NEVADA MUTUAL INSURANCE COMPANY

PHYSICIANS AND SURGEONS SUPPLEMENTAL APPLICATION FOR PROFESSIONAL CORPORATIONS, ASSOCIATIONS

PHYSICIANS AND SURGEONS SUPPLEMENTAL APPLICATION FOR PROFESSIONAL CORPORATIONS, ASSOCIATIONS

1) Name of Entity: _____ Quote/Policy No.: _____

2) Entity Business Address: _____

City:_____ NV Zip: _____ County: _____

3) Is coverage desired for the entity? ☐Yes ☐No

4) If so, effective date of coverage:_____

5) Current form of insurance: ☐Claims Made ☐Occurrence

6) Current carrier:_____

7) Did you purchase a reporting endorsement from your current carrier? ☐Yes ☐No

8) Are you applying for prior acts coverage from NMIC? ☐Yes ☐No

9) Retroactive date used by your current carrier for the entity:_____
(Attach a copy of the current coverage summary or certificate of insurance).

10) Is a separate limit of liability desired for the entity? ☐Yes ☐No

11) Type of practice (Please Describe)
☐Multi-Shareholder Corp. ☐Partnership ☐Corporation ☐Other

12) Description of operations:

☐Private Doctor's Office
☐Physician Owned and Operated Lab
Used for Other than Doctor/Owner Patients
☐Surgi Center
☐Urgent Care Facility
☐Other (Please describe)

☐Community Clinic – Not For Profit
☐Birthing Center
☐Family Planning Clinic
☐Abortion Clinic
☐HMO/PPO

_____
_____
_____

13) Number of Owners:_____or Number of Partners: _____

14) Are all owners or partners involved with NMIC: ☐Yes ☐No

15) Employed or contracted physicians/surgeons of the entity (Additional space on Supplemental Information Form if necessary)

Name	Policy No.	Specialty	Techniques or Procedures Performed	Current Carrier	Limit of Liability

16) Number of employed or contracted physician assistants and surgeon assistants: _____

17) Number of employed or contracted nurse anesthetists: _____

18) Number of employed or contracted nurse midwives: _____

19) Number of employed or contracted nurse practitioners: _____

20) Furnish on the attached supplemental page a list of all other professional employees and independent contractors of the entity and their professional occupation (i.e., RN, LPN, etc.)

Please fully explain all 'Yes" responses on the attached supplemental form.

21) Are all professionals indicated in questions #15 and 20 required to carry professional liability insurance with $1 million/$3 million limits? ☐Yes ☐No

22) Does this entity perform utilization review for a fee for others? ☐Yes ☐No

23) Is this entity currently under contract to supervise any departments within a hospital or other facility, for an HMO or PPO, or any government agency or program? ☐Yes ☐No

24) Is this entity eligible to be licensed to provide medical professional services? ☐Yes ☐No

25) Has a Nevada State license been granted for this entity? ☐Yes ☐No

26) Has this entity's license ever been suspended, restricted, revoked, or surrendered or has probation ever been invoked? ☐Yes ☐No

27) Have any claims or suits ever been made or brought against your entity? ☐Yes ☐No

28) Do you have knowledge of any claims which might be made against this entity or activities that might give rise to a claim or suit in the future (Include any request for medical records) ☐Yes ☐No

29) Does your entity engage in any direct supervision of the anesthesiologists? ☐Yes ☐No
If yes, describe the scope of supervision.

30) Does your entity service contracts on behalf of any employed physicians? ☐Yes ☐No
If yes, provide a copy of these contracts.

31) Do you supervise any non-employed CRNA's? ☐Yes ☐No
If yes, please provide details.

_____

_____

Signing this information supplement does not bind Nevada Mutual Insurance Company to complete the insurance. All information requested in this supplement is considered material and important. If NMIC agrees to be bound under the terms of this supplement, your policy is void if you hide any information deemed important by us, mislead us, or attempt to defraud or lie to us about any matter contained in this supplement.

All owners/partners must sign this entity application form (Please copy if you require additional signature lines.)

_____	_____	_____
Owner/Partner Signature	Title	Date
_____	_____	_____
Owner/Partner Signature	Title	Date
_____	_____	_____
Owner/Partner Signature	Title	Date

Supplemental Information Form

Question #	Response