



NYS MEDICAL INDEMNITY FUND (MIF) APPLICATION

(Please Print)

ENROLLMENT INFORMATION

Form with fields for: (1) Qualified Plaintiff Name (Last, First, Middle), (2) Social Security #, (3) Birth Date, (4) Street Address, City, State, Zip, (5) Phone Number, (5a) Parent/Guardian Name, (6) Diagnosis/Diagnoses, (7) Preferred Language, (8) Medicaid recipient status, (9) Medicaid Number.

If the answer to any or all of the questions 10, 11 or 12 below is YES and you have submitted the requested information as part of applying for or enrolling in another health care program, you may submit a copy of the prior application or enrollment form to answer these questions as long as the information is still current.

Form with fields for: (10) Receiving services from other government programs, (11) Other programs providing services to the Qualified Plaintiff.



(12) Is the Qualified Plaintiff covered by other health insurance? Yes No

(13) If the answer to question 12 is YES, please provide the name, address and phone number of the Qualified Plaintiff's health insurer and the subscriber or membership number used to submit claims on behalf of the Qualified Plaintiff:

(14) Please attach a certified copy of the judgment or court-approved settlement that found or deemed the Qualified Plaintiff to have sustained a birth-related neurological injury on or after April 1, 2011.

(15) Please provide the name, address and phone number of every provider from whom the Qualified Plaintiff is currently receiving health care services, on the last page of this form. If you have submitted this information as (a) part of applying for or enrolling in another health care program or (b) as part of a medical malpractice lawsuit and the information is still current, you may submit a copy of the prior application or enrollment form or the relevant portion of such form to satisfy this requirement.

If you are submitting this form on behalf of the Qualified Plaintiff, please check the appropriate description of your relationship to the Qualified Plaintiff.

Parent Guardian Ad Litem Defendant in malpractice action Guardian Attorney

Name, Address and Phone number of Parent or Other Person(s) Legally Authorized to Apply on Behalf of Qualified Plaintiff:

Signature of Parent or Other Person Legally Authorized to Apply on Behalf of the Qualified Plaintiff

Date



List of Qualified Plaintiff's Current Healthcare Providers:

Name _____ Address _____ Phone Number