



# NCMIC

*Insurance Company*

**Please review the attached application to ensure that all of the information is correct. Complete all other portions of the application, sign and return with all required supporting documentation and payment.**

***General Professional Information:***

- ◇ Signed and dated application
- ◇ A copy of each active license and certification you hold

***Payment Information:***

- ◇ Required Down Payment

***Previous Insurance:***

- ◇ A copy of your current Declarations Page showing your retroactive date, policy period and limits of liability
- ◇ If coming from a previous carrier, the effective date of the policy must be on or after the cancellation date of your previous policy

***Professional Entity Coverage:***

- ◇ For Professional Entity coverage, submit the Request for Professional Entity Coverage application and include a declaration page for each licensed professional practicing within your professional entity.
- ◇ Proof of coverage for all licensed professionals
- ◇ Proof of coverage for all officers and/or directors

***Supporting Documents:***

- ◇ Using the Past Claim Information Form, provide details of any incidents or claims
- ◇ A written explanation and court or board documents for any disciplinary, sanctioned or probationary action



## ***What you need to know about NCMIC's Professional Liability Insurance Coverage***

**Professional liability insurance coverage is available in two forms: Occurrence Coverage and Claims Made Coverage.**

**Occurrence Coverage** provides coverage for injuries that occur during the policy period regardless of when the claim is reported. Claims may be reported in writing at any time during the active policy period or after the policy expires, is cancelled or non-renewed.

**Claims Made Coverage** provides coverage for incidents that occur and are reported in writing on or after the **retroactive date** of the policy, and before the policy expires, non-renews or was cancelled. Upon cancellation, you have the option to purchase an Extended Reporting Endorsement or "Tail Coverage", which will allow claims to be reported for an indefinite period of time after the policy period is no longer active, as long as the injury occurred on or after the retroactive date and before the policy expired, non-renewed or was cancelled. Note: the Extended Reporting Endorsement may not be available if your policy cancels for non-payment of premium.

The **retroactive date** defines the date coverage begins and after which claims may be reported once your policy is in effect. The retroactive date is stated on the declarations and can be concurrent with the effective date of the policy or a date other than the effective date of the policy, upon which you and we agree coverage will be effective. However, if you purchased an Extended Reporting Endorsement from your current carrier, your prior policy was an **Occurrence** policy or you have had a gap in coverage, the retroactive date will be concurrent with the effective date of the new claims made policy.

If your expiring policy was a **Claims Made** policy, and you now desire an **Occurrence** policy, you have the option to apply for **Prior Acts Coverage**. This will allow claims to be reported for an indefinite period of time after your previous policy is no longer active, as long as the injury occurred on or after the retroactive date that you and we agree on and before your previous policy expired, non-renewed or was cancelled. Your **Occurrence** policy will be made effective the date your previous claims made policy expired, non-renewed or was cancelled and any claims resulting from future injuries will be handled under the terms and conditions of the **Occurrence** policy. Note: your application must be received prior to the cancellation of your previous policy to be eligible for Prior Acts Coverage.

### **Effective Date of Coverage**

Upon approval of your application, your policy effective date may be no earlier than the day your completed application is received by NCMIC. If you choose to fax your application, the earliest effective date will be the day after it is received.

### **Professional Entity Coverage Options**

**Shared Limits:** Provides coverage with shared limits of liability to the professional entity for claims that arise from professional services rendered by the insured listed on the declarations page or any other licensed professionals, other than any M.D. or D.O., that may practice with the professional entity. There is no additional premium charge for this coverage.

**Separate Limits:** Provides coverage with separate limits of liability to the professional entity for claims that arise from professional services rendered by the insured listed on the declarations page or any other licensed professionals, other than any M.D. or D.O., that may practice with the professional entity. An additional premium of 20% of the undiscounted base premium will be applied for this coverage.

**Shared Limits MD/DO Exposure:** Provides coverage with shared limits of liability to the professional entity for claims that arise from professional services or professional medical healthcare services rendered by the insured listed on the declarations page or any other licensed professionals, including any M.D. or D.O., that practices with the professional entity. An additional premium charge will be determined upon receipt and approval of the Supplemental Application for Professional Entity Coverage.

**Separate Limits MD/DO Exposure:** Provides coverage with separate limits of liability to the professional entity for claims that arise from professional services or professional medical healthcare services rendered by the insured listed on the declarations page or any other licensed professionals, including any M.D. or D.O., that practices with the professional entity. An additional premium charge will be determined upon receipt and approval of the Supplemental Application for Professional Entity Coverage.

### **EXCEPTIONS:**

- ◇ Only the separate limits options are allowed in KS.
- ◇ Only shared limits (Sole Practitioner, no employees) and separate limits are available in CT.
- ◇ If participating in the IN Patients' Compensation Fund, only the separate limits options are available.
- ◇ MD/DO coverage is not available in NY.



## Section B - COVERAGE INFORMATION

1. Are you currently insured?  Yes  No

2. If "yes", what is your current type of insurance:  Claims Made  Occurrence  
✓ Please provide a copy of your current/expiring Declarations page showing your retroactive date, policy period and limits of liability.

3. Please provide the following information regarding your professional liability insurance for the past five years:

Insurance Company	Dates of Coverage	Claims Made or Occurrence	Policy Limits	If Claims Made, was Tail purchased?
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Choose an Effective Date: \_\_\_\_\_ Upon approval of your application, your policy effective date can be on or after the day your completed application is received by NCMIC. If you choose to fax your application, the earliest effective date will be the day after it is received.

Claims Made  Occurrence

5. Choose a Coverage Type:

6. If you are applying for CLAIMS MADE coverage, are you requesting retroactive coverage from NCMIC?  Yes  No

7. Choose Limits of Coverage:

Note: Limits of coverage are per incident/aggregate per policy year

\$2 Million/\$4 Million  \$1 Million/\$3 Million  \$500,000/\$1 Million  
 \$250,000/\$750,000  \$200,000/\$600,000  \$100,000/\$300,000

The following are exceptions by state:

Colorado - ONLY limits available:  \$2 Million/\$4 Million  \$1 Million/\$3 Million  \$500,000/\$1.5 Million  
 \$300,000/\$1 Million

Connecticut - ONLY limits available:  \$2 Million/\$4 Million  \$1 Million/\$3 Million  \$500,000/\$1.5 Million

Kansas - ONLY limit available:  \$200,000/\$600,000

New York - Additional limits available:  \$1 Million/\$1 Million

Virginia - Additional limits available:  \$2 Million/\$6 Million  \$1.75 Million/\$3 Million  \$1.5 Million/\$3 Million

## Section C - ADDITIONAL COVERAGES AVAILABLE \*

Please complete all questions. If a question does not apply please select NO. Additional coverage will not be provided if a question is left unanswered.

1. If you are legally certified to perform needle acupuncture, do you want coverage for Needle Acupuncture?  Yes  No  
✓ Please attach a copy of your specialty degree of competence and/or state certification(s).

2. If you are a licensed Acupuncturist, do you want coverage for this exposure?  Yes  No  
✓ If "yes", please attach a copy of your Acupuncture License.

3. If you are legally certified to perform Manipulation Under Anesthesia (MUA), do you want coverage for MUA (maximum limits are \$1 million/\$3 million)?  Yes  No  
✓ Coverage will be subject to approval of a supplemental MUA application.

4. If you are a licensed Naturopath, do you want coverage for this exposure?  Yes  No  
✓ If "yes", please attach a copy of your Naturopathic License.

5. If you are a licensed Physical Therapist, do you want coverage for this exposure?  Yes  No  
✓ If "yes", please attach a copy of your Physical Therapy License.  
(Coverage not available in Massachusetts.)

6. If you are a licensed Massage Therapist, do you want coverage for this exposure?  Yes  No  
✓ If "yes", please attach a copy of your Massage Therapy License.

\* Required supplemental application(s) will be sent to you.

## Section D - PROFESSIONAL EXPERIENCE INFORMATION

✓ If you answer "yes" to any questions in Section D, please outline details of the situation on a separate sheet and provide copies of applicable court or board documents.

1. Have you ever been convicted of, pleaded guilty or no contest to any violation of a law or ordinance other than a minor traffic offense?  Yes  No
2. Have you ever been treated for alcoholism, mental illness or a drug addiction?  Yes  No  
✓ If "yes", please attach a statement from your sponsor/treatment professional and provide treatment completion date: \_\_\_\_\_
3. Do you have health problems or disabilities which might affect your practice of chiropractic?  Yes  No
4. Have you ever been the subject of disciplinary proceedings or reprimanded by an administrative agency, hospital, professional association or the Federal Department of Health and Human Services?  Yes  No
5. Have you ever been declined, cancelled or refused issuance or renewal for malpractice insurance? (MO residents need not respond)  Yes  No  
✓ If "yes", please provide copy of notice.
6. Has your license to practice ever been revoked, suspended or subject to probation?  Yes  No
7. Have you had any malpractice claims in the past 5 years?  Yes  No  
✓ If "yes", please provide details on attached Past Claim Information Form and provide details and loss information from your previous insurance company.
8. Has any claim or suit for alleged sexual misconduct ever been brought against you?  Yes  No  
✓ If "yes", please provide details on attached Past Claim Information Form.
9. Have you reported any incidents or claims to a previous insurance company which have not been resolved?  Yes  No  
✓ If "yes", please provide details on attached Past Claim Information Form.
10. Are you aware of possible malpractice claims that haven't yet been brought against you?  Yes  No  
✓ If "yes", please provide details on attached Past Claim Information Form.

## Section E - PRACTICE INFORMATION

1. Do you currently own your practice?  Yes  No
2. Is your practice set up as a separate professional entity (LLC, PC, S-corp etc.)?  Yes  No  
**IF YOU WOULD LIKE COVERAGE FOR THIS ENTITY, PLEASE COMPLETE THE ATTACHED REQUEST FOR PROFESSIONAL ENTITY COVERAGE.**
3. How many patient visits per week are billed through the patient's insurance? \_\_\_\_\_
4. How many patient visits per week are paid by, or billed to the patient directly? \_\_\_\_\_
5. Do you employ any other licensed Chiropractors?  Yes  No
6. Do you have any other licensed chiropractors in your office who are independent contractors?  Yes  No
7. Do you currently utilize injectables in your practice?  Yes  No

## Section F - BILLING INFORMATION

1. Choose your billing frequency:  Annually  Semi-Annually  Quarterly (Not available in CT)  
 Tri-Annual (CT only)
2. Please answer:  
Would you like your payments charged to your checking or credit card account on each premium due date?  Yes  No  
(You will receive reminder notices approximately 30 days in advance.)
3. Choose your payment type:  
 Check/Checking Account  
 **Please attach a voided check for recurring payments.**  
OR  
 Credit Card (Please complete information below)

<input type="checkbox"/> NCMIC MilesAway <sup>®</sup> Credit Card	<input type="checkbox"/> MasterCard <sup>®</sup>	<input type="checkbox"/> VISA <sup>®</sup>
Credit Card Number: _____		Expires _____ / _____ Month Year
Name as it appears on credit card: _____		
<b>Billing Address:</b>		
_____		
Street		
_____	_____	_____
City	State	Zip
Signature of Cardholder: _____		
(Required for all credit card payments.)		

## Section G - SIGNATURE REQUIRED

By signing below I certify that the information provided above is true to the best of my knowledge and that I will notify NCMIC Insurance Company as soon as possible of any changes to said information. I further certify that I am aware that any misrepresentation could adversely affect my coverage and could result in the cancellation of my policy.

Insurance coverage becomes effective upon approval of the application and issuance of the policy. It is agreed that this form shall be the basis of the contract. Acceptance of the premium does not constitute approval of the application. By signing this application the applicant authorizes the Company to conduct any and all necessary background investigations in support of this application of insurance. Quarterly and semi-annual premium payments are subject to a \$5.00 service charge except in the state of Florida which charges \$3.00.

### For recurring payments through my checking account or credit card:

**Checking Account:** I hereby request and authorize NCMIC to draft my checking account to pay my premium. Drafts will occur on each premium due date via electronic debits, checks or drafts payable to the order of NCMIC. I agree that NCMIC's rights in respect to each draw shall be the same as if it were a check signed by me. This will remain in effect until I notify NCMIC to cease recurring payments. Should my bank account change, it is my responsibility to notify NCMIC.

**Credit Card:** I hereby request and authorize NCMIC to draft my credit card to pay my premium. Charges will occur on each premium due date. The authorization will remain in effect until I notify NCMIC to cease recurring payments. NCMIC will assume my credit card renews on a two year basis and submit charges accordingly. Should my credit card change, it is my responsibility to notify NCMIC.

**For a one-time payment through my checking account or credit card:** I hereby request and authorize NCMIC to draft the checking account or charge the credit card listed above for the current premium due. This authorization is only valid for the current premium due and does not apply to any future payments due.

X

X

Signature

Agent Signature

X

X

Date

Date

For residents of all states except CO, District of Columbia, FL, LA, MD, ME, NJ, NY, OK, TN, VA, WA, WV: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

COLORADO: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

DISTRICT OF COLUMBIA: 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.

FLORIDA: 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.

LOUISIANA and WEST VIRGINIA: Any persons 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.

MAINE, TENNESSEE, VIRGINIA and WASHINGTON: 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.

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

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

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (11 NYCRR 86.4(a)) (parallel citation Regulation 95).

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

Coverage offered by NCMIC Insurance Company.



# NCMIC

*Insurance Company*

## Past Claim Information

Complete this form ONLY if you have had professional liability or professional discipline claims brought against you.

**Please photocopy this form as needed.**

1. Patient's Name: \_\_\_\_\_

Please print clearly

2. Date of incident from which claim or suit resulted or is likely to result: \_\_\_\_\_

3. Date claim was made against you: \_\_\_\_\_

4: Allegations made against you: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Explain, in detail, the specifics of the incident which led to the claim: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Claim filed in: State \_\_\_\_\_ County \_\_\_\_\_

Court \_\_\_\_\_ Claim No. \_\_\_\_\_

Date Closed \_\_\_\_\_ Loss Amount \_\_\_\_\_

8. What insurance company was/is involved? \_\_\_\_\_

9. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claim or suit:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you need additional space for claim information, please check here and include details on a separate sheet.

**X**

Signature

**X**

Date



### GENERAL INFORMATION

Name: \_\_\_\_\_  
Last First Middle Initial

Policy Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip

Office Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Your email address will never be sold. It will be used to send you important messages.

### REQUEST TO ADD EMPLOYEE COVERAGE

- Yes, please add the Employee Endorsement to my policy listed above. I understand there is an additional charge of 10% of my basic premium to add coverage for my chiropractic assistants, nurses, and other unlicensed ancillary staff. This Endorsement will be effective on the day following receipt of this form by NCMIC.
- No, I do not want to add the Employee Endorsement to my policy. I understand there is no coverage under my policy for any employees.

### PLEASE READ, SIGN AND DATE

I understand that unless and until this form is returned to NCMIC Insurance Company electing in favor of the Employee Endorsement, no coverage for my employees is in force.

Also, I have no knowledge of any claims or incidents of potential malpractice which may have occurred that I have not yet reported to any insurance carrier. I attest that this statement is true and correct to the best of my belief.

**X**

\_\_\_\_\_  
Signature

**X**

\_\_\_\_\_  
Agent Signature

**X**

\_\_\_\_\_  
Date

**X**

\_\_\_\_\_  
Date

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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.  
 Coverage offered by NCMIC Insurance Company.

### RETURN THIS FORM

**Mail this form to:**  
 NCMIC Insurance Company  
 P.O. Box 9118  
 Des Moines, IA 50306

**Or fax it to:**  
**1-800-996-2642**

**Questions? Call toll free**  
**1-800-247-8043**

All questions must be answered. If you don't have enough space, please attach a separate sheet of paper. **Coverage will be effective only upon receipt and approval by NCMIC.** Please complete a separate request for each corporation to be insured.

## GENERAL INFORMATION

Name: \_\_\_\_\_  
Last First Middle Initial

Policy Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Practice Phone: \_\_\_\_\_ Practice FAX: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Your email address will never be sold. It will be used to send you important messages.

## PROFESSIONAL ENTITY INFORMATION

**IMPORTANT: In order to activate Professional Entity coverage, all licensed professionals must be insured with at least equal limits of liability.**

Professional Entity Name: \_\_\_\_\_

Federal ID #: \_\_\_\_\_ Date of incorporation: \_\_\_\_\_

Are you the owner or the majority shareholder of this Professional Entity?  Yes  No

Is the purpose of your Professional Entity chiropractic in nature?  Yes  No (If "no", please explain below)

Is your professional entity covered under a general liability policy?  Yes  No

Is your professional entity covered under another partner's policy?  Yes  No (If "yes", please attach that declarations page)

If you are requesting claims made coverage, has your professional entity been covered before?  Yes  No

✓ If "yes" and there is no gap in coverage, please provide a copy of your professional entity's current declarations page.

Do you have a website?  Yes  No

If "yes", what is the website address? \_\_\_\_\_

List all chiropractors, including yourself, and other licensed treating personnel, their designations, with whom they are insured, their limits of liability and their coverage expiration date.

**IMPORTANT: All licensed professionals must have malpractice coverage with equal or greater limits of liability. Please provide proof of coverage.**

Name	Designation	Insurance Company	Limits of Liability	Expiration Date

List the officers and/or directors of the professional entity and their professional designation if applicable.

**IMPORTANT: Chiropractic directors and officers must be insured with NCMIC with equal or greater limits of liability. Coverage will be added to only one policy, most often the professional entity president's policy. Please provide proof of coverage.**

Name	Title	Professional Designation/ Relationship to Insured (if applicable)	% of Ownership

**Continued**

## SELECT YOUR COVERAGE

**THE FOLLOWING ENTITY COVERAGE OPTIONS ARE AVAILABLE - PLEASE INDICATE DESIRED COVERAGE:**

- Shared Limits** - Provides coverage with shared limits of liability to the professional entity for claims that arise from professional services rendered by the insured and any other licensed professionals, other than MDs or DOs.
- Separate Limits** - Provides coverage with separate limits of liability to the professional entity for claims that arise from professional services rendered by the insured and any other licensed professionals, other than MDs or DOs. An additional premium of 20% of the undiscounted base premium will be applied for this coverage.
- Shared Limits - MD/DO exposure** - Provides coverage with shared limits of liability to the professional entity for claims that arise from professional medical healthcare services rendered by the insured and any other licensed professionals, including MDs or DOs. An additional premium will be applied for this coverage.
- Separate Limits - MD/DO exposure** - Provides coverage with separate limits of liability to the professional entity for claims that arise from professional medical healthcare services rendered by the insured and any other licensed professionals, including MDs or DOs. An additional premium will be applied for this coverage.

### EXCEPTIONS

- CT - Only Shared Limits (Sole Practitioner, no employees) and Separate Limits are available.
- IN - If participating in the IN Patient's Compensation Fund only Separate Limits are available.
- KS - Only Separate Limits are allowed.
- NY - MD/DO coverage is not available.

## PLEASE SIGN and DATE

All of the information provided within this request for Professional Entity coverage is true and accurate to the best of my knowledge and belief.

**X**

\_\_\_\_\_  
Signature

**X**

\_\_\_\_\_  
Date

**X**

\_\_\_\_\_  
Agent Signature

**X**

\_\_\_\_\_  
Date

For residents of all states except CO, District of Columbia, FL, LA, MD, ME, NJ, NY, OK, TN, VA, WA, WV: 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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

COLORADO: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

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Coverage offered by NCMIC Insurance Company.

## RETURN THIS FORM

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NCMIC Insurance Company  
P.O. Box 9118  
Des Moines, IA 50306

### Or fax it to:

**1-800-996-2642**

### Questions? Call toll free

**1-800-247-8043**

# KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM (May 2009)

Kansas law requires the insurance company to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium. A copy of this completed form must also be furnished to the health care provider.

FOR HCSF USE ONLY

## SECTION I Individual Health Care Provider's Name, designation of M.D., D.O., D.C., D.P.M. or R.N.A. or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization).

Health Care Provider's Name \_\_\_\_\_  
LAST NAME (OR FULL NAME OF HEALTH CARE PROVIDER ENTITY), FIRST NAME, MIDDLE INITIAL AND PROFESSIONAL DESIGNATION

Residence Address: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Address Of Health Care Provider: \_\_\_\_\_

## SECTION II Coverage Limit Selection -First time Health Care Provider Signature Required.

\$100,000/\$300,000       \$300,000/\$900,000       \$800,000/\$2,400,000

\_\_\_\_\_ Date Signed      \_\_\_\_\_ Health Care Provider Signature

**NOTE: FUND LIMITS CANNOT BE INCREASED USING THIS FORM. ALL INCREASES MUST BE APPROVED BY THE BOARD OF GOVERNORS. CONTACT THE HCSF OFFICE FOR THE NECESSARY DOCUMENTS.**

## SECTION III Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

HCSF Rate Classification Number	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No.	For Fund Classes 1 to 14	For Fund Classes 15 to 21	
					HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment

NAME OF INSURANCE COMPANY

NAME OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

TELEPHONE NUMBER AND E'MAIL ADDRESS OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

- THE POLICY IS SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS \_\_\_\_\_%
- THIS KANSAS RESIDENT HEALTH CARE PROVIDER HAS AN ACTIVE MISSOURI LICENSE AND THE 25% MODIFICATION FACTOR WAS INCLUDED IN THE ABOVE SURCHARGE.

### Type of Basic Coverage Professional Liability Policy

Occurrence       Claims Made

Policy Number: \_\_\_\_\_

Inception Date: \_\_\_\_\_  
OF THE BASIC PROFESSIONAL LIABILITY INSURANCE POLICY PERIOD

Coverage Effective Date: \_\_\_\_\_  
ENTER DATE THIS HEALTH CARE PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

Expiration Date: \_\_\_\_\_  
OF THE BASIC PROFESSIONAL LAIBILITY INSURANCE POLICY PERIOD

FOR HCSF USE ONLY

Notice to Health Care Provider: If you should discontinue your basic professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of Governors and request information regarding the availability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.

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