

Please answer all questions. If your answer to any question is "NONE" or "NOT APPLICABLE," please state. If you need more room, attach a separate signed and dated sheet.

1. PLEASE ANSWER THE FOLLOWING

LEGAL Name of Entity: _____

Please note: All owners, along with the entity, must be insured with NCMIC with equal or greater limits of liability.

Date of Incorporation: ____/____/____ **Federal Tax ID No.:** ____ - _____

Mailing address: _____
 STREET CITY STATE COUNTY ZIP

List all practice locations of corporation/partnership:

STATE	COUNTY	ZIP

List all owners of corporation/partnership and % of ownership:

OWNER	% OF OWNERSHIP

List all licensed professionals employed by the corporation/partnership and whether coverage is requested:

NAME	DEGREE	LICENSE #	LICENSE STATE	COV'G REQUESTED?
				Y N
				Y N
				Y N

Please complete an Application for Claims-Made Professional Liability Coverage form for each employee listed above for whom you are requesting coverage.

List all other employees of corporation/partnership:

NAME	TITLE

Do you employ any of the following licensed/registered staff?..... Yes No

If "Yes," please indicate the number of each type of employee below and submit a complete Individual Ancillary Application for each if individual limits are desired.

- | | | |
|--------------------------|----------------------------------|-------------------------|
| ____ Physician Assistant | ____ Paramedic | ____ Nurse Anesthetist |
| ____ Surgical Assistant | ____ Scrub Nurse | ____ Nurse Practitioner |
| ____ H/L Profusionist | ____ Nurse Midwife (No Delivery) | ____ Psychologist |
| ____ O.R. Technician | ____ Nurse Midwife (Delivery) | |

Please indicate the number of the following employed staff:

- | | | |
|----------|-----------------------------------|-----------------------|
| ____ RN | ____ Physical Therapist | ____ Medial Assistant |
| ____ LPN | ____ Radiation Therapy Technician | |

-
1. Name of Applicant: _____
 2. Patient's Name: _____
 3. Date of Incident from which claim or suit resulted or is likely to result:: _____
 4. Date claim was made against you: _____
 5. Allegations made against you: _____

 6. Explain, in detail, the specifics of the incident which led to the claim: _____

 7. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: State, County and Court claim filed in: _____

 8. What insurance company was involved?

 9. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claims or suit:

X _____ **X** _____
DOCTOR'S SIGNATURE DATE

Please photocopy as necessary for each claim or incident.