



287 N. Lindbergh Blvd.  
St. Louis, Missouri 63141  
314-587-8000  
Toll Free: 866 262-4030  
Fax: 314-587-8001  
[www.mpmmins.com](http://www.mpmmins.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](http://www.keanegroup.com)

Keane Producer:  
\_\_\_\_\_

**APPLICATION FOR  
BUSINESS ENTITY PROFESSIONAL LIABILITY INSURANCE  
CLAIMS MADE POLICY**

**IMPORTANT:** The Applicant is applying for CLAIMS MADE COVERAGE. For the Applicant's own protection, report to the Applicant's CURRENT insurer BEFORE ITS 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 the Applicant.

- A corporate representative with the power to personally bind the Applicant must **personally** complete this application.
- Business entity coverage is available only where all physicians and healthcare professionals employed by, belonging to, under contract with, and/or having privileges at, the Applicant are insured by MPM.
- Please type or print legibly in black ink.
- Applicant **MUST** attach the declarations page of its current policy.
- Applicant **MUST** report all circumstances that might reasonably be expected to result in a claim or suit, even if the Applicant believes that the claim or suit would be without merit.
- 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.
- Every** question must be answered. If a question does not apply, mark "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 the Applicant's 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 the Applicant. 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 agents.



**If Applicant elects NOT to purchase Prior Acts Coverage, please complete:**

An extended reporting period endorsement has been purchased.

If YES, please attach a copy of the endorsement to this application.

An extended reporting period endorsement has not and will not be purchased.

Applicant will not purchase tail coverage (reporting period endorsement) from its current carrier where Applicant is insured under a claims-made policy. Applicant understands that its failure to purchase such coverage from its current carrier will result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by its current carrier's policy. Further, Applicant understands and acknowledges that the policy which it is purchasing from Missouri Professionals Mutual will **not** provide prior acts coverage.

|    |  |  |  |
|----|--|--|--|
| 5. | Prior Acts Limit of Liability  | <input type="checkbox"/> \$100,000/\$300,000<br><input type="checkbox"/> \$500,000/\$1,000,000<br><input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$200,000/\$600,000<br><input type="checkbox"/> \$500,000/\$1,500,000<br><input type="checkbox"/> \$1,000,000/\$3,000,000 |
| 6. | Deductible requested   | <input type="checkbox"/> None<br><input type="checkbox"/> \$10,000<br><input type="checkbox"/> \$30,000<br><input type="checkbox"/> Other: _____   | <input type="checkbox"/> \$5,000<br><input type="checkbox"/> \$20,000<br><input type="checkbox"/> \$50,000   |
| 7. | Date Entity was Incorporated or Formed                                       | _____ / _____ / _____  |  |
| 8. | Retroactive Date Requested for Applicant                                     | _____ / _____ / _____  |  |
| 9. | If the dates listed in Questions #7 and #8 are not the same, please explain: |  |  |

**III. INSURANCE HISTORY**

|     |  |
|-----|--|
| 10. | <p>Please list all previous professional liability insurers, dating back to the incorporation/formation of the Applicant. Begin with the current insurer first.</p> <p>Name: _____</p> <p><input type="checkbox"/> Claims Made, Retroactive Date (m/d/y): _____ <input type="checkbox"/> Occurrence</p> <p>From (m/d/y): _____ To (m/d/y): _____</p> <p>Policy Number: _____ Limits: _____</p> <p>Name: _____</p> <p><input type="checkbox"/> Claims Made, Retroactive Date (m/d/y): _____ <input type="checkbox"/> Occurrence</p> <p>From (m/d/y): _____ To (m/d/y): _____</p> <p>Policy Number: _____ Limits: _____</p> <p>Please explain gaps in coverage in the Notes Section.</p> |
| 11. | Whether or not the Applicant is applying for retroactive coverage, please provide a copy of the Applicant's current policy including all endorsements; state the annual premium amount; and provide a copy of the declaration page.  |

**IV. PRACTICE INFORMATION**

**12. Physician/Healthcare Provider Schedule:** Please list all physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives and advanced practice nurses who have been employed by or associated with the Applicant since the date of incorporation/formation (see question #7) on Exhibit B. **THIS EXHIBIT IS VERY IMPORTANT. PLEASE COMPLETE FULLY AND CAREFULLY.**

**IMPORTANT:** All physicians and midwives (including all M.D.s, D.O.s, surgeons, and certified nurse midwives) are excluded from coverage under any Policy that may be issued unless specifically named on the Policy Declaration or specifically provided coverage by individual name under an endorsement. If Applicant requests coverage for a current or former physician and/or midwife associated or formerly associated with Applicant or its group, Applicant must name the person above on Exhibit B.

|      |   |   |   |
|------|---|---|---|
| 13a. | How many of the following non-physician individuals are currently employed by or associated with the Applicant? | <input type="checkbox"/> CRNA # _____<br><input type="checkbox"/> Nurse Practitioner # _____<br><input type="checkbox"/> OR Technician # _____<br><input type="checkbox"/> Med Lab Tech # _____<br><input type="checkbox"/> Pharmacist # _____<br><input type="checkbox"/> Scrub Nurse # _____<br><input type="checkbox"/> Med Assistant # _____<br><input type="checkbox"/> RN # _____<br><input type="checkbox"/> Optometrist # _____<br><input type="checkbox"/> Optician # _____<br><input type="checkbox"/> LVN/ LPN # _____ | <input type="checkbox"/> CNM # _____<br><input type="checkbox"/> Physician Assistant # _____<br><input type="checkbox"/> Radiology Technician # _____<br><input type="checkbox"/> Physiotherapist # _____<br><input type="checkbox"/> Psychologist # _____<br><input type="checkbox"/> Surgical Assistant # _____<br><input type="checkbox"/> Other: _____ # _____<br><input type="checkbox"/> Other: _____ # _____ |
|------|---|---|---|

|      |  |  |
|------|--|--|
| 13b. | List below the name of each individual currently employed by or associated with the Applicant. |  |
|      | <b>Name</b>  | <b>Occupation (i.e. M.D., D.O., CRNA, Nurse Practitioner, OR Tech., Med. Lab Tech., Pharmacist, Scrub Nurse, Med. Asst., RN, Optometrist, Optician, LVN/LPN, CNM, P.A., Radiology Tech., Physiotherapist, Psychologist, Surg. Asst., etc.)</b> |
|      | _____  | _____  |
|      | _____  | _____  |
|      | _____  | _____  |
|      | _____  | _____  |
|      | _____  | _____  |
|      | _____  | _____  |
|      | _____  | _____  |

|     |   |
|-----|---|
| 14. | Total Number of Current Employees/Agents: _____ |
|-----|---|

|     |  |
|-----|--|
| 15. | Are any of the individuals listed in questions #13a or #13b independent contractors?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>If independent contractors, do they have their own individual coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>If "Yes", supply a certificate of insurance. If "No", explain coverage arrangements in the Notes Section of this application. |
|-----|--|





|     |   |  |
|-----|---|--|
| 21. | Practice Structure:   | <b>Provide an explanation and/or details in the Notes Section where necessary.</b>   |
|     | a.  | Is the Applicant's business operated or leased by a management company? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br><i>If yes, state the name of the management company:</i><br>_____<br>Please attach a copy of the Applicant's Management Agreement  |
|     | b.  | Is the Applicant considering any changes in operations, products or services in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|     | c.  | Have there been any significant changes in Applicant's practice during the past five years? (e.g. changes of specialties, addition or deletion of procedures?) <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|     | d.  | Since the date of formation/incorporation (see question #7), are credentials for all physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives and advanced practice nurses employed by, under contract with, belonging to, or having privileges at Applicant verified prior to such individual becoming affiliated with the Applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|     | e.  | Since the date of formation/incorporation (see question #7), are new physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives and advanced practice nurses employed by, under contract with, belonging to, or having privileges at Applicant required to maintain professional liability coverage?<br>If yes: What limits?<br>\$ _____ each incident<br>\$ _____ aggregate                      |
|     | f.  | Since the date of formation/incorporation (see question #7), has the Applicant maintained an ongoing risk management program? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|     | g.  | Since the date of formation/incorporation (see question #7), do physicians employed by, under contract with Applicant share employees? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|     | h.  | Since the date of formation/incorporation (see question #7), do physicians employed by, under contract with Applicant share calls? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
|     | i.  | Since the date of formation/incorporation (see question #7), has the specialty or subspecialty of any physicians employed by, under contract with, Applicant changed? <input type="checkbox"/> Yes <input type="checkbox"/> No   |
|     | j.  | Volume of practice (weekly average):<br>Number of scheduled patients seen by Applicant: _____ per week<br><br>Number of walk-in patients seen by Applicant: _____ per week<br><br>Number of patients seen only by a paramedical professional: _____ per week<br>Average weekly total:  |
| 22. | Since the date of formation/incorporation (see question #7), has Applicant obtained <input type="checkbox"/> written (please attach copy) or <input type="checkbox"/> verbal informed surgical consent from patients? |  |

#### V. RATING INFORMATION

|     |  |
|-----|--|
| 23. | Since the date of incorporation/formation (see question #7), has the Applicant's services ever included or do they currently include the administration of anesthesia in a non-hospital setting? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Applicant answered YES to the above question, please explain in the Notes Section of this application. |
|-----|--|

|     |  |
|-----|--|
| 24. | <p>Since the date of incorporation/formation (see question #7), has the Applicant signed any contractual agreement in which the Applicant has agreed to indemnify (hold harmless) other persons or entities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(If so, please note that MPM is not a party to Indemnification or hold harmless agreements under its policies and, accordingly, will not be responsible for any liability incurred under such agreements)</p> <p>If Applicant answered YES to the above question, please explain in the Notes Section of this application.</p>      |
| 25. | <p>Since the date of incorporation/formation (see question #7), has Applicant's services included or do the services currently include any forms of alternative medicine, including chiropractic, holistic, naturopathic, Homeopathic, or ayurvedic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Applicant answered YES to the above question, please explain in the Notes Section of this application.</p>   |
| 26. | <p>Since the date of incorporation/formation (see question #7), have the Applicant's services involved or do the services currently involve diagnostic, consulting or other professional services in States other than MO? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Applicant answered YES to the above question, please explain in the Notes Section of this application.</p>   |
| 27. | <p>Since the date of incorporation/formation (see question #7), has the Applicant or does the Applicant currently participate in pharmaceutical testing or clinical investigation studies not approved by the United States Food &amp; Drug Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Applicant answered YES to the above question, please explain in the Notes Section of this application.</p>  |
| 28. | <p>Is the Applicant covered by another professional liability insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please name the carrier:</p>   |
| 29. | <p>Has any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>  |
| 30. | <p>Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant had its membership in any professional society or association ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>   |
| 31. | <p>Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p> |
| 32. | <p>Has the Applicant or physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant had Medicare/Medicaid fraud charges filed against them? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>   |
| 33. | <p>Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>   |

|     |  |
|-----|--|
| 34. | Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant ever had a grievance filed against them by a county or state medical society, or been censured or received a private reprimand from any such organization or hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If YES, please explain in the Notes Section of this application. |
| 35. | Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant ever had professional liability insurance refused, cancelled or non renewed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If YES, please explain in the Notes Section of this application.   |

## VI. LOSS INFORMATION

|     |  |
|-----|--|
|     | <b>IMPORTANT:</b> MPM will rely on the accuracy of all statements made in determining whether or not to issue a policy of insurance. Incomplete or incorrect information given by the Applicant, in the event of a claim, could lead to the denial of insurance coverage by MPM. In addition, MPM may, in its discretion require an increased premium retroactively in the event of a claim arising from information not fully and completely disclosed at the time of this application.   |
| 36. | Has the Applicant ever:<br>a. Been a party to a lawsuit alleging medical malpractice or negligence? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. Had a claim for medical malpractice settled on its behalf with or without the filing of a lawsuit? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If any of the answers to questions #36a through #36b is YES please complete <b>FORM-A</b> .  |
| 37. | Has any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant ever:<br>a. Been a party to a lawsuit alleging medical malpractice or negligence? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>b. Had a claim for medical malpractice settled on its behalf with or without the filing of a lawsuit? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If any of the answers to questions #37a through #37b is YES please complete <b>FORM-A</b>  |
| 38. | Does the Applicant or any physician, surgeon, physicians' assistant, certified registered nurse anesthetist, certified nurse midwife, midwife or advanced practice nurse employed by, belonging to, under contract with, or having privileges at Applicant have knowledge of any facts or circumstances arising out of any patient care provided by Applicant or by any employee or agent of Applicant or others at the Applicant's request or referral or direction which resulted in a patient or a patient's representative, friend or relative becoming dissatisfied with the outcome of a procedure, treatment or diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If YES, provide an explanation in the Notes Section of this application. |
| 39. | Does the Applicant or any physician, surgeon, physicians' assistant, certified registered nurse anesthetist, certified nurse midwife, midwife or advanced practice nurse employed by, belonging to, under contract with, or having privileges at Applicant of any facts or circumstances relating to or arising out of any patient care provided by the Applicant or by any employee or agent of Applicant or by others at the Applicant's request, referral or direction which have resulted in a claim or lawsuit that has been reported to the Applicant's current or prior professional liability carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If YES, please complete <b>FORM-A</b> .   |

|     |  |
|-----|--|
| 40. | <p>Does the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant know of any facts or circumstances arising out of any patient care provided by that Applicant or by any employee or agent of Applicant or by others at the Applicant's request or referral or direction which could possibly result in a claim being made against the Applicant, even if it is only a remote possibility or even if Applicant believes the claim or suit would be without merit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please provide an explanation in the Notes Section.</p>  |
| 41. | <p>Is the Applicant or any physician, surgeon, physicians' assistant, certified registered nurse anesthetist, certified nurse midwife, midwife or advanced practice nurse employed by, belonging to, under contract with, or having privileges at Applicant aware of any of the following circumstances:</p> <p>a. A request for records from a patient and/or attorney related to an adverse outcome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. A letter or other communication from a patient, patient's representative, friend, relative or attorney regarding medical treatment of a patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?</p> <p>i. Cardiac arrest <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ii. Postoperative coma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>iii. Postoperative neurological deficits <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>iv. Unexpected death within 48 hrs. postoperatively <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>v. All others <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. A request for the medical records of a patient who was deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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 Applicant or any physician or healthcare professional employed by, belonging to, under contract with, or having privileges at Applicant prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES to any of the above questions #41a through 41f, please explain in the Notes Section of this application.</p> |
| 42. | <p>Has the Applicant or any physician, surgeon, physicians' assistant, certified registered nurse anesthetist, certified nurse midwife, midwife or advanced practice nurse employed by, belonging to, under contract with, or having privileges at Applicant received a letter from an attorney wherein the attorney states that the applicant or any of its employees or physicians may have acted negligently in the treatment of a patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>  |
| 43. | <p>Has the Applicant or any physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives or advanced practice nurses employed by, belonging to, under contract with, or having privileges at Applicant 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please explain in the Notes Section of this application.</p>  |

44. Other than the incidents, events and claims disclosed on Form A attached hereto, since the date of formation/incorporation (see question 7), there are no circumstances, acts, errors or omissions, known to Applicant or of which Applicant should reasonably be aware which could result in a professional liability claim against Applicant or any of Applicant's employees, contractors, equity holders, officers or directors.

Name of Applicant: \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant understands and agrees 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. Applicant further understands and agrees 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.

Applicant hereby declares that its statements in this application and any attachments hereto are true and accurate and complete, and that Applicant has 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 Applicant is applying, Applicant agrees to immediately notify Missouri Professionals Mutual ("Company") of any information, fact or circumstance that amends, modifies or changes any information contained in this application. Applicant further agrees to be bound by the underwriting guidelines of Missouri Professionals Mutual.

In accordance with the provisions of Section 383.035, RSMo, Applicant hereby states that Applicant acknowledges and understands 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 Applicant may not be charged such rate by the Company for coverage and may be charged an increased rate. Applicant hereby acknowledges and consents to such increased rate to be charged by the Company for medical malpractice coverage under the Company Policy.

Applicant hereby authorizes the present and prior professional liability insurance carriers and any and all attorneys who have represented Applicant 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 Applicant's acceptability to the Company as a professional liability insurance risk.

Applicant also authorizes all medical associations and medical societies in which it is or has been a member, all hospitals in which Applicant now holds or has held staff privileges, the State Board of Medical Examiner for the State of Missouri and any other State in which Applicant has practiced, or resided, and any and all entities and physicians having information regarding Applicant, 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 Applicant's acceptability to the Company as a professional liability insurance risk.

Applicant hereby releases and agrees 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.

Applicant 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 Applicant. Applicant agrees that it 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 Applicant hereby expressly waives any right it may have to compel such disclosure.

Applicant further agrees 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.

Applicant acknowledges that it is responsible for payment of all unpaid assessments and premiums regardless of whether anyone has agreed to pay premiums on Applicant's behalf.

Applicant authorizes release and exchange of information involving past and future underwriting and claims matters, including but not limited to investigations for material information on Applicant's reputation.

Applicant understands and acknowledges 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, Applicant accepts the following conditions during the processing and consideration of its application – regardless of whether or not Applicant is granted insurance – and for the duration of the insurance which may be issued to Applicant: To the fullest extent permitted by law, Applicant extends absolute immunity to, and releases 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 Applicant’s 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.

Applicant hereby declares and warrants that the foregoing statements and particulars are, to the best of Applicant’s knowledge and recollection, complete and correct and that it has not suppressed or misstated any material facts. Applicant understands that this is an application for insurance and not an insurance binder.

Applicant acknowledges that acceptance into the Company’s insurance program is not a right of every applicant for insurance, and that its 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 the signature of a corporate representative with the power to personally bind Applicant on this Application, Applicant hereby, as of the date Applicant shall become a member, (or in the event this is a renewal application, the date provided below) constitutes and appoints Timothy H. Trout or in his absence the then current Chairman of the Board of Directors of the Company as Applicant’s proxy with full power of substitution to represent the undersigned by casting by proxy the vote to which the Applicant is entitled at all general, annual and/or special meetings of the members of the Company to be held between the date Applicant shall become a member and the date thirty-six (36) months from the date of the signature below of a corporate representative with the power to personally bind Applicant, 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 ratifies 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 Applicant agrees 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. Applicant agrees 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 Applicant’s policy is written, regardless of any intervening termination of said policy. Applicant agrees that any representative appearing on its behalf and appointed by Applicant has authority to do so.

Applicant authorizes 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 Applicant has designated as its contact in this application.

Name of Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Broker (Producer) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Broker License No: \_\_\_\_\_

An underwriter may contact the Applicant for further information or clarification. The Company acknowledges receipt of this application.

Missouri Professionals Mutual

By: \_\_\_\_\_

Date: \_\_\_\_\_



**Form A – Supplement to Application  
Claim/Incident Report**

Please complete this form to report any facts or circumstances arising out of any patient care provided by the Applicant or by any employee of agent of Applicant or by others at the Applicant's request or referral which could possibly result in a claim, even if it is only a remote possibility, and even if Applicant believes the claim or suit would be without merit. Please otherwise utilize this form to respond to any questions on Applicant's application where it responded with a "Yes." [Attach copies of patients' charts, operative notes or other documents as appropriate to explain the facts and circumstances.]

**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 Applicant became aware of this Claim:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**11. 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 or any physician or healthcare professional employed by, belonging to, under contract with, or having privileges at Applicant in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that the Applicant or any other person did so, pertaining to this Claim?**

Yes  No

**14. Status of Claim** (check applicable answer):

- Suit threatened, no action taken       Suit Settled Out-of-Court       Awaiting Med/Dental Screening Panel Review
- Suit filed but dropped by claimant      a. Date claim paid \_\_\_\_\_  
b. Amount paid \_\_\_\_\_       Awaiting mediation
- Summary Judgment in Applicant's Favor      c. Did Applicant want to settle this claim?  Yes  No       Awaiting court action  
Reserve Amount: \_\_\_\_\_
- Court outcome in Applicant's favor       Court outcome in favor of plaintiff
- Jury Verdict       Jury Verdict  
 Directed Verdict       Directed Verdict
- Amount of Loss Payment: \$ \_\_\_\_\_

**15. Name and address of the attorney assigned to Applicant's case:** \_\_\_\_\_

**16. To the Applicant's knowledge, was any settlement paid by another party involved (i.e., 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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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. 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 Applicant or any physician or healthcare professional employed by, belonging to, under contract with, or having privileges at Applicant in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that Applicant or any other person did so, pertaining to this Incident?**

Yes  No

**14. Please provide any other relevant information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Exhibit B:**  
**Physician/Healthcare Provider Schedule**

Please list all physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives and advanced practice nurses who have been employed by or associated with the Applicant since the date of incorporation/formation (see question #7).

**If needed please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).**

| Full Name | Occupation<br>(i.e. M.D., D.O.,<br>CRNA, Nurse<br>Practitioner, OR Tech.,<br>Med. Lab Tech.,<br>Pharmacist, Scrub<br>Nurse, Med. Asst., RN,<br>Optometrist, Optician,<br>LVN/LPN, CNM, P.A.,<br>Radiology Tech.,<br>Physiotherapist,<br>Psychologist, Surg.<br>Asst., etc.) | Dates of<br>Employment<br>/Association | Status  | Present<br>Malpractice<br>Carrier and<br>& Policy<br>Number | Do you<br>want<br>coverage<br>for this<br>Person?               | Is Tail<br>Coverage<br>currently<br>in effect<br>for this<br>person? |
|-----------|---|--|---|---|---|--|
|           |   |  | <input type="checkbox"/> Shareholder/<br>Partner<br>% ____ Ownership<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent<br>Contractor |   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No      |
|           |   |  | <input type="checkbox"/> Shareholder/<br>Partner<br>% ____ Ownership<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent<br>Contractor |   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No      |
|           |   |  | <input type="checkbox"/> Shareholder/<br>Partner<br>% ____ Ownership<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent<br>Contractor |   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No      |
|           |   |  | <input type="checkbox"/> Shareholder/<br>Partner<br>% ____ Ownership<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent<br>Contractor |   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No      |
|           |   |  | <input type="checkbox"/> Shareholder/<br>Partner<br>% ____ Ownership<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent<br>Contractor |   | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No      |

**IMPORTANT:** All physicians and midwives (including all M.D.s, D.O.s, surgeons, and certified nurse midwives) are excluded from coverage under any Policy that may be issued unless specifically named on the Policy Declaration or specifically provided coverage by individual name under an endorsement. If Applicant requests coverage for a current or former physician and/or midwife associated or formerly associated with Applicant or its group, Applicant must name the person above on Exhibit B.