MPM | Missouri Professionals Mutual

www.mpmins.com

287 N. Lindbergh Blvd. St. Louis, Missouri 63141 314-587-8000 Toll Free: 866 262-4030 Fax: 314-587-8001 www.mpmins.com	**Send Completed Application To**: The Keane Insurance Group, Inc. 135 W. Adams Avenue St. Louis, Missouri 63122 314-966-7733 800-966-7731 Fax: 314-966-7797 www.keanegroup.com Keane Producer: ___________________________

ANCILLARY PERSONNEL APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE POLICY

IMPORTANT: You are applying for CLAIMS MADE COVERAGE. For your own protection, report to your CURRENT insurer BEFORE YOUR CURRENT POLICY EXPIRES ANY:
Incident which might lead to a claim;
Request for medical records;
Unfavorable result in treatment;
Knowledge of a patient or family member who might consider bringing a claim against you.

THIS APPLICATION WILL BE ATTACHED TO AND FORM A PART OF ANY POLICY THAT MAY BE ISSUED

- □ Applicant must personally complete this application.
- □ Please type or print legibly in black ink.
- □ You **MUST** attach a curriculum vitae (CV) to this Application or complete Form G and your CV will be incorporated into this application and any policy that may be issued.
- □ You **MUST** attach the declarations page of your current policy.
- □ You **MUST** report all circumstances that might reasonably be expected to result in a claim or suit even if you believe that the claim or suit would be without merit.
- □ **Every** question must be answered. If a question does not apply to you, mark it “N/A” (not applicable).
- □ If space is insufficient for a complete reply, please attach a separate sheet.
- □ Incomplete answers and/or missing attachments may delay the processing of your application.
- □ This is an Application only. Completion of this Application or its receipt by MPM or an agent or broker does not bind MPM to issue a policy to you. Before coverage can be bound or a policy issued, this Application must be approved by MPM’s underwriting department and the initial payment must be received by MPM or its agent.
- □ If the applicant or claimant knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I. GENERAL INFORMATION

1.	Name of Insured	
	Clinic Name	(First) (Middle) (Last) (M.D./D.O./other)
	Primary Office Address	
	Other Office Address	(Number) (Street) (City) (State) (Zip) (County)
	Mailing Address	(Number) (Street) (City) (State) (Zip) (County)
	Residential Address	(Number) (Street) (City) (State) (Zip) (County)
	Billing Address	(Number) (Street) (City) (State) (Zip) (County)
	(if different from mailing)	(Number) (Street) (City) (State) (Zip) (County)
	Telephone Numbers	( ) _____ - __________ ( ) ______ - __________ ( ) _____ - _________
	Email	(Office) (Office Fax) (Residential) ___________________________________@___________________________________
	Social Security #	____________ - __________ - ______________
	Date of Birth	________ / ____________ / _______________
	Please Check the Applicable Box	This application is for: ☐ Certified Nurse Midwife (CNM) ☐ Certified Registered Nurse Anesthetist (CRNA) ☐ H/L Perfusionist ☐ Certified Nurse Practitioner (NP) ☐ Physician Assistant (PA) ☐ Surgeon Assistant ☐ Other ___________________
	Supervising Physician	
	Please provide the name(s) of all professional and/or medical societies of which you are a member. ____	

II. POLICY OPTIONS

2.	**Desired Effective Date**	_________ / ___________ / ___________
3.	**Limit of Liability (circle one) per occurrence/annual aggregate**	$100,000/$300,000 $200,000/$600,000 $500,000/$1,000,000 $500,000/$1,500,000 $1,000,000/$1,000,000 $1,000,000/$3,000,000
4.	**Do you want prior acts coverage?**	☐ Yes ☐ No If your current policy is or any previous policies are claims made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage), there will be no coverage for any claim from any act or omission that took place during that period of claims made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims made policy. **Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier. Even if prior acts coverage is written, it will not cover any claims, conduct, circumstances, occurrences, accidents, or medical incidents likely to give rise to a claim which are known to you or which should have been known to you on the date of this application.**
5.	**Prior Acts Limit of Liability (circle one)**	$100,000/$300,000 $200,000/$600,000 $500,000/$1,000,000 $500,000/$1,500,000 $1,000,000/$1,000,000 $1,000,000/$3,000,000
6.	**Deductible requested**	☐ None ☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 ☐ Other ____________
7.	**Retroactive Date Requested for you**	_________ / ___________ / ___________

III. MEDICAL BACKGROUND

PLEASE ATTACH A COMPLETE COPY OF CURRENT C.V. (with all educational information including but not limited to medical school(s) or other education, nursing schools, internships, residency programs, type of residency, military training and any other relevant experience.

8. Medical Education

Institution	State	Degree/Certification	From	To	Date Graduated
A. Institution	State	Degree/Certification	From	To	Date Graduated
B. Institution	State	Degree/Certification	From	To	Date Graduated
C. Institution	State	Degree/Certification	From	To	Date Graduated

D. How many hours of continuing medical education do you attend annually: ______________________

9. State(s) where currently licensed:

a. ______ # ______________ Type of License __________ Date of License _________ Expiration _________ % of Practice _____

b. ______ # ______________ Type of License __________ Date of License _________ Expiration _________ % of Practice _____

c. ______ # ______________ Type of License __________ Date of License _________ Expiration _________ % of Practice _____

If any of your licenses are or have been inactive, suspended, restricted, or revoked, please attach a document providing explanation.

10. Number of hours worked for your physician/corporation/partnership per week: ______________________________

11. Do you work for anyone other than this physician/corporation/partnership? ☐ Yes ☐ No

If YES, please explain: ____

12. Do you have any medically related duties that are insured by another company **or for which you do not desire MPM coverage?** ☐ Yes ☐ No

If YES, please explain: ____

13. Do you ever work in an operating room? ☐ Yes ☐ No

If YES, do you: ☐ Observe ☐ Assist ☐ Other: ______________________

14. Please provide a brief description of your duties: ____

15. To what extent are you supervised, and by whom? ____

16. Do you ever work in an emergency room? ☐ Yes ☐ No
If YES, do you: ☐ Observe ☐ Assist ☐ Other: ______________________

17. Please provide a brief description of your duties: ____

18. To what extent are you supervised, and by whom? ____

19. Do you have an employment contract in any capacity involving the practice of medicine? ☐ Yes ☐ No
If YES, please provide a copy

IV. PRACTICE HISTORY

20. Where have you practiced your profession for the past ten (10) years other than your current practice locations? Please explain any gaps in your practice. Use Remarks Section for additional locations.

21. Entity Name & Address: ____ from __/__/__ to __/__/__

22. Entity Name & Address: ____ from __/__/__ to __/__/__

23. Entity Name & Address: ____ from __/__/__ to __/__/__

24. Please explain any breaks of more than 3 months in your training or practice:

____

V. CLAIM INCIDENT AND INSURANCE HISTORY

25. Please identify a contact person the Company may contact relating to the information contained in this application as well as future claims or incidents.

Contact Name: ______________________________
Title: ______________________________________
Telephone Number: __________________________

I authorize the Company to release and discuss all information contained in this application and any information relating to any future claim or incident to the person I have designated as my contact above.

26. Have you ever been insured by MPM for professional liability? ☐ Yes ☐ No

If YES, please list the policy number and the name of the previous employer: ___________________________

27. List professional liability insurers for the past 5 years:

Company	Policy Number	Limits	From	To	Type of coverage form? Occurrence	Claims Made
____________	___________	_____	__/__/__	__/__/__	____	____
____________	___________	_____	__/__/__	__/__/__	____	____
____________	___________	_____	__/__/__	__/__/__	____	____

28. If current policy is Claims Made, are you applying for retroactive (nose) coverage? ☐ Yes ☐ No
If NO, attach a copy of your prior carrier's extended reporting endorsement (tail).

29. Whether or not you are applying for retroactive coverage, please provide a copy of your current policy including all endorsements; state the annual premium amount; and provide a copy of the declaration page.

30. **Have you ever:**

a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, nonrenew or revoke your privileges? ☐Yes ☐ No

b. Has your membership in any professional society or association ever been suspended or revoked? ☐ Yes ☐ No

c. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ☐ Yes ☐ No

d. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? ☐ Yes ☐ No

e. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐ Yes ☐ No

f. been evaluated, treated or hospitalized for any of the following: ☐ Yes ☐ No
☐ alcoholism ☐ central nervous system stimulants or depressants
☐ mental or emotional disorders ☐ drug addiction

g. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? If YES, please submit a letter from your treating physician addressing your state of health and whether any condition exist which could adversely affect the practice of your medical specialty. ☐ Yes ☐ No

h. had Medicare/Medicaid fraud charges filed against you? ☐ Yes ☐ No

i. signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? (If so, please note that MPM is not a party to Indemnification or hold harmless agreements under it's policies and, accordingly, will not be responsible for any liability incurred under such agreements) ☐ Yes ☐ No

j. Have you ever been refused board certification? ☐ Yes ☐ No

k. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? ☐ Yes ☐ No

l. been contacted by any hospital committee or group (other than an official peer review committee) that has reviewed (i) any issue regarding your delivery of medical services which you know or should have reason to know was of significant concern to a hospital where you have privileges, or (ii) any issue which arose out of any unexpected occurrence involving death or serious physical or psychological injury? ☐ Yes ☐ No

If you answered YES to any of the above questions #30a through 30l, please explain in the Notes Section of this application.

31. Have you **ever**:

a. Been a party to a lawsuit alleging medical malpractice or negligence? ☐ Yes ☐ No

b. Had a claim for medical malpractice settled on your behalf with or without the filing of a lawsuit? ☐ Yes ☐ No

c. Received a letter from an attorney wherein the attorney states that you may have committed malpractice or acted negligently in the treatment of a patient? ☐ Yes ☐ No

d. Received a letter from a patient or relative of the patient wherein the patient or relative of the patient claims that you committed malpractice or acted negligently in the treatment of a patient? ☐ Yes ☐ No

e. Given a deposition in a lawsuit where you were not a party in the lawsuit but your employer was a party to the lawsuit and the lawsuit alleged medical malpractice? ☐ Yes ☐ No

If you answered YES to any of the above questions #31a through 31e, please complete Form A-claim/incident report for each affirmative answer.

32. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? ☐ Yes ☐ No

b. A letter communication from a patient, patient’s representative, friend, relative or attorney regarding your medical treatment of a patient? ☐ Yes ☐ No

c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? ☐ Yes ☐ No

d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?

i. Cardiac arrest ☐ Yes ☐ No
ii. Postoperative coma ☐ Yes ☐ No
iii. Postoperative neurological deficits ☐ Yes ☐ No
iv. Unexpected death within 48 hrs. postoperatively ☐ Yes ☐ No
v. All others ____

e. A request for the medical records of a patient who was deceased? ☐ Yes ☐ No

f. A request for medical records of a patient who was admitted to a hospital as a result of an adverse reaction to medicine that you prescribed? ☐ Yes ☐ No

If you answered YES to any of the above questions #32a through 32f please complete Form A-claim/incident report for each affirmative answer.

33. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No

If you answered YES to the above question #33, please complete Form A-claim/incident report.

34. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT) that have not been reported to your current OR prior professional liability carrier?

☐ Yes ☐ No

If you answered YES to the above question #34, please complete Form A-claim/incident report.

35. Was each incident reported to your professional liability insurance carrier? ☐ Yes ☐ No
If the incident was not reported to your professional liability insurance carrier, include an explanation.

If you answered YES to the above question #35, please complete Form A-claim/incident report. Coverage will not be provided by Missouri Professionals Mutual for known incidents or claims described above, on Form A or any attachments.

36. Other than the incidents, events and claims disclosed on Form A attached hereto, since the retroactive date requested, there are no circumstances, acts, errors or omissions, known to me or of which I should reasonably be aware, prior to the effective date of the policy for which I am applying, which could result in a professional liability claim against me or against any entity of which I am an employee, equity holder, officer or director.

Signature: _____________________________________ Date: _________________________________

I understand and agree that any Policy issued to the applicant hereunder will have been issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand and agree that failure to provide true and complete responses to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any Policy issued.

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF YOUR POLICY THAT MAY BE ISSUED.

I hereby represent the truth of my statements and reasons mentioned in this application and any attachments, and that I have not withheld any information that is reasonably likely to influence the judgment of the company in considering this application for professional liability insurance. Up to the effective date of the policy for which I am applying, I agree to immediately notify Missouri Professionals Mutual ("Company") of any information, fact or circumstance that amends, modifies or changes any information contained in this application. I further agree to be bound by the underwriting guidelines of Missouri Professionals Mutual.

In accordance with the provisions of Section 383.035, RSMo, I hereby state that I acknowledge and understand that the Company has published standard rates for coverage and that due to underwriting, marketplace, type of practice, area of practice and past history reasons I may not be charged such rate by the Company for coverage and may be charged an increased rate. I hereby acknowledge and consent to such increased rate to be charged by the Company for medical malpractice coverage under the Company Policy.

I hereby authorize the present and prior professional liability insurance carriers and any and all attorneys who have represented me in connection with any claim of professional liability to release to the Company upon its request for information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I also authorize all medical associations and medical societies in which I am or have been a member, all hospitals in which I now hold or have held staff privileges, the State Board of Medical Examiner for the State of Missouri and any other State in which I have practiced, or resided, and any and all entities and physicians having information regarding me, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I hereby release and agree to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, 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.

I hereby acknowledge 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 me. I agree that I 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 I hereby expressly waive any right I may have to compel such disclosure.

I further agree that the Company and all persons and organizations described above may rely upon a photostatic copy of the foregoing authorization, which shall be of equal validity with the signed original.

Acceptance of advance payment does not bind the Company to provide insurance.

I acknowledge that I am responsible for payment of all unpaid assessments and premiums regardless of whether anyone has agreed to pay premiums on my behalf.

I authorize release and exchange of information involving past and future underwriting and claims matters, including but not limited to investigations for material information on my reputation and fitness to practice medicine.

I understand and acknowledge upon acceptance of this application by the Company, this application shall become a part of the Policy and operate as a contract between the insured and the Company.

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me: To the fullest extend permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees, Missouri Professional Management, L.L.C., its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's underwriting committee. Submission of a payment or deposit with this application and

provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

By my signature on this Application, I hereby, as of the date I shall be become a member, (or in the event this is a renewal application, the date provided below) constitute and appoint Timothy H. Trout or in his absence the then current Chairman of the Board of Directors of the Company as my proxy with full power of substitution to represent the undersigned by casting by proxy the vote to which the undersigned is entitled at all general and special meetings of the members of the Company to be held between the date I shall become a member and the date thirty-six (36) months from the date of my signature below, at which time this proxy shall expire unless extended by the undersigned, whenever the undersigned is not personally present, or at any adjournment thereof, as if the undersigned were personally present; and the undersigned hereby rarifies and confirms all that may be done by virtue hereof. This proxy may be revoked by the member delivering a written notice revoking this proxy to the Secretary of the Company or as provided by law, but in the absence of such revocation it shall remain valid during the time herein specified; nor shall failure to use this proxy render it void.

Upon becoming a member of the Company I agree to accept and will be bound by the Articles of Association and the By-laws of the Company, as both may be amended from time to time, including provisions with respect to the obligation to pay assessments as and when charged. I agree to the duties and obligations of a member as provided in the above referenced Articles and By-laws, including the obligation to pay assessments as and when charged, and/or levied, during the period for which my policy is written, regardless of any intervening termination of said policy. I agree that any representative appearing on my behalf and appointed by me has authority to do so.

Signature: ____ **Date:** _________________________

Broker (Producer) Signature: ________________________ **Date:** _________________________

Broker License No: _________________________________

An underwriter may contact you for further information or clarification.

The Company acknowledges receipt of this application.

Missouri Professionals Mutual

By: _______________________________________ Date: _________________________

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Form A – Supplement to Application
Claim/Incident Report

Please complete this report for each claim or incident for which you responded YES on your application. Attach copies of patient's charts, operative notes or other documents as appropriate.

If there has been more than one claim or incident, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

Section I.

Use this section for reporting a Claim.

1. Name of Patient: ____________________

Age: __________ Sex: __________

Address: ____________________

City/State/Zip: ____________________

2. Date Reported to Insurance Company: ____________________

3. Name of Insurance Company: ____________________

4. Date of Claim: ____________________

5. Location of Claim: ____________________

6. Description of Claim: ____________________

7. Extent and Nature of the Injury: ____________________

8. Present Condition of the Patient: ____________________

9. Extent, Nature and Type of Claim: ____________________

10. State how and when you became aware of this Claim: ____________________

11. Other physicians, insureds, professionals or entities involved: Please attach a separate piece of paper if necessary.

Name: ____________________

Address: ____________________

Telephone Number: ____________________

Name: ____________________

Address: ____________________

Telephone Number: ____________________

12. Other Witnesses: Please attach a separate piece of paper if necessary.

Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________

Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________

13. 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

14. Status of Claim (check applicable answer):

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary Judgment in your Favor

☐ Suit Settled Out-of-Court

a. Date claim paid ________

b. Amount paid ___________

c. Did you want to settle this claim? ☐ Yes ☐ No

☐ Awaiting Med/Dental Screening Panel Review

☐ Awaiting mediation

☐ Awaiting court action

Reserve Amount: _______

☐ Court outcome in your favor

☐ Jury Verdict

☐ Directed Verdict

☐ Court outcome in favor of plaintiff

☐ Jury Verdict

☐ Directed Verdict

Amount of Loss Payment: $___________

15. Name and address of the attorney assigned to your case: ______________________________

____

16. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

☐ Yes ☐ No

If "yes," list settlement amount: $____________

17. Please provide any other relevant information: ______________________________

____

____

Signature: ______________________________

Print Name: ______________________________

Date: ______________________________

Section II.

Use this Section for reporting an Incident.

1. Name of Patient: ____
Age: ___________ Sex: ___________
Address: ____
City/State/Zip: ____

2. Date Reported to Insurance Company: ______________________________

3. Name of Insurance Company: ______________________________

4. Date of Incident: ______________________________

5. Location of Incident: ______________________________

6. Description of Incident: ______________________________

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7. Extent and Nature of the Injury: ______________________________

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8. Present Condition of the Patient: ______________________________

____

9. Extent, Nature and Type of Claim Anticipated: ______________________________

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____

10. State how and when you became aware of this Incident: ______________________________

____

____

11. Other physicians, insureds, professionals or entities involved: Please attach a separate piece of paper if necessary.
Name: ______________________________
Address: ______________________________
____
Telephone Number: ______________________
Name: ______________________________
Address: ______________________________
____
Telephone Number: ______________________

12. Other Witnesses: Please attach a separate piece of paper if necessary.
Name: ______________________________
Address: ______________________________
____
Telephone Number: ______________________
Name: ______________________________
Address: ______________________________
____
Telephone Number: ______________________

13. 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 Incident?

☐ Yes ☐ No

14. Please provide any other relevant information: ___________________________________

____

____

Signature: ____

Print Name: ____

Date: ____

Form G – Educational Information

(To be completed in the event a current C.V. is not available)

Medical School: ______________________________________ from ___/____/____ to ____/____/____

Internship: ______________________________________ from ___/____/____ to ____/____/____

Residency: ______________________________________ from ___/____/____ to ____/____/____

Type of Residency: ______________________________________ Completed: ___ Yes ___ No

Other Training (fellowships, military service, etc.):

Name and type: ______________________________________ from ___/____/____ to ____/____/____

Name and type: ______________________________________ from ___/____/____ to ____/____/____