Missouri Medical Malpractice Joint Underwriting Association

4700 Country Club Drive
Jefferson City, MO 65109
Phone: 573-893-5300
Fax: 573-893-3748

Physician and Surgeon Professional Liability Application

Section I - Personal Information

Name of Applicant (First, Middle, Last)		❑ M.D. ❑D.O.
Date of Birth	Place of Birth	Social Security Number

Type of Practice:
❑ Individual ❑ Sole Proprietor ❑ Owner ❑ Employee ❑ Shareholder/Partner ❑ Independent Contractor ❑Intern/Resident/Fellow ❑ 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 _____

<u>For Agent's Use Only (If applicable)</u>

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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Section III - Coverage Selection

Requested Effective Date of Coverage: _____
Month Day Year

Requested Retroactive Date: _____
Month Day Year

If no Retroactive Date (Prior Acts) is requested, please explain why:

- ❑ Reporting Coverage will be obtained from current claims-made carrier
- ❑ Current coverage is on occurrence form
- ❑ 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: 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 Claims Made Professional Liability Coverage
  $500,000 each medical incident/$1,500,000 annual aggregate
- ❑ Individual Claims Made Professional Liability Coverage
  $1,000,000 each medical incident/$3,000,000 annual aggregate

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

Section IV - Insurance History

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ 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:

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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? ❑ Yes ❑ 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? ❑ Yes ❑ 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? ❑ Yes ❑ 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		

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

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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?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ 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	❑ Employee
Name	Specialty	❑ Employee
Name	Specialty	❑ 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 : ❑ Partnership ❑ L.L.C. ❑ Association or Corporation ❑ Solo Incorporated (No Employed or Contracted Physicians) ❑ Other		
Is coverage desired for business entity? ❑ Yes ❑ No		
Retroactive Date	Corporate Tax Identification Number	Date of Incorporation

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

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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
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.

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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. Do you participate in the certification of patients for the use of medical marijuana? ❑ Yes ❑ No

    If Yes, do you certify more than the standard 4 ounces per month? ❑ Yes ❑ No

    (If Yes, please explain how you determine the medically appropriate amount.)

Provide detailed explanation below:

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Please Check any of the following Procedures you will perform:

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

_____ _____

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
- ❑ 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: _____