NCMIC
Insurance Company

Request for Extern Malpractice Coverage

Please complete all information below. Along with this application, send a letter from your state licensing board or college showing that you are involved in the Extern Program.
Supervising ND must be insured with NCMIC.
Limits of liability will be shared with the supervising ND's limit; a separate limit does not apply.
Premium must be received in full before the policy can become effective. Premium is 10% of the base rate.
Coverage will be effective only upon receipt of your Request for Coverage and approval by NCMIC.

1. PLEASE TELL US ABOUT YOURSELF

Applicant Name: _____
LAST FIRST MIDDLE INITIAL

Mailing Address: _____
STREET

_____
CITY STATE COUNTY ZIP

Social Security Number: _____ ☐ Male ☐ Female

Date of Birth: _____ / _____ / _____ Date of Graduation: _____ / _____ / _____

Naturopathic College Attended: _____

Proposed Effective Date *(Date the application is received at NCMIC or later if specified)*: _____ / _____ / _____

Email Address: _____
Your e-mail address will never be sold. It will be used to send you important notices.

2. PRACTICE INFORMATION

Name of Supervising Doctor: _____
LAST FIRST MIDDLE INITIAL

Practice Address: _____
STREET

_____
CITY STATE COUNTY ZIP

Practice Phone No: (_____) _____ Fax No: (_____) _____

3. PLEASE SIGN, DATE AND RETURN

I understand that I am limited to practice at the office of the above mentioned supervising doctor and must be directly under the supervision of the ND. Coverage will be null and void on the earliest of the following: (1) Termination of extern program; (2) Licensure; (3) One year from the effective date of the extern policy.

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 is a crime and subjects the person to criminal and civil penalties. Insurance coverage becomes effective upon approval of the application. It is agreed that this form shall be the basis of the contract. Acceptance of the premium does not constitute approval of the application. The foregoing answers are complete and correct to the best of my knowledge and belief. By signing this application the applicant authorizes the Company to conduct any and all necessary background investigations in support of this application of insurance.

X _____ X _____
SIGNATURE DATE

X _____ X _____
AGENT SIGNATURE DATE

Please mail or fax this completed form to:
NCMIC Insurance Company, P.O. Box 9118, Des Moines, IA 50306 ▪ FAX: 1-800-996-2642