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: ______________________

APPLICATION FOR CLINICS
(Medical, Public Health, Dental, etc.)
PROFESSIONAL LIABILITY INSURANCE
CLAIMS MADE POLICY

IMPORANT: You are applying for Claims Made Coverage. For your own protection, report to your CURRENT insurer BEFORE THE 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 YOUR POLICY.
If space is insufficient for a complete reply, please attach a separate sheet.
PLEASE TYPE OR PRINT LEGIBLY
ALL QUESTIONS MUST BE ANSWERED

I. GENERAL INFORMATION

1. Clinic Name:____
2. Desired effective date: ______/______/______
3. Full name of applicant:____
4. Principal Business Address: ____

____
City State Zip County

Office Telephone #:____________ Backline #:____________________________

Fax #:______________________________

5. E-Mail Address:____

II. LIMITS OF COVERAGE – Professional Liability

6. ____ $100,000/300,000 ______ $200,000/600,000 ________ $500,000/1,000,000
____ $1,000,000/1,000,000 ______$1,000,000/3,000,000

7. Deductible Requested: $________________________________

OFFICE PREMISES LIABILITY

8. Please list your general liability insurance carrier, as well as any other insurance coverage carriers, i.e. workmen's compensation, etc.

Type of Insurance	Carrier

III. INFORMATION ABOUT THE PRACTICE

9. Type of Practice:

_____ Professional Corporation (for profit) _____ Partnership
_____ Professional Corporation (non-profit) _____ Professional Association
_____ Other (describe):____

10. Date established:____

11. Number of Employees: Full time_____ Part time______ **Total**______

12. Business, corporate or partnership name:_______________________________

13. Name of all physicians, partners or members of the firm who provide professional services. Also include % of ownership, if applicable. **Provide a copy of certificate for each practicing physician/professional employee.**

Name %	Present Insurer	Policy Number	Expires

14. Please list all non-physician employees are employed by you or your group, i.e. technicians, assistants, CRNA, NP, etc., and any appropriate designations (please use separate sheet, if needed):

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

15. Professional societies or associations in which your entity is a member:
____

16. Please attach a copy of letterhead or other business stationery.

IV. OPERATIONS/PROFESSIONAL SERVICES

17. States in which clinics are registered and licensed to practice: ___________________________
If none, please explain.

18. Clinic's professional specialty (ies):____

19. Do you maintain any beds for overnight occupancy? ______ Yes ______ No

20. Total square feet that you occupy (all locations):______________________________

21. List all procedures performed at this surgical facility, as well as percentages:

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

22. Does clinic use a collection agency? Yes_____ No_____
If yes, name of agency:____

Does the agency have authority to file a collection suit on clinic's behalf?
Y es____ No _____

23. Do owners, partners or directors (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?
Y es_____ No_____

If yes, give details including name, location, size and number of beds:
____

24. Do you own or operate any business other than that shown in question 3?
Y es______ No_____
If yes, please attach detailed explanations of this activity:
____

25. Names and locations of any hospitals or institutions Clinic uses in practice:
____
____

26. Do you perform any abortions in your professional office (include trimester, method and number of abortions performed per month):____________________________________

27. Number of annual x-ray exposure: for diagnosis_____ for treatment _____

If x-ray treatment is given, what qualifications are required of the staff?
____
____
____
____

28. If specializing in pathology, please include a **copy of your latest CAP scores.**

29. Does this entity supervise any individuals other than your own employees?
Yes____ No_____

If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals.

Number	Type of Profession
_______	____
_______	____
_______	____
_______	____
_______	____
_______	____
_______	____

30. Are all members of your clinic licensed in accordance with applicable state and federal regulations?
Yes______ No______ If no, please attach explanation

31. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
Fee for Service	$ _________________	$ _________________
Government Funding	$ _________________	$ _________________
Other_________________	$ _________________	$ _________________
Total Gross Revenue	$ _________________	$ _________________

32. Please provide number of clinic visits/number of surgeries (if applicable):

Type of Visit	12-24 Months ago	Last 12 Months	Next 12 Months
Clinic Visit	___________	___________	___________
Laboratory	___________	___________	___________
Emergency Room	___________	___________	___________
Surgery	___________	___________	___________

33. If you have a training school, please complete the following. Attach a separate sheet if needed.

Specify Profession for Which Students are Being Trained	Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in	Number of Clinical Setting	Qualifications of Faculty (i.e. MD, RH, PhD, etc.

34. Is this entity under contract to any individual or entity other than that shown in Question 3? Yes______ No______

If this contract contains a hold-harmless agreement, copy of contract must be attached.

35. Is this entity under contract to any federal government entity?
Yes______ No______

36. Please provide the name(s) of all professional and/or medical societies of which you are a member. _
____

V. CLAIM, INCIDENT AND INSURANCE HISTORY

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event or a claim, could lead to a denial of liability.

37. 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.

38. List applicant's professional liability insurers for the past 5 years:

Policy No.	Limits	From	To	Type of coverage form? Occurrence	Claims Made	Company
____________________	__________	__/__/__	__/__/__	_____	_______	
____________________	__________	__/__/__	__/__/__	_____	_______	
____________________	__________	__/__/__	__/__/__	_____	_______	
____________________	__________	__/__/__	__/__/__	_____	_______	
____________________	__________	__/__/__	__/__/__	_____	_______	

39. If applicant's current policy is Claims Made, is applicant applying for retroactive (nose coverage)?
☐ **Yes** ☐ **No**
If yes, Retroactive Date requested:______________________

40. **Whether or not applicant is applying for retroactive coverage, please provide a copy of applicant's current policy including all endorsements; state the annual premium amount; and provide a copy of the declaration page.**

41. In the last 10 years, has any claim or suit been brought against the applicant and/or any of its employees or physicians? ☐Yes ☐No

If yes, complete the supplement claim information Form A for each claim, suit, incident or request for records. Provide a copy of carrier loss runs.

42. Was each incident reported to applicant's professional liability insurance carrier?
☐Yes ☐No

If the incident was not reported to applicant's professional liability insurance carrier, include an explanation.

43. **Has the applicant ever:**

a. Had its membership in any professional society or association ever been suspended or revoked?
☐ Yes ☐ No

b. 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

c. had Medicare/Medicaid fraud charges filed against it? ☐ Yes ☐ No

d. signed any contractual agreement in which the applicant has 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

e. Has the applicant ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital?
☐ Yes ☐ No

If the applicant answered YES to any of the above questions #43a through 43e, please complete Form A-claim/incident report for each affirmative answer.

44. Has the applicant **ever**:

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

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

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

If the applicant answered YES to any of the above questions #44a through 44d, please complete Form A-claim/incident report for each affirmative answer.

45. 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 the applicant, its employees or physicians even if its is 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 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 ____ ☐ Yes ☐ No

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 the applicant answered YES to any of the above questions #45a through 45f please complete Form A-claim/incident report for each affirmative answer.

46. Do you have knowledge of, 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 the applicant answered YES to the above question #46, please complete Form A-claim/incident report.

47. 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 applicant's current OR prior professional liability carrier? ☐ Yes ☐ No If yes, please explain.

If the applicant answered YES to the above question #47, please complete Form A-claim/incident report.

48. 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 the applicant is applying for, which could result in a professional liability claim against the applicant, or one of its employees or physicians or its.

Signature of Entity Officer: ____

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.

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

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

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, market place, 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.

Name of Applicant (printed)________________________________

By:____________________________________

Print name:______________________________

Title:__________________________________ Date__________________________

Agent/Broker (Producer) Signature: ____________________________Date:_________________________

License No:_____________________________

An underwriter may contact you for further information or clarification.

I acknowledge receipt of this application.

Missouri Professionals Mutual

By: ____Date:_________________________

Form A – Supplement to Application
Claim/Incident Report

Please complete this report for each claim or incident for which the applicant responded YES on its 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 the applicant 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 the applicant, its employees and/or physicians in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that the applicant, or its employees or physicians 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 the applicant's 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 of Entity Officer: _________________________________

Print Name: ____

Date: ____

Section II.

Use this Section for reporting an Incident.

1. Name of Patient: ____

Age: __________ Sex: __________

Address: ____

City/Sta te/Zip: ____

2. Date Reported to Insurance Company:________________________________

3. Name of Insurance Company:________________________________

4. Date of Incident: ____

5. Location of Incident: ____

6. Description of Incident: ____

____

____

7. Extent and Nature of the Injury: ________________________________

____

____

8. Present Condition of the Patient: ________________________________

____

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

____

____

10. State how and when the applicant 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 the applicant, its employees, and/or physicians in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that the applicant, its employees, or physicians did so, pertaining to this Incident?

☐ Yes ☐ No

14. Please provide any other relevant information: ________________________________

____

____

Signature of Entity Officer:____

Print Name: ____

Date: ____