

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

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
- Business Entity Claims-Made Prior Acts Coverage (for business entity indicated above)
\$500,000 each medical incident/\$1,500,000 annual aggregate
- Business Entity Claims-Made Prior Acts Coverage (for business entity indicated above)
\$1,000,000 each medical incident/\$3,000,000 annual aggregate

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:

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Section IV - Practice Information

List all states where you are licensed to practice and license numbers.

State	License No.	% of Patients seen, examined or treated in each state
Missouri		

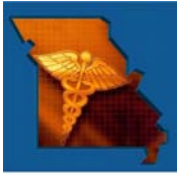
Please provide the name and location of all hospitals where you hold active staff or courtesy privileges. Indicate below if you want a Certificate of Insurance issued to these facilities, on your behalf.

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
			<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 your practice or the procedures you perform? Yes No
5. In the past 5 years, has there been a change in the number of hours you work per week? Yes No

Section V - Allied Health Care Providers

Do you provide supervision (to non-employees) to any allied health care providers? Yes No



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List all such certified health care providers that you employ or only provide supervision:

Name	Specialty	<input type="checkbox"/> Employee <input type="checkbox"/> Supervise Only
Name	Specialty	<input type="checkbox"/> Employee <input type="checkbox"/> Supervise Only
Name	Specialty	<input type="checkbox"/> Employee <input type="checkbox"/> Supervise Only

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 Employee or Contracted Physicians) <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

List the full name and current professional liability carrier of all other dentists affiliated with business entity for which coverage is desired.

Full Name	Name of Carrier
Full Name	Name of Carrier
Full Name	Name of Carrier

Section VII - Rating Information

1. What is your specialty? (Check all boxes that apply)

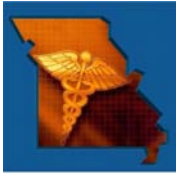
- | | |
|---|---|
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Pedodontics |
| <input type="checkbox"/> Maxillo-facial Surgery | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Periodontics |
| <input type="checkbox"/> Endodontics | <input type="checkbox"/> Prosthodontics |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Other _____ |

2. What is the nature of your practice? (Check all boxes that apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Category I | No anesthesia - No extraction |
| <input type="checkbox"/> Category II | No anesthesia - No dental implants - No oral surgery - Includes Orthodontics/Endodontics - Includes Periodontics |
| <input type="checkbox"/> Category III | No anesthesia - Includes dental implants |
| <input type="checkbox"/> Category IV | Includes intravenous sedation |
| <input type="checkbox"/> Category V | Oral Surgery |

3. Please indicate which procedures you perform (Check all boxes that apply)

- | | |
|---|---|
| <input type="checkbox"/> Orthodontic Full Mouth Banding | <input type="checkbox"/> Cleft Lip and Palate Surgery |
| <input type="checkbox"/> Surgical/Anchor portion of Dental Implants | <input type="checkbox"/> Sleep Apnea Therapy |
| <input type="checkbox"/> Endosteal Implant | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Intermaxillary Fixation for Obesity/Weight Control | <input type="checkbox"/> Subperiosteal Implant |
| <input type="checkbox"/> Sinus Lifts | <input type="checkbox"/> Mandibul Multi-quadrant-Ramus Frame Implant |
| <input type="checkbox"/> Parotid Gland Surgery | <input type="checkbox"/> Management of Malignant Lesions |
| <input type="checkbox"/> Sargenti Root Canal method utilizing N2 or similar paste or method | <input type="checkbox"/> Face Lifts |
| <input type="checkbox"/> Molar Endodontics | <input type="checkbox"/> Intermaxillary Fixation for Obesity/Weight Control |
| <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Sargenti Root Canal method utilizing N2 or similar paste or method |
| <input type="checkbox"/> TMJ Arthroscopy | <input type="checkbox"/> TMJ Surgery |
| <input type="checkbox"/> Molar Endodontics | <input type="checkbox"/> TMJ Arthroscopy |
| <input type="checkbox"/> TMJ Implants | |
| <input type="checkbox"/> Vitec Implant | |

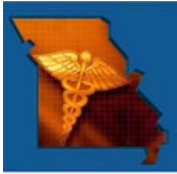


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- 4. Are you employed full time by the Federal Government or are you in active duty in the military service? Yes No
- 5. Do you own or operate a surgery center, laboratory, or other outpatient facility? Yes No
- 6. Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are currently licensed, including but not limited to the use of telecommunication technology? Yes No
- 7. Do you treat or review treatment of any state, local federal correction facility, jail or prison? Yes No
- 8. Do you use a collection agency, which has the authority to file collection suits without your knowledge? Yes No
- 9. Do you practice as a company dentist? Yes No
- 10. Do you participate in pharmaceutical testing /clinical investigation studies that are not FDA approved?
If yes, please explain below. Yes No
- 11. Do you provide services to any nursing home or similar facility?
If yes, please explain below. 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?
If yes, please explain below. 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 narcotics or dental license 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 addition or mental health? Please provide explanation below. Yes No
If yes, 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 dental program? (If yes, please attach a copy of your recovery plan) Yes No
- 18. Have you ever been denied a dental license? 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
- 23. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or or other medical review committee? If yes, please explain below. Yes No
- 24. Have you ever altered a medical or dental record? If yes, please explain below. Yes No
- 25. Has your ability to participate with Medicare or Medicaid ever been revoked, suspended, placed on Probation or voluntarily surrendered? If yes, please explain below. Yes No

Provide detailed explanations below.



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Section VIII - 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

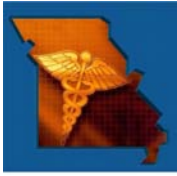
I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the company. I agreed to notify the company if there is any future material change in 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** _____

Application Checklist:

- Five-year Company Loss History
- Copy of Missouri Dental License
- Curriculum Vitae
- 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 X - 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 X - 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: _____

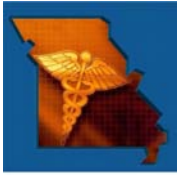
Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

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: _____