NCMIC
Insurance Company

# Home-Based Office

Complete this form ONLY if all or part of your practice is home-based.

1. Name: _____
LAST FIRST MIDDLE INITIAL

2. Are there separate entrances for your home and office? ..... ☐ YES ☐ NO

3. Is there a separate patient reception room in your home office? ..... ☐ YES ☐ NO

4. Do you have individual treatment rooms? ..... ☐ YES ☐ NO

5. What equipment do you use for treatment? _____

_____

6. How many people do you have on staff? _____

7. Do you have general liability coverage for your home-based office? ..... ☐ YES ☐ NO

8. What percentage of your practice is based out of your home? ..... _____%

X _____ X _____
SIGNATURE DATE

X _____ X _____
AGENT SIGNATURE DATE