

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY

10. Does the corporation/partnership **employ or contract** any healthcare providers (MDs, Dentist, Hygienists, Nurses, X-ray techs, Med lab techs, Physical therapists, medical assistants, etc)? YES NO

If yes, please complete the following Employee Information section in full. All sections must be complete. If the answer is No, None or N/A, please indicate this on the application. If physicians are not insured by IRMIA please provide certificate of insurance showing ISO code reported to the Indiana Patient's Compensation Fund.

Employee Information

Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
Surgery None Minor Major <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	OB Yes No <input type="checkbox"/> <input type="checkbox"/>	Radiation Therapy Yes No <input type="checkbox"/> <input type="checkbox"/>	Current Insurer & Expiration Date	Participates in the Indiana Patient's Compensation Fund* <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Professional Designation		Indiana License #	Specialty	Sub-Specialty
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*Note:

- If shareholders/partners, employees and contractors in the following list **are eligible** to qualify as healthcare providers for the Indiana Patient's Compensation Fund on an individual basis per Article 18 34-18-2-14 (1), they **are required** to participate. Please provide proof of such participation for each employee unless they have an IRMIA policy. This list includes physicians, dentists, nurse anesthetist, nurse practitioners, nurse midwives, optometrists, podiatrists, and psychologists.
- **This participation must be in force for the length of the policy being requested.**

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IMPORTANT
Please Read Carefully and Sign

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree this application shall be the basis of the contract with the Indiana Residual Malpractice Insurance Authority (IRMIA). I agree to notify IRMIA if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician or dentist, firm or professional association.

By completing this application for professional liability insurance, the shareholders or partners of the above named entity affirm that they are licensed to provide professional services in my specialty in the state of Indiana and have made a diligent effort to obtain coverage as required by Indiana Code (IC) 34-18-17-6 and have been declined by two or more insurers as evidenced by the attached declination letters. The shareholders/partners do hereby apply for coverage with IRMIA and warrant the above statements and answers. The shareholders/partners also authorize the release of claim and suit information from any prior insurer.

The Medical Protective Company is the appointed "Risk Manager" for IRMIA and is providing the application solely under those auspices. As a result, the application for insurance is provided solely for the purpose of evaluating the applicant's qualifications for coverage under IRMIA and should not be seen as an offer of insurance from The Medical Protective Company. Pursuant to I.C. 34-18-17-3, The Medical Protective Company's separate, personal, and independent assets are not liable for or subject to use or expenditures for the purpose of providing insurance by IRMIA.

If the "Risk Manager" declines to accept your application, you will be notified of the decision in writing, including the reasons for the declination. If this occurs, you will have 10 days from the date of the notice to file an appeal with the Commissioner of Insurance who will review the decision of the "Risk Manager" and enter an appropriate order.

Signature of Authorized Representative	Title	Date of Signature
Printed Name of Authorized Representative		Telephone Number
		Fax Number

IMPORTANT: This application must be signed by both the applicant and the producer (if applicable)

Signature of Producer	Indiana P & C License Number	Date of Signature	
Name of Agency/Independent Agent		Telephone Number	
Agency IRS Number		Fax Number	
		E-Mail Address	
Agency Mailing Address	City	State	Zip