

Missouri Medical Malpractice Joint Underwriting Association

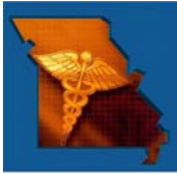
Post Office Box 219680
Kansas City, Missouri 64121-9680
Phone: 1-866-586-1693
Fax: 1-866-258-4892

Section IV- Rating Information

1. Has your medical specialty changed? _____ 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.

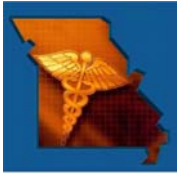
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Please classify your surgical practice, if applicable:	Please check any of the following procedures you will perform:	
<input type="checkbox"/> Cardiac <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Colon and Rectal <input 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):



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Please check any of the following Procedures you will perform:

- 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:
- 33. Please describe the number and nature of **Category I CME** hours you have received over the past 36 months?

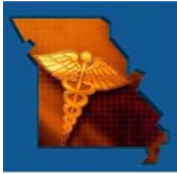
Provide detailed explanation below:

Section V- 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



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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 VI – Hospital Privileges

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

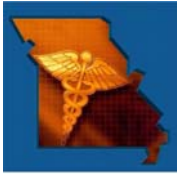
- How many scheduled patients do you see per week? _____
- How many walk-in patients do you see per week? _____
- How many hours do you work per week? _____
- In the past 5 years, has there been a change in your medical specialty, sub-specialty or the procedures you perform? Yes No
- In the past 5 years, has there been a change in the number of hours you work per week? Yes No
- Are you subject to the Federal Tort Claims Act? Yes No

Section VII - Loss Information

- 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"
 - Indicate number closed, dropped, dismissed _____
 - Indicate number pending or open _____
 - 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
- 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.



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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: _____

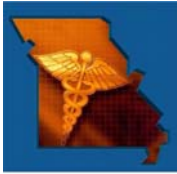
Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

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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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.

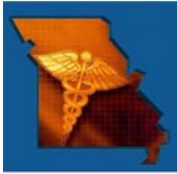
I UNDERSTAND THAT ANY MATERIAL MISPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT AFFECT, PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT, AND/OR REQUIRE RETROACTIVE UPWARD PREMIUM ADJUSTMENT.

Applicant's Signature

Date

Application Checklist:

- Copy of Missouri License
- Curriculum Vitae
- Allied Health Care Provider Application for each Allied Health Care Provider
- Signature and Date on Application
- Completed, Signed Authorization to Release Information



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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: _____