



Medical Mutual™
PROTECTING OUR PROFESSION

For Office Use Only:

RETIRED VOLUNTEER HEALTHCARE PROFESSIONAL APPLICATION
Non-Assessable Claims-Made Coverage
(Please type or print in black ink.)

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.

If not previously insured with Medical Mutual, please complete the Medical Practitioners Professional Liability Application.

I. GENERAL INFORMATION

Applicant Name (first, middle, last, designation)				Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female					
Mailing Address		City	State	Zip Code	County
Medical License Number	State	Expiration Date		Status	
Medical Specialty			Sub-specialty		
E-mail Address				Telephone Number	

II. PERSONAL AND INSURANCE HISTORY

- 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.
- Total number of hours spent each month in a professional capacity as a healthcare professional volunteer: _____ hours
- Name and address of volunteer location _____

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

II. PERSONAL AND INSURANCE HISTORY (continued)

9. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location?
 Yes No If yes, please explain: _____
10. Have you ever been or are you currently under a "consent order"? Yes- Attach copy No
11. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment? Yes No
 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 felony criminal activity?
 Yes No If yes, please explain: _____
14. Has any claim or suit for alleged sexual misconduct ever been brought against you?
 Yes No If yes, please explain: _____
15. Has your professional liability insurance ever been surcharged, written with a deductible or written in a non-standard market?
 Yes No If yes, please 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					

II. PERSONAL AND INSURANCE HISTORY (continued)

- 17. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? Yes No
- 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? Yes No

If "Yes" to 17 or 18 above and within the last 10 years, please complete the following for each such circumstance. If you need more space, attach additional sheet.

III. CLAIMS HISTORY

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. I certify the representations in this application to be true and understand that the policy if issued, is conditioned upon the truth of the representations in this application. I further understand that the falsity of any representations made in this application for insurance could cause the denial of a claim or the cancellation of 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

NOTICE TO APPLICANTS: 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 subjects such person to criminal and civil penalties.

If not previously insured with Medical Mutual, please complete the Medical Practitioners Professional Liability Application.