

# 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

## Physician and Surgeon Professional Liability Application

### Section I - Personal Information

Name of Applicant (First, Middle, Last)		<input type="checkbox"/> M.D.	<input type="checkbox"/> D.O.
Date of Birth	Place of Birth	Social Security Number	
Type of Practice: <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Owner <input type="checkbox"/> Employee <input type="checkbox"/> Shareholder/Partner <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Intern/Resident/Fellow <input type="checkbox"/> Other If owner, employee, shareholder, partner, independent contractor, indicate name of facility/entity: _____			

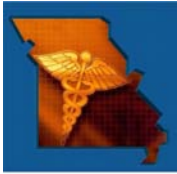
### Section II - Practice Locations

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
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 \_\_\_\_\_

#### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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## 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
- Business Entity Occurrence Professional Liability Coverage (for business entity indicated above)  
\$500,000 each medical incident/\$1,500,000 annual aggregate
- Business Entity Occurrence Professional Liability Coverage (for business entity indicated above)  
\$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
- 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
- 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
  - Reporting Coverage or Prior Acts Policy 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 - 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



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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 V - Medical Training**

Name of Medical School(s) Attended	Location	Degree	Date Graduated

Name of Hospital Where Internship Served		Location of Hospital Where Internship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name of Hospital Where Residency Served		Location of Hospital Where Residency Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Name of Hospital Where Fellowship Served		Location of Hospital Where Fellowship Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

1. If you are a Foreign Medical School Graduate, are you certified by the Educational Council for Foreign Medical Graduates or have you completed the Fifth Pathway Program?  Yes  No
2. Are you American Board Certified?  Yes  No      Name of Specialty Board? \_\_\_\_\_
3. Have you participated in any continuing Medical Education within the last three years?  Yes  No      # of Category 1 credit hours? \_\_\_\_\_

## **Section VI - 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		



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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
			<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 medical specialty, sub-specialty 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
6. Are you subject to the Federal Tort Claims Act?  Yes    No

### **Section VII - Allied Health Care Providers**

Following is list of allied health care providers for which coverage does not extend and a separate policy is required.

Physician Assistants, Surgeon Assistants, Certified Nurse Midwives, Certified Nurse Practitioners, Psychologists, Emergency Medical Technicians, Perfusionists, Chiropractors, Certified Nurse Anesthetists, Cytotechnologists, Optometrists, Podiatrists.

Do you employ any of the above listed allied health care providers?    Yes    No

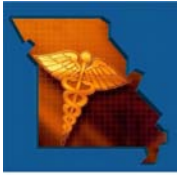
List all such allied health care providers:

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

Eligible Allied Health Care Providers may apply for coverage with the Missouri Medical Malpractice JUA.

### **Section VIII -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 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



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List the full name, relationship (employee or owner/partner) and current professional liability carrier of all other physicians affiliated with business entity. If coverage for these individuals is requested, please complete a separate application.

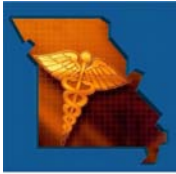
Full Name	Name of Carrier
Full Name	Name of Carrier
Full Name	Name of Carrier

## Section IX - Rating Information

1. What is your medical specialty? \_\_\_\_\_ Percentage of Practice? \_\_\_\_\_
2. What is your medical sub-specialty? \_\_\_\_\_ Percentage of Practice? \_\_\_\_\_
3. Do you perform? (Check all boxes that apply)
  - No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia
  - Perform minor surgical procedures or assist in surgery on your own patients
  - All other types of surgery and procedures performed under general anesthesia and assisting in surgery on patients other than your own
  - Obstetrics including normal deliveries and c-sections
4. Do you practice in or staff an urgent care center, walk-in urgi-center or similar minor emergency clinic?  Yes  No
5. Are you employed full time by the Federal Government or are you in active duty in the military service?  Yes  No
6. Do you practice any forms of alternative medicine, including chiropractic, holistic, Chinese, naturopathic, Homeopathic, ayurvedic?  Yes  No
7. Do you own or operate a hospital, sanitarium, or clinic with regular bed and board facilities?  Yes  No
8. Do you own or operate a surgery center, facility, laboratory, or other outpatient facility?  Yes  No
9. Do you do outside peer reviews or medical exams, or have a contract with an insurance company to do reviews?  Yes  No
10. Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program?  Yes  No
11. 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
12. Do you treat or review treatment of any state, local federal correction facility, jail or prison?  Yes  No
13. Do you use a collection agency, which has the authority to file collection suits without your knowledge?  Yes  No
14. Do you practice as a Medical Director at a blood bank?  Yes  No
15. Do you practice as a company physician?  Yes  No
16. Do you participate in pharmaceutical testing/clinical investigation studies that are not FDA approved?  Yes  No  
If yes, please explain below.
17. Do you provide services to any nursing home or similar facility?  Yes  No
18. Have you performed and/or do you currently perform silicone breast implants?  Yes  No
19. Will you be performing activities, which will be covered by another professional liability policy?  Yes  No
20. Do you practice medicine as an employee or independent contractor?  Yes  No

Provide detailed explanation below, or on attachment.

Please Check any of the following Procedures you will perform:

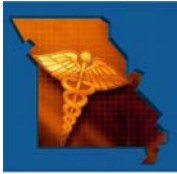


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Please classify your surgical practice, if applicable:	Please check any of the following procedures you will perform:	
<input type="checkbox"/> Cardiac <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Colon and Rectal <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Gastric Bypass/Bariatric Surgery <input type="checkbox"/> General <input type="checkbox"/> Gynecology <input type="checkbox"/> Hand <input type="checkbox"/> Head and Neck <input type="checkbox"/> Laryngology <input type="checkbox"/> Neurology <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Normal Deliveries <input type="checkbox"/> C-Sections <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedic <input type="checkbox"/> Spine Surgery <input type="checkbox"/> No Spine Surgery <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Otorhinolaryngology <input type="checkbox"/> Including elective cosmetic procedures <input type="checkbox"/> Not including elective cosmetic Procedures <input type="checkbox"/> Plastic <input type="checkbox"/> Podiatry <input type="checkbox"/> Rhinology <input type="checkbox"/> Thoracic _____ % <input type="checkbox"/> Urology <input type="checkbox"/> Vascular _____ % <input type="checkbox"/> Other	<input type="checkbox"/> Elective Abortions <input type="checkbox"/> Acupuncture <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Anesthesia <input type="checkbox"/> Spinal <input type="checkbox"/> Caudal <input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Other <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Assist in Major Surgery <input type="checkbox"/> On Own patients <input type="checkbox"/> On Patients of Others <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <input type="checkbox"/> Cosmetic _____ % of Practice <input type="checkbox"/> Reconstructive _____ % of Practice <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Cholecystectomy, Laparoscopic <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cryosurgery (other than external lesions) <input type="checkbox"/> Dermatological Surgery <input type="checkbox"/> Chemical peels <input type="checkbox"/> Chemabrasion <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat Transfer <input type="checkbox"/> Hair transplants <input type="checkbox"/> Silicone Injections <input type="checkbox"/> Tumescent Liposuction <input type="checkbox"/> Other _____ <input type="checkbox"/> Dermatopathology <input type="checkbox"/> D&C <input type="checkbox"/> Encephalography <input type="checkbox"/> Endoscopic laser therapy <input type="checkbox"/> Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy <input type="checkbox"/> ERCP <input type="checkbox"/> Exchange Transfusions in newborns How many per year? <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reductions <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Hip nailings <input type="checkbox"/> Hyperbaric Medicine <input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Intensive care for newborns within a Tertiary Care Unit <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Laser Skin Resurfacing <input type="checkbox"/> Laser surgery <input type="checkbox"/> Left Heart Catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Lumbar Fusion <input type="checkbox"/> Mammography <input type="checkbox"/> Myelography <input type="checkbox"/> Norplant Insertion/Extraction <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Pain Management <input type="checkbox"/> Medication Only <input type="checkbox"/> Dorsal Root Gangliotomies <input type="checkbox"/> Thoracic Sympathectomies <input type="checkbox"/> Spinal Cord Stimulators <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps <input type="checkbox"/> Sphenopalatine Lesioning <input type="checkbox"/> Cordotomies <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Pedicle Screws for Spinal Surgery <input type="checkbox"/> Permanent Pacemaker <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Radiation/X-ray Therapy <input type="checkbox"/> Radiopaque Dye <input type="checkbox"/> Scoliosis Surgery <input type="checkbox"/> Shock Therapy <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Weight Control _____ % of practice <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastric Stapling <input type="checkbox"/> Medications Prescribed:
	<input type="checkbox"/> None of the above <input type="checkbox"/> Other Procedures (List):	

If you are applying for coverage for an obstetrical practice, do you have privileges to perform C-sections at each hospital you staff?      Yes       No

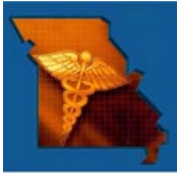


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- 21. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation or reprimand ever been invoked?  Yes  No  
If yes, please explain below.
- 22. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation or reprimand ever been invoked?  Yes  No  
If yes, please explain below.
- 23. 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?  Yes  No  
If yes, please explain below, and answer the following question:  
Have you had a relapse following your initial treatment?  Yes  No
- 24. Have you ever been asked to participate in or have you volunteered to participate in an impaired physician program? (If yes, please attach a copy of your recovery plan)  Yes  No  
If yes, please explain below.
- 25. Have you ever been denied a medical license or been denied certification by a specialty board?  Yes  No  
If yes, please explain below.
- 26. Have you ever been accused of sexual misconduct of any kind?  Yes  No  
If yes, please explain below.
- 27. 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?  Yes  No  
If yes, please explain below.
- 28. 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?  Yes  No  
If yes, please explain below.
- 29. 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?  Yes  No  
If yes, please explain below.
- 30. 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 other medical review committee?  Yes  No  
If yes, please explain below.
- 31. Have you ever altered a medical or dental record?  Yes  No  
If yes, please explain below.
- 32. Has your ability to participate with Medicare or Medicaid ever been revoked, suspended, placed on Probation or voluntarily surrendered?  Yes  No  
If yes, please explain below.

Provide detailed explanation below:

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## Section X - 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.

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**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

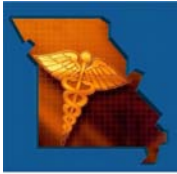


## ***Missouri Medical Malpractice Joint Underwriting Association***

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### **Application Checklist:**

- Copy of most current declaration page
- Five-year Company Loss History
- Copy of Missouri License
- Curriculum Vitae
- Copy of Business Letterhead
- Supplemental Loss Information for each loss
- Allied Health Care Provider Application for each Allied Health Care Provider
- 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: \_\_\_\_\_  
\_\_\_\_\_

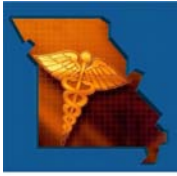
Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim?  Yes  No

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: \_\_\_\_\_