** signed a contract with or been followed by a monitoring organization such as the Mississippi Physician Health Program or another State's Physician Health Program?	☐	☐
36. Have your hospital staff privileges **EVER** been suspended, revoked, or in any other way restricted, either voluntarily or involuntarily, or are you under investigation? If "Yes", please explain.	☐	☐
37. Have you EVER been arrested, charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere (no contest) for any violation of any law? If "Yes", please explain. Note: You must answer "yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted.	☐	☐
38. Have you **EVER** been evaluated for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, mental illness or other psychiatric treatment? If "Yes", please explain. If you are currently under the care of a mental health practitioner, please provide a letter from the practitioner indicating the diagnosis, history of treatment, short and long-term prognosis, and plans for follow-up.	☐	☐
39. Have you suffered an illness or disability that has prevented or restricted your practice? If "Yes", please explain.	☐	☐
40. Has any insurance company (including Lloyds of London) **EVER** canceled, declined to issue, refused to renew your insurance, or offered professional liability insurance only on special terms? If "Yes", please explain.	☐	☐
41. A. Has any legal action or claim **EVER** been presented against you, or are you aware of any possible claim, regardless of dollar amount, that may be filed against you alleging professional errors, omissions, or any other type of medical negligence? If "Yes", complete *Claim Information Form* attached to the end of this application and include all actions, even though no payments may have been made on your behalf. If No Claims, write "No Claims" on *Claim Information Form*, sign, date, and return with application.	☐	☐
B. If "Yes", have you reported such claim or potential claim in writing to your insurer? If you have not reported said claim(s), please explain why.	☐	☐
42. Have any judgments **EVER** been rendered against you or any out-of-court settlements **EVER** been made on your behalf from an incident alleging professional errors or omissions? If "Yes", please provide details regardless of dollar amount.	☐	☐

Medical Marijuana:

	YES	NO
43. Do you certify patients for the use of medical marijuana?	☐	☐

A. What percentage of your total practice population have you certified for the use of medical marijuana?

☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

B. What percentage of patients in your practice that you have certified for the use of medical marijuana are minors (under the age of 18)?

☐ N/A ☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

C. What percentage of patients in your practice that you have certified for the use of medical marijuana are between the ages of 18-25?

☐ N/A ☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

	YES	NO
44. Does anyone else in your practice certify patients for the use of medical marijuana? (If "Yes", please list each person below.)	☐	☐

A. What percentage of the total practice population have they certified for the use of medical marijuana?

☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

B. What percentage of patients in the practice that they have certified for the use of medical marijuana are minors (under the age of 18)?

☐ N/A ☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

C. What percentage of patients in the practice that they have certified for the use of medical marijuana are between the ages of 18-25?

☐ N/A ☐ 1-5% ☐ 6-10% ☐ 11-20% ☐ 21-49% ☐ 50+%

	YES	NO
45. Are you certified for the personal use of medical marijuana?	☐	☐

If you answered "yes" to questions 43-45, you are not covered to certify patients for the use of medical marijuana unless and until you receive a written acknowledgment from MACM.

If you answered "no" to questions 43-45, but you or someone in your practice begins certifying patients for the use of medical marijuana, or you or someone in your practice becomes certified for the personal use of medical marijuana during this policy year, you have a duty to contact MACM.

Obstetrics:

	YES	NO
46. Do you practice Obstetrics? If "No", go to section below. If "Yes", answer the following questions.	☐	☐
A. Do you perform or anticipate performing, assist in, or serve as "back-up" for ANY deliveries, home birth services, etc., conducted outside of a hospital setting? If "Yes", please explain on page 15.	☐	☐
B. Do you perform Vaginal Birth After Cesarean Section (VBAC)?	☐	☐
C. How many deliveries do you perform per year? ☐		

Emergency Medicine:

	YES	NO
47. Do you or will you provide emergency medicine services OR staff or "moonlight" in a Hospital or Free Standing Emergency Department (not including being on call for your specialty)? If "No", go to next section below. If "Yes", please answer the following questions.	☐	☐
48. If "Yes" to Question 47, do you wish to be insured by MACM for this exposure?	☐	☐
If you answered "Yes" to Question 48, please answer the following questions. If you answered "No" to Question 48, go to next section below.		
A. Will you be reading your own X-Rays?	☐	☐
If "YES", will they subsequently be read by a Radiologist?	☐	☐
B. Please list the location(s) where you will practice Emergency Medicine. ☐		

Surgical Procedures:

Do you perform any of the following? If "Yes", please list procedures in the space provided. If additional space is needed, please use page 15.	YES	NO
49. Plastic or Reconstructive surgery for functional purposes ONLY (no elective cosmetic surgery)? If "Yes", please list procedures. ☐	☐	☐
50. Plastic or Reconstructive surgery for cosmetic purposes? If "Yes", please list procedures. ☐	☐	☐
51. Other cosmetic procedures/treatments? If "Yes", please list procedures. ☐	☐	☐
52. Do you perform any invasive procedures **in your office** that require anesthesia or sedation? If "Yes", please list each procedure, including the anesthesia or sedation utilized and the individual who administers it. ☐	☐	☐

Diagnostic Procedures:

Please answer "Yes" or "No" to each of the following questions. If "Yes", please list procedures in the space provided. If additional space is needed, please use page 15.	**YES**	**NO**
53. Injection of chemical (not including radioactive) substances intrathecally or into blood vessels, lymphatics, sinus tracts, fistulae, or spinal cord for radiological diagnostic study? If "Yes", please list procedures.	☐	☐
54. Injection of radioactive substance for radiologic diagnostic study? If "Yes", please list procedures.	☐	☐
55. Needle biopsies? If "Yes", please list organs.	☐	☐
56. Fine needle biopsies (22 gauge needle or less) of solid tumors? If "Yes", please answer below.	☐	☐
A. Superficial lesions?	☐	☐
B. Deep lesions?	☐	☐
C. Breast lesions for diagnostic purposes?	☐	☐
57. Proctoscopy, Sigmoidoscopy, Colonoscopy, EGD or ERCP? If "Yes", please answer below.	☐	☐
A. For observational diagnostic exam only?	☐	☐
B. For examinations with biopsy, cauterization, ligation, fulguration, or other tissue invasive procedures?	☐	☐
58. Endoscopies, other than those described in Question 57, for examination purposes ONLY? If "Yes", please list procedures.	☐	☐
59. Endoscopies, other than those described in Question 57 with biopsy, cauterization, ligation, fulguration? If "Yes", please list procedures.	☐	☐

Anesthesia:

	YES	NO
60. Do you perform any method of anesthesia other than local anesthesia?	☐	☐

If "No", go to next page. If "Yes", please answer completely the following questions and explain in the space provided. If additional space is needed, please use page 15.

61. Do you administer any of the following?	☐	☐
A. Inhalation anesthesia?	☐	☐
B. Sedation/Analgesia? (i.e. "conscious sedation")	☐	☐
C. Spinal, caudal, epidural, intrathecal or brachial plexus block anesthesia or other neuraxial anesthesia? If "Yes", please specify.	☐	☐
D. Pudendal, axillary, Celiac, Bier or other nerve blocks? If "Yes", please specify.	☐	☐

62. If you are not an anesthesiologist and have answered "Yes" to any of 61 A-D, please list the facilities (e.g. office, hospital, ASC, etc), location (city), type of anesthesia utilized and procedures.

Facility Name	Location	Type of Anesthesia	Procedures

Common Medical Practice Questions:

Please answer "Yes" or "No" to each of the following questions. If "Yes", please explain in the space provided. If additional space is needed, please use page 15.

	YES	NO
63. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any **Certified Registered Nurse Anesthetist**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐
64. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any **Nurse Practitioner**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐
65. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any **ACUTE CARE Nurse Practitioner**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐
66. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any **Delivering Nurse Midwife**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐
67. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any licensed **Physician Assistant**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐
68. Do you sign protocol for, employ, or consult or collaborate with, or are you responsible for the supervision of, any licensed **Radiologist Assistant**? If "Yes", please answer below. Total Number Supervised ____ Employed by ____	☐	☐

If you answered "Yes" to Question **63**, **64**, **65**, **66**, **67**, or **68** above, the CRNA, Nurse Practitioner, Acute Care Nurse Practitioner, Nurse Midwife, Physician Assistant or Radiologist Assistant MUST have limits of liability of at least $1 Million for you to be covered for consulting, collaborating, supervising or signing protocol.

69. Do you perform or anticipate performing any experimental procedures not sanctioned or approved by your specialty board? If "Yes", please describe on page 15.	☐	☐
70. Do you perform Acupuncture Procedures (including Acupuncture anesthesia)? If "Yes", describe on page 15. Coverage for this exposure can **ONLY** be provided with special approval from MACM.	☐	☐
71. Does your practice consist of any satellite office locations? If "Yes", please list all locations and state nature of practice at each on page 15.	☐	☐
72. Do you directly or indirectly contract with a prison or correctional facility to provide or oversee medical services for inmates? If "Yes", which facility? Please provide contract.	☐	☐
73. Do you currently serve or anticipate serving as a Medical Director for a nursing home or rehabilitation facility? If "Yes", please list facility(s) and location(s) on page 15.	☐	☐
74. Do you currently serve or anticipate serving as a Medical Director for a hospice? If "Yes", please list facility(s) and location(s) on page 15.	☐	☐
75. Do you currently serve or anticipate serving as a Medical Director for any facility other than a hospice or nursing home? If "Yes", please list facility(s) and location(s) on page 15.	☐	☐
76. Do you treat and/or supervise patients undergoing Hyperbaric Oxygen Therapy? If "Yes", how many CME hours have you completed in Hyperbaric Treatment? ____ (Minimum 40 hours required.) From where? ____	☐	☐

Common Medical Practice Questions (continued):

Please answer "Yes" or "No" to each of the following questions. If "Yes", please explain in the space provided. If additional space is needed for "Yes" answers, please use page 15.	YES	NO
77. Do you perform wound care services? If "Yes", where?	☐	☐
A. Do you perform wound care procedures under local anesthesia?	☐	☐
B. Do you perform wound care procedures that require general anesthesia?	☐	☐
78. Do you give IV therapy in your office for purposes other than hydration? If "Yes", list medications.	☐	☐
79. Do you perform procedures utilizing laser? If "Yes", please list procedures.	☐	☐
80. Does your practice consist of patients undergoing treatment for chronic pain (Pain Management)? Chronic Pain is defined as a patient receiving controlled substances for the treatment of pain for more than 6 months, not including terminal disease pain. If "Yes", please explain. Percentage of practice ____ %.	☐	☐
81. Do you perform Neonatal Medicine? If "Yes", and you are not a Neonatologist, please describe procedures performed and nature of your practice. (Attend deliveries, stabilization for transport, on-going management of sick babies, procedures performed, etc.)	☐	☐
82. Do you perform Chelation Therapy? If "Yes", please explain for what conditions, list procedures, and indicate which chelating agents are used.	☐	☐
83. Do you engage in Telemedicine? (i.e., The use of telecommunications and/or computer technology by you at one location to provide healthcare services, diagnoses, consultations or treatment for a patient located at another location. Examples: Teleradiology, telepathology, teledermatology, telecardiology, telepsychiatry). If "Yes", please explain on page 15.	☐	☐
84. Do you engage in Interstate Medicine (i.e. do you ever review and render medical opinions or diagnoses regarding images, slides, specimens, test results or other patient data relating to a patient located outside of the State of Mississippi, whether by mail, courier, or electronic means)? If "Yes", please explain on page 15.	☐	☐
85. Do you perform, anticipate performing, or assist in the performance of any Bariatric Procedures? If "Yes", please explain.	☐	☐
86. Do you perform any surgical procedures or treatment not generally performed by a physician of your medical specialty? If "Yes", please explain.	☐	☐
87. Do you use the services of, or contract with, a Nighthawk Radiology Company?	☐	☐
88. Do you practice medicine in communities other than that in which your home or primary office is located? If "Yes", name the hospital(s) or other facilities involved, maximum distance from your home/office and describe the details of the practice on page 15. Please read notice below.	☐	☐

Important Notice - Coverage provided to a MACM insured does not apply to ITINERANT SURGERY

Itinerant Surgery is surgery that is performed in a distant community, not readily accessible to the operating surgeon from the standpoint of postoperative care, and in which the operating surgeon will depend on others to assume a significant responsibility for postoperative care.

Common Medical Practice Questions (continued):

89. Do you perform any of the following procedures? Please answer "Yes" or "No" to each.

	YES	NO
Assist in Major Surgery (not primary surgeon)	☐	☐
Chemabrasion	☐	☐
Chemotherapy	☐	☐
Colposcopy of Uterine Cervix with Biopsy	☐	☐
Cryosurgery of Uterine Cervix	☐	☐
Dermabrasion	☐	☐
Hair Transplants	☐	☐
Moh's Surgery	☐	☐
Take and / or interpret X-rays	☐	☐
Temporary fracture immobilization pending referral	☐	☐
Apply casts	☐	☐
Bone Marrow Transplant /Peripheral Blood Stem Cell (BMT/PBSC)	☐	☐
Cardiac Catheterization	☐	☐
Chorionic Villi Biopsy	☐	☐
CVP Lines	☐	☐
Dilation and Curettage	☐	☐
Exchange Transfusions	☐	☐
Kyphoplasty/Vertebroplasty	☐	☐
Mesotherapy or other methods to reduce fat and cellulite	☐	☐
Myelography	☐	☐
Myringotomies with Tubes	☐	☐
Peripheral Angioplasties	☐	☐
Permanent Pacemaker Implants (Not Epicardial)	☐	☐
Prenatal Care	☐	☐
Radiation Therapy	☐	☐
Supervise or Perform Hemodialysis	☐	☐
Temporary Pacemaker Implants	☐	☐
Vasectomies	☐	☐

	YES	NO
Advanced TEE and/or Coronary Sinus Catheters	☐	☐
Amputation of digits (fingers and toes) other than tying skin tags	☐	☐
Cardiac Ablation Procedures	☐	☐
Cardiac Valvuloplasty	☐	☐
Cerebral Angioplasty, Stenting, Endovascular Coiling or Embolization	☐	☐
Cerebral Thrombectomy	☐	☐
Coronary Angioplasties	☐	☐
Coronary Atherectomy	☐	☐
Electroconvulsive Therapy	☐	☐
Fallopian Tube Interruption	☐	☐
Implantable Cardiac Defibrillators	☐	☐
PFO Closures	☐	☐
Pilonidal Cystectomies	☐	☐
Transcatheter Aortic Valve Replacement (TAVR)	☐	☐
Amputations other than digits	☐	☐
Liposuction	☐	☐
Thyroid Surgery	☐	☐

Common Medical Practice Questions (continued):

89. (cont'd) Do you perform any of the following procedures? Please answer "Yes" or "No" to each.

	YES	NO
Breast Implants	☐	☐
Intervertebral Disc Injections	☐	☐
Thoracic Surgery NOT including Cardiovascular Surgery	☐	☐
Vascular Surgery including Peripheral, but not including Cardiovascular Surgery	☐	☐
Laparoscopic Surgery	☐	☐
Posterior Lumbar Interbody Fusion (PLIF)	☐	☐
Surgical Spinal Procedure with or without instrumentation	☐	☐

90. Do you interpret any of the following imaging studies?	YES	NO
A. Computed Tomography (CT)	☐	☐
B. Magnetic Resonance Imaging (MRI)	☐	☐
C. Positron Emission Tomography (PET)	☐	☐
D. Carotid Doppler	☐	☐
E. Ultrasound	☐	☐
F. Mammography	☐	☐
G. Nuclear Medicine Scans	☐	☐
H. Other - Please Explain:	☐	☐

	YES	NO
91. Do you perform any surgical procedures (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) **not previously described herein**? If "Yes", please explain.	☐	☐

Request for Certificates of Insurance:

92. We will automatically send certificates to those hospitals and healthcare facilities indicated on page 3, Question 16, if you have checked the box authorizing us to release a certificate to them. If you want certificates of insurance to be sent to other entities such as preferred provider networks, insurance companies, credentialing organizations, etc., please list below. Requests for certificates to additional locations after your application has been processed will require your written authorization.

FACILITY NAME	LOCATION

Please use the area below for additional information for questions which you answered "Yes"

Question Number **Explanation**

Remember to answer any of the questions numbered here in red (if any):

IMPORTANT: BEFORE SIGNING READ THE FOLLOWING

ARBITRATION OF DISPUTES

Applicant is on notice and understands that in the event Medical Assurance Company of Mississippi issues a policy of insurance to Applicant, his/her insurance policy will contain the following binding arbitration provision. By my signature, I hereby agree and consent to the following:

IF THERE IS A DISPUTE BETWEEN APPLICANT AND MEDICAL ASSURANCE COMPANY OF MISSISSIPPI (MACM), THE APPLICANT AND MACM AGREE NOT TO PROCEED AGAINST THE OTHER TO SEEK RELIEF OR DAMAGES THROUGH A CIVIL ACTION IN STATE OR FEDERAL COURT. ANY DISPUTE WILL BE SUBMITTED TO AND SETTLED BY BINDING ARBITRATION IN MADISON COUNTY, MISSISSIPPI, OR ANY OTHER MUTUALLY AGREED UPON LOCATION. UNLESS APPLICANT AND MACM AGREE OTHERWISE, THE ARBITRATION SHALL BE CONDUCTED BY AN ARBITRATOR SELECTED BY THE AMERICAN ARBITRATION ASSOCIATION AND PURSUANT TO THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION.

UNLESS BARRED BY THE STATUTE OF LIMITATIONS, APPLICANT OR MACM MAY INITIATE AN ARBITRATION BY SERVING ALL PARTIES WITH A NOTICE OF THE NATURE OF THE CLAIM AND DEMAND FOR ARBITRATION. A CLAIM BY APPLICANT OR MACM WILL BE WAIVED AND FOREVER BARRED, IF, ON THE DATE OF THE DEMAND FOR ARBITRATION, THE CLAIM WOULD BE BARRED BY THE APPLICABLE STATUTE OF LIMITATIONS IN A CIVIL CASE. APPLICANT AND MACM WILL PAY THE FEES OF THE ARBITRATOR AND THE AMERICAN ARBITRATION ASSOCIATION AS PROVIDED BY ITS RULES, AND THE FINDING OF ANY ARBITRATOR. APPLICANT AND MACM WILL MAKE EVERY EFFORT TO MAINTAIN AS CONFIDENTIAL ALL INFORMATION AND EVIDENCE DEVELOPED IN ARBITRATION, EXCEPT TO THE EXTENT NECESSARY TO ENFORCE ANY ARBITRATION AWARD.

ACKNOWLEDGEMENT

I understand that Medical Assurance Company of Mississippi will rely upon the information provided in my application to determine the eligibility for, the extent of, and the premium for this insurance coverage.

I also understand that Medical Assurance Company of Mississippi will only consider for coverage the medical practices and procedures and practice locations described in my application form.

I also understand that in the event Medical Assurance Company of Mississippi issues a policy of insurance to me, my insurance policy is deemed to include this initial application and all supplemental applications and renewal applications.

I further understand that in the event Medical Assurance Company of Mississippi issues a policy of insurance to me, my coverage will be void if I have concealed, failed to disclose, or misrepresented any pertinent information concerning this insurance.

I further understand that I must immediately advise Medical Assurance Company of Mississippi in writing if in the future there occurs any change with respect to information previously provided by me.

DESIGNATION AND AUTHORIZATION

In the event that Medical Assurance Company of Mississippi accepts this application, I hereby designate and authorize the acting Clinic Manager or other authorized designee to complete my renewal insurance application furnished by Medical Assurance Company of Mississippi and to receive any and all policy documents, including but not limited to premium notices and invoices.

I, the undersigned physician, am on notice that:

- Designating and authorizing either the designee or the Clinic Manager in no way relieves me of my obligation to ensure that the information furnished to Medical Assurance Company of Mississippi is true and correct.

- I am bound by the representations made by my designee or the Clinic Manager just as I would be bound by my representations in the event that I completed the insurance application furnished by Medical Assurance Company of Mississippi on my own behalf.

- Medical Assurance Company of Mississippi will rely upon the information provided by my designee or the Clinic Manager to determine the eligibility for, the extent of, and the premium for my desired insurance coverage.

- Neither my designation nor my authorization relieves me of my continuing duty to advise Medical Assurance Company of Mississippi in writing of future changes with respect to the information provided by my designee or the Clinic Manager.

- I acknowledge and understand that my coverage, if any, will be void if I, my designee or the Clinic Manager have concealed, failed to disclose or misrepresented any pertinent information concerning this insurance.

- This Designation and Authorization to Complete Insurance Application may only be revoked through written notice to Medical Assurance Company of Mississippi.

I have carefully read and understand the above, and do herein expressly and voluntarily designate and authorize the Clinic Manager or other authorized designee at the time my renewal insurance is provided by or submitted to Medical Assurance Company of Mississippi, to complete on my behalf the renewal insurance application furnished by Medical Assurance Company of Mississippi. I further consent to and fully acknowledge all of the foregoing provisions.

ATTESTATION

I, by my signature, agree to the terms of the application and certify that all information provided is true and that no factual details have been omitted.

Signature of Physician

Date Signed

Printed Name of Physician

AUTHORIZATION TO RELEASE INFORMATION

To: My prior professional liability insurance carriers, past and present medical associations or societies, state medical licensure agencies and authorities, medical schools, and any hospital at which I have held or now hold staff privileges.

I authorize the release and disclosure of information requested by Medical Assurance Company of Mississippi regarding my medical education and training, medical licensure, past and future claims, staff privileges, employment and other underwriting matters.

You may permit Medical Assurance Company of Mississippi or its representative to examine and make copies of all such records and/or furnish such copies of such information to Medical Assurance Company of Mississippi

If this authorization is presented to any hospital, such hospital is authorized to provide Medical Assurance Company of Mississippi with copies of all past and present employment or staff privilege records of the undersigned in said hospital.

You are authorized to honor a machine copy of this Authorization to Release Information as fully as if it were the original. You are also authorized to honor this Authorization to Release Information regardless of the date of this authorization.

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 errors, omissions or mistakes contained in such released information.

I request that all information, with your charges therefore, be sent to Medical Assurance Company of Mississippi, 404 W. Parkway Place, Ridgeland, MS, 39157.

Dated this the _____day of_____, 20_____.
(date) (month) (year)

_____ _____
Signature of Physician Printed Name of Physician

Mississippi Medical License Number: _____

Medical Assurance Company of Mississippi

Claim Information Form

(Print or Type)

YOU MAY COPY THIS FORM TO REPORT MORE THAN ONE CLAIM

Applicant's Name: _____

Patient's Name: _____ Patient's attorney (if any): _____

Date of incident: _____ Date claim was made: _____

Explain the incident in detail:

Status of Claim: ☐ Active ☐ Dismissed ☐ Dropped ☐ Closed ☐ Closed with **no** payment

Amount of settlement or judgment (if closed) $_____

Amount of settlement or judgment on your behalf (if closed) $_____

Name and address of Insurance Company involved	Claims Representative _____
	Defense Counsel _____

I understand that this Claim Information Form is a part of my Application for Professional Liability Coverage.

_____ _____

Signature of Applicant Date