



**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or "Tail Coverage", which will allow claims to be reported for an indefinite period of time after the policy period is no longer active, as long as the injury occurred on or after the retroactive date and before the policy expired, non-renewed or was cancelled.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.

Prospect Number: \_\_\_\_\_

Return this form and down payment by: **MAIL: NCMIC Insurance Company, P.O. Box 9118, Des Moines, IA 50306**  
**FAX: 1-800-996-2642 or EMAIL: submissions@ncmic.com**  
 Questions? Call toll-free 1-800-247-8043

To help with timely approval of your request for coverage, please complete all questions and provide any additional requested documentation as indicated. If information is not complete, coverage approval may be delayed or rejected. If your answer to any question is "NONE" or "NOT APPLICABLE", please write "N/A".

## Section A - GENERAL INFORMATION

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

2. Have you ever been insured with NCMIC?  YES  NO

a. If "yes" and under a different name, specify previous name:

\_\_\_\_\_ Last First Middle Initial

3. Social Security Number: \_\_\_\_\_ 4. Date of Birth: \_\_\_\_\_

5. Gender:  Male  Female

6. Name of Practice: \_\_\_\_\_

7. Primary Practice Address:  
(Not a P.O. Box)

\_\_\_\_\_ Street \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State  Zip  
Must have State's County

8. Home Street Address:  
(Not a P.O. Box)

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

9. Billing Address:  
 \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

10. Where would you like mail sent?  Practice Address  Home Address  Billing Address

11. Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

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

## Section B - EDUCATION AND LICENSURE INFORMATION

1. Name of Chiropractic College Attended: \_\_\_\_\_

2. Graduation Date: \_\_\_\_\_ Original License Date: \_\_\_\_\_  
Month / Year Month / Year

3. License Information: **(Please attach a copy of each active license you hold.)**

State	License Number	License Issue Date	% of Practice in this State

## Section C - COVERAGE INFORMATION

1. Are you currently insured?  Yes  No  
 ✓ Please provide a copy of your current/expiring Declarations page showing your retroactive date, policy period and limits of liability.
2. Please provide the following information regarding your professional liability insurance for the past five years:

Insurance Company	Effective Date	Expiration Date	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
					<input type="checkbox"/> Yes <input type="checkbox"/> No

3. 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 submit your application online, by email, or by fax, the earliest effective date will be the day after it is received.
4. Choose a Coverage Type:  Claims Made  Occurrence
5. If CLAIMS MADE, are you requesting retroactive coverage from NCMIC?  Yes  No
6. 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:**

<b>Colorado</b> ONLY limits available <input type="checkbox"/> \$2 Million/\$4 Million <input type="checkbox"/> \$1 Million/\$3 Million <input type="checkbox"/> \$500,000/\$1.5 Million <input type="checkbox"/> \$300,000/\$1 Million	<b>Connecticut</b> ONLY limits available <input type="checkbox"/> \$2 Million/\$4 Million <input type="checkbox"/> \$1 Million/\$3 Million <input type="checkbox"/> \$500,000/\$1.5 Million	<b>Kansas</b> ONLY limit available: <input type="checkbox"/> \$200,000/\$600,000 <hr/> <b>New York</b> Additional limits available <input type="checkbox"/> \$1 Million/\$1 Million	<b>Virginia</b> Additional limits available <input type="checkbox"/> \$2.05 Million/\$6.15 Million <input type="checkbox"/> \$2 Million/\$6 Million <input type="checkbox"/> \$1.75 Million/\$3 Million <input type="checkbox"/> \$1.5 Million/\$3 Million
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## Section D - 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 or a licensed Acupuncturist, do you want coverage for this exposure?  Yes  No  
 ✓ If yes, please attach a copy of your specialty degree of competence and/or state certification(s).
2. If you are legally certified to perform Manipulation Under Anesthesia (MUA), do you want coverage for this exposure (maximum limits are \$1 million/\$3 million)?  Yes  No  
 ✓ Coverage will be subject to approval of a supplemental MUA application.
3. 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.
4. 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.)
5. 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.

**\* If you answered "YES" to any of the above, the required supplemental application(s) will be sent to you.**

## Section E - PROFESSIONAL EXPERIENCE INFORMATION

If you answer "YES" to any questions below, please outline details of the situation on a separate sheet and provide copies of applicable court, board or agency 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/Incident Information Form.
8. 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/Incident Information Form.
9. Are you aware of possible malpractice claims, suits or regulatory agency investigations that haven't yet been brought against you?  Yes  No  
✓ If "yes", please provide details on attached Past Claim/Incident Information Form.
10. 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/Incident Information Form.

## Section F - PRACTICE INFORMATION

Please complete all questions. If a question does not apply or additional coverage is not requested, please select "NO".

1. Do you currently own your practice?  Yes  No  
✓ If "yes", 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, YOU MUST COMPLETE THE ATTACHED REQUEST FOR PROFESSIONAL ENTITY COVERAGE.**

2. How many hours per week are professional services provided to patients in your office? \_\_\_\_\_  
Professional Services include examination, consultation and adjustment as well as any time the patient spends with a chiropractic assistant or massage therapist.
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

**Section G - SIGNATURE REQUIRED**

By signing below I certify that the aforementioned statements and answers are 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.

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 where the charge is \$3.00.

**For residents of all states except AR, 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.

**Arkansas, 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.

**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.

**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.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, 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, shall be sanctioned for each violation with the penalty of 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 imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Coverage offered by NCMIC Insurance Company.

**X** \_\_\_\_\_  
Signature

**X** \_\_\_\_\_  
Date

**X** \_\_\_\_\_  
Agent Signature

**X** \_\_\_\_\_  
Date

**PLEASE NOTE:** This billing information form must be completed and signed prior to policy issuance and valid payment received before coverage is in force.

- Applicant's Name: \_\_\_\_\_  
Last First Middle Initial
- Choose your billing frequency:  Annually  Semi-Annually  Quarterly  Tri-Annual  
(N/A in CT) (CT only)
- Select your payment method:  Bank Account  Credit / Debit Card
- Would you like your payments charged to your bank or credit/debit card account on each premium due date? (You will receive reminder notices approximately 30 days in advance.)  Yes  No

**Please complete the requested payment information below.**

**BANK ACCOUNT INFORMATION**

Bank Name: \_\_\_\_\_

ABA / Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Name as it appears on the account: \_\_\_\_\_

**Accountholder Address:**

Street \_\_\_\_\_

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

**CREDIT / DEBIT CARD INFORMATION**

NCMIC MilesAway® Credit Card  MasterCard®  VISA®

Card Number: \_\_\_\_\_ Expires \_\_\_\_\_ / \_\_\_\_\_  
Month Year

Name as it appears on card: \_\_\_\_\_

**Billing Address:**

Street \_\_\_\_\_

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

Signature of Cardholder: \_\_\_\_\_  
(Required for all credit card payments.)

**PLEASE READ, SIGN AND DATE for all payment methods**

**For recurring payments through my bank account or credit/debit card:**

**Bank Account:** I hereby request and authorize NCMIC to draft my bank 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/Debit Card:** I hereby request and authorize NCMIC to draft my credit/debit 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/debit card renews on a two year basis and submit charges accordingly. Should my credit/debit card change, it is my responsibility to notify NCMIC.

**For one-time payment:** I acknowledge that I am the accountholder or have authorization to use this bank account or credit/debit card for one-time payment. I hereby request and authorize NCMIC to draft this bank account or charge the credit/debit 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**

Authorized Signature

**X**

Date

Complete this form for EACH professional liability claim/incident, professional discipline claim/incident or Medicare/CMS or Medicaid billing audit in the past 5 years. **Please make copies of this form as needed (each claim/incident requires an individual form).**

1. Doctor's Name: \_\_\_\_\_  
Last First Middle Initial

2. Patient's Name: \_\_\_\_\_  
Please print clearly

3. Date of incident from which claim, suit or regulatory agency investigation resulted or is likely to result: \_\_\_\_\_

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

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

6. Did the incident result in a claim or regulatory agency investigation against you?  Yes  No  
**If "YES", please complete questions 7 - 12**

7. Date claim or regulatory agency investigation was commenced: \_\_\_\_\_

8. Present status or disposition of claim or regulatory agency investigation including amount reserved or amount of settlement or judgment, if any: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Please provide the following information regarding where the claim or regulatory agency investigation commenced.

State \_\_\_\_\_ County \_\_\_\_\_

Court / Agency \_\_\_\_\_ Case Number \_\_\_\_\_

10. Is the claim or regulatory agency investigation open or closed?  Open  Closed  
**If "CLOSED", please provide the following information**

Date Closed \_\_\_\_\_ Loss Amount or Fine Paid \_\_\_\_\_

11. What insurance company was/is involved? \_\_\_\_\_  
**Please attach loss history information from previous insurance company at time of claim or regulatory agency investigation.**

12. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claim, suit or regulatory agency investigation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**X**

\_\_\_\_\_  
 Signature

**X**

\_\_\_\_\_  
 Date

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

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

2. Policy Number: \_\_\_\_\_

3. Mailing Address: \_\_\_\_\_  
Street City NY State Zip

4. Office Phone: \_\_\_\_\_ 5. FAX: \_\_\_\_\_

6. Home/Cell Phone: \_\_\_\_\_ 7. 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.**

1. Professional Entity Name: \_\_\_\_\_

2. Type of Professional Entity:  LLC  LLP  PC  S-Corp  Other: \_\_\_\_\_

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

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

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

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

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

8. 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.**

9. Do you have a website?  Yes  No  
**If "yes", what is the website address?** \_\_\_\_\_

10. Are there other licensed professionals practicing in this entity/office other than yourself?  Yes  No  
**If "yes", please provide the requested information for each licensed individual in your office.**  
**IMPORTANT: All licensed professionals must have malpractice coverage with equal or greater limits of liability.**

Name	Designation	Insurance Company	Limits of Liability	Expiration Date

**Please provide a declarations page for each individual listed above.**

11. Are there other owners, officers and/or directors of the professional entity other than yourself?  Yes  No  
**If "yes", please provide the requested information for yourself and each officer and/or director of the professional entity.**  
**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

**Please provide a declarations page for each individual listed above. Continued**

## SELECT YOUR COVERAGE, SIGN and DATE

**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.

By signing below I certify that the aforementioned statements and answers are 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.

**For residents of all states except AR, 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. **Arkansas, Louisiana and West Virginia:** 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. **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. **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). **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, 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, shall be sanctioned for each violation with the penalty of 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 imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**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.

<p><b>X</b> _____ Signature</p> <p><b>X</b> _____ Agent Signature</p>	<p><b>X</b> _____ Date</p> <p><b>X</b> _____ Date</p>
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<b>Mail:</b> NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	<b>Fax:</b> <b>1-800-996-2642</b>	<b>Or Email:</b> <b>submissions@ncmic.com</b>	<b>Questions? Call toll free</b> <b>1-800-247-8043</b>
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