



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or "Tail Coverage", which will allow claims to be reported for an indefinite period of time after the policy period is no longer active, as long as the injury occurred on or after the retroactive date and before the policy expired, non-renewed or was cancelled.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 page 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 or email 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 Request 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 Request 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 Address
 _____ City State Zip
LA State Must have State's County

8. Home Address:
(Not a P.O. Box) _____ Street Address City State Zip

9. Where would you like to receive your billing? Practice Address Home Address Other Address
 If other, please provide Billing Address:

_____ Street Address City State Zip

10. Where would you like to receive policy-related mailings? Practice Address Home Address Billing Address

11. Office Phone: _____ Fax: _____ Home/Cell Phone: _____

12. Email: _____ Website: _____
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. Original License Date: _____ Graduation Date: _____
Month / Year Month / Year

3. Please complete the information for each state license held. (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
 ✓ If "yes", please attach a copy of your current/expiring Declarations page.
2. Have you had professional liability insurance within the last five years? Yes No
 ✓ If "yes", please provide professional liability coverage information for the past five years (in chronological order).

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 Type of Coverage: 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:

Colorado 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	Connecticut 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	Kansas ONLY limit available: <input type="checkbox"/> \$200,000/\$600,000 <hr/> Rhode Island ONLY limits available <input type="checkbox"/> \$2 Million/\$4 Million <input type="checkbox"/> \$1 Million/\$3 Million	Virginia Additional limits available <input type="checkbox"/> \$2.25 Million/\$6.75 Million <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
 ✓ If "yes", please attach a copy of your MUA certification(s).
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 questions, the required supplemental application(s) will be sent to you and coverage will be subject to approval.**

Section E - PROFESSIONAL EXPERIENCE INFORMATION

If you answer "YES" to questions 1-6 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 provide treatment completion date: _____.
Provide details and attach a statement from your sponsor/treatment professional.
 3. Do you have health problems or disabilities which might affect your practice of chiropractic? Yes No
✓ If "yes", please provide a brief description on a separate sheet of paper.
 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
✓ If "yes", please provide a brief description on a separate sheet of paper.
 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 a brief description and attach a copy of notice.
 6. Has your license to practice ever been revoked, suspended or subject to probation? Yes No
✓ If "yes", please provide a brief description and attach board documents.
 7. Have you had any malpractice claims in the past 5 years? Yes No
 8. Have you reported any incidents or claims to a previous insurance company which have not been resolved? Yes No
 9. Are you aware of possible malpractice claims, suits or regulatory agency investigations that haven't yet been brought against you? Yes No
 10. Has any claim or suit for alleged sexual misconduct ever been brought against you? Yes No
- If "yes" to questions 7-10, please complete a Past Claim/Incident Information Form for each claim/incident.**

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
2. Would you like to apply for Professional Entity Coverage? Yes No
✓ If "yes", you must complete the attached Request for Professional Entity Coverage for each entity.
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. How many hours per week are you available for patient appointments or walk-ins? _____
6. Do you employ any other licensed Chiropractors? Yes No
7. Do you have any other licensed chiropractors in your office who are independent contractors? Yes No
8. Do you currently utilize injectables in your practice? Yes No

Section G - SIGNATURE REQUIRED

By signing this application 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.

For residents of all states except AL, AR, CO, LA, MD, ME, NJ, NY, OK, TN, VA, WA, WV and District of Columbia and Puerto Rico: 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.

Alabama, 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.

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

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.

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.

1. Applicant's Name: _____
Last First Middle Initial

2. Choose your billing frequency: Annually Semi-Annually Quarterly Tri-Annual
(N/A in CT) (CT only)

3. Select your payment method: Bank Account Credit / Debit Card

4. Would you like to have this premium payment and future premium payments automatically charged to this account on each premium due date? Yes No

(You will receive reminder notices approximately 30 days in advance.)

• If NO, the payment information below will be used for a one-time payment.

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

Card Type: 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 charge 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 a 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 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 claim information, please check here and include details on a separate sheet.

X _____ **X** _____
 Signature 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 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 equal or greater limits of liability.

1. Professional Entity Name: _____
2. Practice Address: _____
Street City State Zip
3. Type of Professional Entity: LLC LLP PC S-Corp Other: _____
4. Federal Tax ID #: _____ Date of incorporation: _____
5. Are you the owner or the majority shareholder of this Professional Entity? Yes No
6. Is the purpose of your Professional Entity chiropractic in nature? Yes No (If "no", please provide explanation)
7. Is your professional entity covered under a general liability policy? Yes No
8. Is your professional entity covered under another partner's policy? Yes No (If "yes", please attach a copy of partner's declarations page)
9. 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.
10. Do you have a website? Yes No
If "yes", what is the website address? _____
11. 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 attach a declarations page for each licensed individual listed above.

12. 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 attach 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 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

- 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 this application 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 AL, AR, CO, LA, MD, ME, NJ, NY, OK, TN, VA, WA, WV and District of Columbia and Puerto Rico: 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. **Alabama, 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. **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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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>X _____ Signature</p>	<p>X _____ Date</p>
<p>X _____ Agent Signature</p>	<p>X _____ Date</p>

RETURN THIS FORM BY MAIL, FAX OR EMAIL

Mail: NCMIC Insurance Company P.O. Box 9118 Des Moines, IA 50306	Fax: 1-800-996-2642	Email: submissions@ncmic.com	Questions? Call toll free 1-800-247-8043
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*****CLAIMS-MADE POLICY:**

Your primary insurance policy provides CLAIMS MADE coverage for professional liability. Except to the extent as may otherwise be specifically provided in your policy, such primary coverage is limited to claims arising from medical incidents occurring on or after the initial effective date stated in the declarations ("retroactive date") and first reported to your company while the policy is in force. HOWEVER, THE PCF RETROACTIVE DATE IS THE DATE OF YOUR QUALIFICATION WITH THE FUND, WHICH MAY OR MAY NOT MATCH THE RETROACTIVE DATE ESTABLISHED ON YOUR PRIMARY POLICY. Claims occurring prior to the qualification date with the Fund, REGARDLESS OF THEIR COVERAGE THROUGH YOUR PRIMARY POLICY, are not covered by the Fund.

The above indicated insurance company hereby certifies limits of liability, on behalf of the Health Care Provider referenced above, of not less than One Hundred Thousand (\$100,000.00) Dollars for each claims against said Health Care Provider during the policy term as a result of medical malpractice or allegations thereof. The Insurance Company further certifies that said policy of insurance complies in all respects with the provisions regarding financial responsibility of health care providers as set forth in La. R.S.40:1299.41 et seq.

It is further certified that Agent of said company agrees to remit the required surcharge amount for coverage excess of primary limits to the Louisiana Patients' Compensation Fund, as set further in La.R.S. 40:1299.44 A. (3).

It is further acknowledged that in the event of termination of policy herein, or any endorsed reduction of liability limits, such termination or change shall not be effective unless such notice of the same has been delivered to the Louisiana Patients' Compensation Fund not less than thirty (30) days prior to such change. Notice shall be considered to have been given upon placing same in the United States Mail by First Class Mail, a copy of which shall have been mailed to the Health Care Provider.



800-247-8043

Date

Signature & Phone Number of Authorized Representative
Not valid Unless Signed by a Duly Authorized Representative

PART 3: LOUISIANA PATIENTS' COMPENSATION FUND

It is agreed that the insured under the above primary limits has been advised by the Company's Agent:

(1) that he or she is eligible to qualify for coverage under the Louisiana Patients' Compensation Fund for the provisions of La. R.S. 10:1299.41 et seq., as a "health care provider" that is already carrying underlying malpractice liability coverage at limits of \$100,000/\$300,000 or more:

(2) that to qualify, the insured undertakes to pay the required surcharge, and this surcharge will be collected by the Company's Agent and remitted to the Fund on a calendar-year basis; and

(3) that if qualified, the insured is entitled to a \$500,000 limitation of malpractice liability for death, or injury to any person and to coverage under that Fund for an excess liability (over the minimum underlying limits required by the Fund) up to a per claim limit of \$500,000.

(4) COST AND RESERVE REPORTING REQUIREMENTS:

By the signature below, I acknowledge and agree that the Patients' Compensation Fund has hereby given notice to the Insured of the cost and reserve reporting requirements set forth in LAC 37:III, §§1101-1105.

(5) CLAIMS MADE PRIMARY POLICIES ONLY:

I understand that, regardless of the retroactive date established by my primary policy, I will only receive coverage through the Fund for claims which occur after my qualification with the Fund. For a claim to be covered by the Patients' Compensation Fund, I must have been qualified with the Fund both at the time the medical incident occurred, and at the time the claim was filed with my primary carrier.

I wish to qualify for coverage under the provisions of La. R.S. 40:1299.41 et seq. I am therefore returning a copy of this statement to my insuring company, NCMIC INSURANCE COMPANY and/or agent _____, with a check for _____ payable to the Louisiana Patients' Compensation Fund.

**TO: LOUISIANA PATIENT'S COMPENSATION FUND
P. O. BOX 3718
BATON ROUGE, LA 70821**

Date

Signature of Insured
NOT VALID WITHOUT SIGNATURE

This endorsement is subject to all agreements, conditions and exclusions of the policy unless such agreements, conditions and exclusions are expressly eliminated hereby.

**LOUISIANA PATIENT'S COMPENSATION FUND
CORPORATION APPLICATION**

(for those with underlying self-insurance and primary insurance)

NAME AND PHYSICAL ADDRESS OF CORPORATION

(Please designate whether it is APMC, AMC APC, INC, LLC, LLP, etc.)

**LIST ALL LOUISIANA HEALTH CARE PROVIDERS WHO ARE ELIGIBLE FOR ENROLLMENT BY
PAYMENT OF A SURCHARGE IN ACCORDANCE WITH THE PCF RATE MANUAL.**

**THIS INCLUDES THOSE WHO ARE EMPLOYED BY/AT THE ABOVE CORPORATION AND ANY
ADDITIONAL LOCATIONS IN LOUISIANA OR HEALTH CARE FACILITIES IN LOUISIANA OWNED BY
THE CORPORATION TO BE INCLUDED IN THE CORPORATE COVERAGE WITH THE PCF:**

NOTE:

No charge will be made to cover such entity if all shareholders/partners and professional employees are qualified with the PCF. Otherwise a charge of 20% of each class rate will be made for shareholders/partners and employees not qualified in the PCF. A separate Certificate of Insurance is required that lists all enrolled health care providers in the Corporation/Partnership.

Does the corporation own other health care related facilities outside of LA (Please note that this is for informational purposes only and that the PCF cannot provide coverage for healthcare facilities outside of LA)?

YES / NO please circle

If yes, in what states? _____

I further certify that the appropriate security (proof of financial responsibility) is in place and current at

_____ .

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

CONTACT PERSON AND PHONE #: _____

DO NOT WRITE BELOW THIS LINE

SURCHARGE AMOUNT RECEIVED: _____ EFFECTIVE: _____

FORM/AMOUNT OF SECURITY DEPOSIT RENDERED: _____