

RETIRED VOLUNTEER HEALTHCARE PROFESSIONAL APPLICATION

- Medical Mutual Insurance Company of North Carolina
 - Medical Security Insurance Company
- (both hereinafter referred to as the "Company")

Answer all questions which apply to your practice. Coverage will not be considered until this application is fully completed and all necessary documents have been received.

(Please TYPE or PRINT in black ink.)

I. GENERAL INFORMATION

Applicant Name (last, first, middle, designation)			Date of Birth (mm/dd/yy)	
Mailing Address	City	State	Zip Code	County
NC Medical License Number	State	Expiration Date	Status	
Medical Specialty	Sub-specialty			
Board Certification (Name of Board)			Exp. Date	

1. Desired Policy Effective Date: _____
Note: The only limits of liability available under the Retired Volunteer Healthcare Professional Program are \$1,000,000 each incident/\$3,000,000 annual aggregate.
2. Total number of hours spent each month in a professional capacity as a healthcare professional volunteer: _____ hours
3. Name and address of volunteer location _____

4. Duties at the volunteer location _____
5. Date officially retired from the practice of medicine: _____
6. Number of hours of continuing education completed within the past two years: _____ hours
7. Is all the work you provide in a professional capacity as a healthcare professional done without remuneration? Yes No
8. Are you performing obstetrical, prenatal, invasive, or surgical procedures? Yes No

II. PERSONAL AND INSURANCE HISTORY

9. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location?
 No Yes - Explain: _____
10. Have you ever been or are you currently under a "consent order"? No Yes - Attach copy

II. PERSONAL AND INSURANCE HISTORY (continued)

11. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment? No Yes – Explain and provide dates and locations of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

12. Have you ever been questioned, investigated, or requested to appear before any of the following:

A. A state licensing board or equivalent? Yes No

B. A specialty or medical association? Yes No

C. A Medicare/Medicaid agency? Yes No

D. Other? Yes No

If “Yes”- Explain: _____

13. Have you ever been charged with any criminal activity?
No Yes - Explain: _____

14. Has any claim or suit for alleged sexual misconduct ever been brought against you?
No Yes - Explain: _____

15. Has your professional liability insurance ever been surcharged, written with a deductible or written in a non-standard market?
No Yes - Explain: _____

16. Provide the following information regarding your professional liability insurance for the most recent five (5) years. Use additional sheet if necessary:

	First Prior Carrier	Second Prior Carrier	Third Prior Carrier	Fourth Prior Carrier	Fifth Prior Carrier
Insurance Company					
Policy Number					
Policy Period					

III. CLAIMS HISTORY

17. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? No Yes
18. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? No Yes

If "Yes" to 17 or 18 above, please complete the following for each such circumstance. If you need more space, attach additional sheet.

CLAIM, SUIT OR INCIDENT

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence
Date Claim reported: <input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed: <input type="checkbox"/> N/A	Amount paid on your behalf \$

Allegation(s):

IV. AUTHORIZATION AND RELEASE

I understand that this is an application and is not an insurance binder and acknowledge that the foregoing statements and answers are complete and correct to the best of my knowledge and belief. I further understand that an incorrect or incomplete response could void my protection if coverage is written as a result of this application.

I, the undersigned Applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the Company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

Signature of Retired Volunteer Healthcare Professional Applicant

Date