

LOCUM TENENS APPLICATION

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

According to information supplied to us, you will practice medicine as a locum tenens for a physician insured by the Company. Please answer all questions completely, and as they relate to the requested coverage. If a question does not apply to you, write "N/A". Do not leave any question unanswered.

The Insured Physician being replaced must complete Section VII. on Page 4 in order for this application to be reviewed and underwritten by Medical Mutual Insurance Company of North Carolina.

(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	

II. MEDICAL TRAINING AND EDUCATION

Medical School: Institution	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Residency: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes
Fellowship: Institution	Specialty	State	From	To	Completed? <input type="checkbox"/> No <input type="checkbox"/> Yes

III. LOCUM TENENS INFORMATION

1. Name of Insured you will replace as a locum tenens: _____
 Name and address of employing group: _____

2. Dates coverage needed--**be specific and advise actual dates** you will have patient contact or be on call for the Insured or employing group:

3. Have you previously been covered by the Company as a locum tenens? Yes No
If yes, who did you replace as a locum tenens? _____

IV. PERSONAL AND INSURANCE INFORMATION

4. Are you currently practicing as a physician? Yes No
If yes, where? _____
5. Do you currently have professional liability insurance coverage? Yes No
If yes, please give name of carrier _____
6. If yes to 5. above, will your current carrier provide coverage while you are acting as locum tenens? Yes No
If no, please explain _____
7. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location? Yes No
Explain: _____
8. Have you ever been or are you currently under a "consent order"? Yes (attach copy) No
9. 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. _____

10. 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: _____
11. Have you ever been charged with any criminal activity? Yes No
Explain: _____
12. Has any claim or suit for alleged sexual misconduct ever been brought against you? Yes No
Explain: _____
13. Has your professional liability insurance ever been surcharged, written with a deductible or written in a non-standard market? Yes No
Explain: _____

V. CLAIMS HISTORY

14. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? Yes No
15. 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 14 or 15 above, please complete the following for each such circumstance. If you need more space, attach additional sheet.

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):	

VI. AUTHORIZATION AND RELEASE

I understand that I will not have a separate limit of liability that will apply to me as the Locum Tenens, that I will share Limits of Liability with the insured physician for whom I am substituting and that such coverage extends only for those dates specified above. I further understand this is an application for locum tenens coverage only and is not an insurance binder. The coverage, if extended, will be claims made, and I understand that I do not have any rights under this policy to purchase an extended reporting endorsement for the period(s) of substitution. The foregoing statements and answers are complete and correct to the best of my knowledge. I also understand that an incorrect or incomplete response 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 Locum Tenens Applicant

Date of Signature

VII. AUTHORIZATION BY SUBSTITUTED INSURED PHYSICIAN

I, _____, hereby acknowledge and authorize Medical Mutual Insurance Company of NC to add this Locum Tenens Applicant to my coverage, provided all applicable underwriting criteria are met, for the dates noted in Section III.2. If coverage is approved, I further understand that I will have no professional liability coverage for any professional services I might render or fail to render from 12:01am until midnight on the date(s) listed in Section III.2. of this application, and that the Locum Tenens Applicant will share in my Limits of Liability during such substitution.

Signature of Insured

Date of Signature