

Missouri Medical Malpractice Joint Underwriting Association

Post Office Box 219680
Kansas City, Missouri 64121-9680
Phone: 1-866-586-1693
Fax: 1-866-258-4892

Allied Health Care Provider Professional Liability Application

Section I - Personal Information

Name of Applicant (First, Middle, Last)		Designation
Date of Birth	Place of Birth	Social Security Number
Type of Practice:		
<input type="checkbox"/> Individual <input type="checkbox"/> Owner <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other		

Check the one that applies:

- | | |
|--|---|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Surgeon Assistant |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Certified Nurse Practitioner |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Emergency Medical Technician |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Certified Nurse Anesthetist | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Other | |

Section II - Practice Locations

Primary Practice Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number
Home Address (Street, City, State, Zip Code)		
County	Home Phone Number	Home Fax Number

For Agent's Use Only (If applicable)

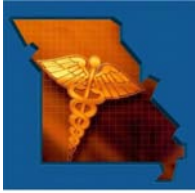
Name of Agency: _____ Name of Agent: _____

Address: _____ Phone Number: _____

Email Address: _____ Fax Number: _____

Signature: _____ Date: _____

Are you authorized to place casualty insurance under subdivision 1(4) of Section 375.018, RSMo? Yes No



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Secondary Practice Address (Street, City, State, Zip Code)		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

1. May we communicate with you by fax? Yes No
 2. May we communicate with you by e-mail? Yes No E-Mail Address _____

Section III - Coverage Selection

Requested Effective Date of Coverage: _____
Month Day Year

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Association, and receipt of payment.

Coverage Type and Limits of Liability (check all that apply)

- Individual Occurrence Professional Liability Coverage
\$500,000 each medical incident/\$1,500,000 annual aggregate
- Individual Occurrence Professional Liability Coverage
\$1,000,000 each medical incident/\$3,000,000 annual aggregate

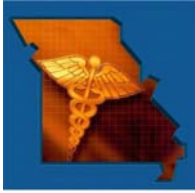
Prior Acts Policy (For Claims-Made Exposure with Current Carrier) (check all that apply)

- Individual Claims-Made Prior Acts Coverage
\$500,000 each medical incident/\$1,500,000 annual aggregate
- Individual Claims-Made Prior Acts Coverage
\$1,000,000 each medical incident/\$3,000,000 annual aggregate
- Prior Acts Coverage Not Requested (please indicate reason below)
 - Reporting Coverage will be obtained from current claims-made carrier
 - Current coverage is on occurrence form
 - Previous coverage provided on a shared limit of liability basis with employer
 - Reporting Coverage or Prior Acts Coverage will not be obtained from the Association or from my current claims-made carrier. I understand that failure to obtain Reporting Coverage will leave me without complete coverage.

Important: A separate Prior Acts Policy for your claims-made exposure with your current carrier is available from the Association upon verification of active coverage and retroactive date, and if no gaps in coverage exist.

Section IV - Medical Training

Name of School(s) Attended	Location	Degree	Date Graduated



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Section V - Insurance History

Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier				
Form of Coverage <input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date				
Retroactive Date (NA for occurrence)				
Was Extended Reporting Coverage obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. Have you ever practiced without professional liability coverage? Yes No
2. Was your professional liability coverage ever placed with a non-admitted carrier? Yes No
3. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No
4. Do you owe any outstanding premium to any carrier? Yes No

If any answer to questions 1 - 4 above is "Yes", please provide dates and explanations below:

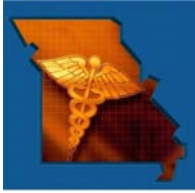
Section VI - Business Entity

Name of Business Entity		
Type : <input type="checkbox"/> Partnership <input type="checkbox"/> L.L.C. <input type="checkbox"/> Association or Corporation <input type="checkbox"/> Solo Incorporated (No Employed or Contracted Individuals) <input type="checkbox"/> Other		
Is coverage desired for business entity? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Retroactive Date	Corporate Tax Identification Number	Date of Incorporation

Section VII - Practice Information

Type of Certificate/License you currently hold:

State	Type	License Number	% of Patients seen, examined or treated in each state
Missouri			



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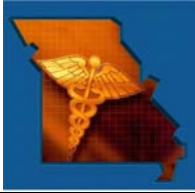
1.	If owner, employee, shareholder, partner, independent contractor, please indicate business name: _____
2.	Name of supervising physician: _____
3.	To what extent are you supervised? _____ _____
3.	Do you work for anyone other than this physician/business? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Brief description of your duties: _____ _____
5.	Number of hours of continuing medical education completed in the past two years: _____ hours.

List all locations where you have practice in the last five years.	Start Date and End Date (m/y)

Please provide the name and location of all hospitals where you hold active staff or courtesy privileges. Indicate below if you want a Certificate of Insurance issued to these facilities, on your behalf.

Name	Complete Mailing Address	Nature of Privileges	Certificate Desired?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

1. How many scheduled patients do you see per week? _____
2. How many walk-in patients do you see per week? _____
3. How many hours do you work per week? _____
4. In the past 5 years, has there been a change in the type of your practice? Yes No
5. In the past 5 years, has there been a change in the number of hours you work per week? Yes No
6. Are you subject to the Federal Tort Claims Act? Yes No

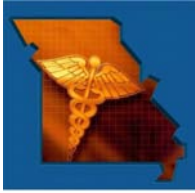


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Section VIII - Rating Information

1. Do you ever work in an operating room? Yes No
2. Do you ever work in an emergency room? Yes No
3. Do you assist in surgery? Yes No
4. Are you under contract in any capacity involving the practice of medicine? Yes No
5. Do you practice in or staff an urgent care center, walk-in urg-i-center or similar minor emergency clinic? Yes No
6. Are you employed full time by the Federal Government or are you in active duty in the military service? Yes No
7. Do you practice any forms of alternative medicine, including chiropractic, holistic, Chinese, naturopathic, homeopathic, ayurvedic? Yes No
8. Do you practice in or staff a hospital, sanitarium, or clinic with regular bed and board facilities? Yes No
9. Do you practice in or staff a surgery center, facility, laboratory, or other outpatient facility? Yes No
10. Do you treat or review treatment of any state, local federal correction facility, jail or prison? Yes No
11. Do you provide services to any nursing home or similar facility? Yes No
12. Will you be performing activities, which will be covered by another professional liability policy?
If yes, please explain below. Yes No
13. Do you practice medicine as an employee or independent contractor? Yes No
14. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation or reprimand ever been invoked?
If yes, please explain below. Yes No
15. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation or reprimand ever been invoked?
If yes, please explain below. Yes No
16. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse sexual addiction or mental health?
If yes, please explain below, and answer the following question:
Have you had a relapse following your initial treatment? Yes No
17. Have you ever been asked to participate in or have you volunteered to participate in an impaired healthcare provider program? (If yes, please attach a copy of your recovery plan)
If yes, please explain below. Yes No
18. Have you ever been denied a license or certification?
If yes, please explain below. Yes No
19. Have you ever been accused of sexual misconduct of any kind?
If yes, please explain below. Yes No
20. Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee?
If yes, please explain below. Yes No
21. Other than a minor traffic offense, have you ever been indicted for, charged with, convicted of , pled guilty to, or entered into a plea agreement for a violation of any law or ordinance?
If yes, please explain below. Yes No
22. In the past twelve months, have you had any injury, illness, or other event occur that may impair, lessen or diminish your physical or mental ability to practice medicine?
If yes, please explain below. Yes No



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Section IX - Loss Information

1. Are you now, or have you ever been, involved directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? Yes No

If "Yes" A. Indicate number closed, dropped, dismissed _____

B. Indicate number pending or open _____

C. Total number of cases (A+B) _____

If "Yes," Have all claim/suits indicted in "C" above been reported to your current or prior professional liability carrier? Yes No

2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services? Yes No

If "Yes" How many? _____

If "Yes" Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? Yes No

Important: For each loss indicated in questions 1 and 2 above 1) you are required to complete the attached Supplementary Loss Information Form and 2) A 5-Year Carrier Loss Run is needed from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.

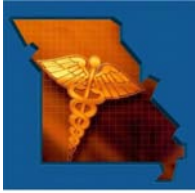
Please Read and Sign

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 that this application shall be the basis of the contract with the company. I agreed to notify the company if there is any future material change in any answers to this application, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other physician, firm or professional association.

I UNDERSTAND THAT ANY MATERIAL MISPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT AFFECT, PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT, AND/OR REQUIRE RETROACTIVE UPWARD PREMIUM ADJUSTMENT.

Applicant's Signature

Date

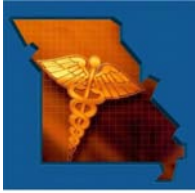


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Application Checklist:

- Copy of most current declaration page
- Five-year Company Loss History
- Copy of Missouri License or Certification
- Curriculum Vitae
- Copy of Business Letterhead (if applicable)
- Supplemental Loss Information for each loss
- Signature and Date on Application
- Verification of Extended Reporting or Prior Acts
- Completed, Signed Authorization to Release Information



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Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

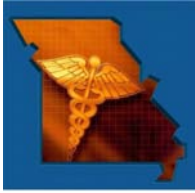
Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____



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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Missouri Medical Malpractice Joint Underwriting Association (the "Association") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Association upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for the State of Missouri and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Association upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Association, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Association and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

Date: _____