

Missouri Professionals Mutual 287 N. Lindbergh Blvd. St. Louis, Missouri 63141 314-587-8000 Toll Free: 866 262-4030 Fax: 314-587-8001 www.mpmmins.com	<p>Send Completed Application To: The Keane Insurance Group, Inc. 10777 Sunset Office Dr. Ste. 200 St. Louis, Missouri 63127 314-966-7733 800-966-7731 Fax: 314-966-7797 www.keanegroup.com</p> Keane Producer: _____
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**RENEWAL APPLICATION FOR
 MEDICAL PROFESSIONAL LIABILITY INSURANCE
 CLAIMS MADE POLICY**

THIS RENEWAL APPLICATION AND ALL PREVIOUS APPLICATIONS
 WILL BE ATTACHED TO AND FORM A PART OF YOUR POLICY

Name of Insured: _____

Retroactive Date of Insured Under Current Policy: _____ (“Retroactive Date”)

Email Address: _____

Current Policy # _____

PLEASE COMPLETE THE ENTIRE APPLICATION.

This is an Application only. Completion of this Application or its receipt by Missouri Professionals Mutual (the “Company”) or an agent or broker does not bind Company to issue a policy to you. Before coverage can be bound or a policy issued, this Application must be approved by the Company’s underwriting department and the initial payment must be received by the Company 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.

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: _____
Email Address: _____
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.

7.	<p>In the past year have any prior carriers settled a claim on your behalf or have any incidents or claims been dismissed or resolved in any way? If "yes", please complete the following: Name of Carrier _____ Claimant's Name _____ Date of Treatment _____ Settlement Amount _____ Date Paid _____</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>If you answered YES to the above question # 7 please complete Forms A – Claim Report and/or A-1 - Incident Report for each affirmative answer. Any Policy issued as a result of this Application 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, unless such is endorsed onto the Policy.</p>			
<p>IMPORTANT: The Company 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 you, in the event of a claim, could lead to the denial of insurance coverage by the Company.</p>			
8.	<p>Do you know of any facts or circumstances that have occurred since your most recent application/renewal application arising out of any patient care provided by you or others at your request or referral or direction which could possibly result in a claim being made against you or your corporation, even if it is only a remote possibility in your mind and even if you believe the claim or suit would be without merit? If so, have you reported these circumstances to our claims department?</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>If you answered YES to the above question # 8, please complete Form A- claim/incident report for each affirmative answer</p>			
9.	<p>Since your most recent application/renewal application have you utilized or do you utilize medical subcontractors or medical agents, on or off site, for purposes of providing professional medical services? If so, explain who and under what circumstances. _____ _____</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

I hereby declare that my statements in this application and any attachments hereto are true and accurate and complete, 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 the 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 Company's underwriting guidelines.

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 Examiners 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.

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 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 me 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 extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, Missouri Professional Management, L.L.C., MPM Claims Management, L.L.C., MPM Client Services, L.L.C., and all of their respective 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 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. I further acknowledge that acceptance of advance payment does not bind the Company to provide insurance.

By my signature on this application, I hereby, as of the date provided below, constitute and appoint Timothy H. Trout or, in his absence, the 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, annual and/or special meetings of the members of the Company to be held between the date I shall become a member and the date 36 months from the date of my signature below, at which time this proxy shall expire unless renewed 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, I agree to accept and will be bound by the Articles of Association and the Bylaws 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 Bylaws, 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.

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 in this application.

I understand and agree that the warranties, representations and conditions contained in the previous Applications continue in full force and effect. I further agree and understand that the responsibilities, duties and obligations stated in the previous Applications also continue in full force and effect. I declare that the information provided herein is true and together with the Applications shall be the basis of the Company's underwriting.

Signature: _____ **Date:** _____

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is executed in favor of the Company and shall be effective as of the effective date of any Policy issued by the Company as a result of this Application.

Recitals

The Company and the Insured have an insurer/insured relationship by virtue of a professional liability policy issued by the Company to the Insured (the "Policy"). The Company and the named Insured(s) on the Policy are committed to complying with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the Privacy Regulations, the Insured(s) is(are) a "covered entity," and, as defined by 45 C.F.R. § 164.502(e) and 45 C.F.R. § 164.504(e), the Company is a Company of the Insured(s). The Company must use and/or disclose Protected Health Information in its performance of services under the Policy. The Company agrees to abide by the assurances, terms, and conditions contained herein in the performance of its obligations. This Agreement sets forth the manner in which Protected Health Information that is provided to, or received by, the Company, from or on behalf of the Insured(s) will be handled. The Company agrees as follows:

Section 1 Definitions

- 1.1 **Company:** "Company" shall mean MPM.
- 1.2 **Covered Entity:** "Covered Entity" shall mean the Insured(s) named in the Policy.
- 1.3 **Designated Record Set:** "Designated Record Set" means "Designated Record Set" as defined in 45 C.F.R. § 164.501.
- 1.4 **Individual:** "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
- 1.5 **Privacy Rule:** "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. parts § 160 and § 164, subparts A and E.
- 1.6 **Protected Health Information (PHI):** "Protected Health Information" (PHI) shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 164.501, limited to the information received by the Company from, or on behalf of, Covered Entity.
- 1.7 **Required by Law:** "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.501.
- 1.8 **Secretary:** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

Section 2 Obligations and Activities of the Company

The Company agrees to the following:

- 2.1 **Not to Use or Disclose PHI Unless Permitted.** The Company agrees not to use, or further disclose, PHI other than as permitted or required by the Agreement or as Required by Law.
- 2.2 **Use Safeguards.** The Company agrees to use reasonable and appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or as otherwise Required by Law.
- 2.3 **Report Inappropriate Disclosures of PHI.** The Company agrees to report to Covered Entity any use or disclosure of the PHI not permitted by this Agreement or Required by Law of which it becomes aware.
- 2.4 **Compliance of Agents.** The Company agrees to require and ensure that any agents, including subcontractors, to whom it provides PHI received from, or created or received by the Company on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to the Company with respect to such information.
- 2.5 **Access.** To the extent the Company maintains the Designated Record Set, the Company agrees to provide access to PHI in the original Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to the Company, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. § 164.524.
- 2.6 **Amendments.** To the extent the Company maintains the Designated Record Set, Company agrees to incorporate any amendment(s) to PHI in the original Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. § 164.526.
- 2.7 **Disclosure of Practices, Books, and Records.** Unless otherwise prohibited by law, the Company agrees to make internal practices, books, and records which are directly related to the protection of PHI available to the Covered Entity or to the Secretary, during normal business hours, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule. The Company shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Company's receipt of such request.
- 2.8 **Accounting.** The Company agrees to maintain sufficient documentation of any disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- 2.9 **Release of Documentation of Disclosures.** The Company agrees to provide to Covered Entity information collected in accordance with Section 2.8 of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of

disclosures of PHI in accordance with 45 C.F.R. § 164.528. The Company shall have a reasonable time within which to comply with such requests and, in no case shall access be required in less than five business days after the Company's receipt of such request.

- 2.10 Security of Electronic Protected Health Information (EPHI).** The Company agrees to: (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains or transmits on behalf of Covered Entity; (2) ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and (3) report to the Covered Entity any security incident of which it becomes aware.

Section 3 Permitted Uses and Disclosures by Company

3.1 Use of PHI for Specified Purposes

Under the Insurance Policy, the Company provides the Covered Entity with insurance products and services, hereinafter "Services" that involve the use and disclosure of PHI as defined by the Privacy Regulations. These Services may include, among others, the provision of professional liability insurance; receiving and evaluating incidents, claims, and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance and other functions necessary to perform these Services. Except as otherwise limited in this Agreement, the Company may use or disclose PHI on behalf of, or to provide services to, Covered Entity that are necessary for Company to perform its obligations under this Agreement, under law, and under the Insurance Policy. Moreover, the Company may disclose PHI for the purposes authorized by this Agreement: (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section 3.2 through 3.4 of this Section below; or (ii) as otherwise permitted by the terms of this Agreement. All other uses not authorized by this Agreement are prohibited.

- 3.2 Use of PHI for Company Management and Administration.** The Company may use PHI for the proper management and administration of the Company or to carry out the legal responsibilities of the Company.

- 3.3 Disclosure Required by Law or With Reasonable Assurances.** The Company may disclose PHI for the proper management and administration of the Company and to carry out its legal responsibilities, provided that disclosures are Required by Law, or provided that the Company obtains the following reasonable assurances from the person or entity to whom the PHI is disclosed: 1) the PHI will remain confidential; 2) the PHI will be used or further disclosed only as required by law or for the purposes for which it was disclosed; and, 3) the person or entity will notify the Company of any instances of which the person or entity is aware in which the confidentiality of the information has been breached.

- 3.4 Data Aggregation Services.** Company may use PHI to provide data aggregation services to the Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

Section 4 Impermissible Requests by Covered Entity

The Company understands that the Covered Entity shall not request Company to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except that, despite this Section 4, Company may use or disclose PHI for data aggregation or management and administrative activities of Company as is otherwise permitted by this Agreement.

Section 5 Term and Termination

- 5.1 Term.** The Term of this Agreement shall be effective during the term of the Insurance Policy between the Company and the Covered Entity, and shall terminate when all of the PHI provided by Covered Entity to Company, or created or received by Company on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

- 5.2 Termination for Cause.** Upon Covered Entity's knowledge of a material breach by Company of this Agreement, Covered Entity shall provide an opportunity for Company to cure the breach. If Company fails or is unable to cure the breach after a reasonable period of time Covered Entity may terminate this Agreement.

- 5.3 Effect of Termination.** Upon termination of this Agreement or the Insurance Policy, the protections of this Agreement will remain in force and Company shall make no further uses and disclosures of PHI except for the proper management and administration of its business or to carry out its legal responsibilities or as Required by Law.

Section 6 Miscellaneous Provisions

- 6.1 Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the Section in effect or as amended, and for which compliance is required.

- 6.2 Amendment.** The Company agrees to take such action as is necessary to amend this Agreement from time to time as is necessary, as determined by the Company, for compliance with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

- 6.3 Survival.** The rights and obligations of the Company under this Agreement shall survive the termination of this Agreement and the termination of the Policy.

6.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

Signature: _____

Date: _____

Agent/Broker (Producer) Signature: _____

Date: _____

Agent/Broker License No: _____

An underwriter may contact you for further information or clarification.

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

Please complete this form to report any facts or circumstances relating to any patient care provided by you or others at your request or referral which resulted in a claim, even if you believe the claim or suit to be without merit. [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, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

1. **Name of Patient:** _____

2. **Name of Insurance Company:** _____

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

- | | |
|--|--|
| <input type="checkbox"/> Suit threatened,
no action taken | <input type="checkbox"/> Suit Settled Out-of-Court
Screening Panel Review |
| <input type="checkbox"/> Suit filed but dropped by
claimant | a. Date claim paid _____
b. Amount paid _____
c. Did <u>you</u> want to settle this
claim? <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | | |
|---|--|
| <input type="checkbox"/> Dismissed With Prejudice | <input type="checkbox"/> Dismissed Without Prejudice |
| <input type="checkbox"/> Awaiting mediation | <input type="checkbox"/> Awaiting court action |
| Reserve Amount: _____ | |

- | | |
|--|--|
| <input type="checkbox"/> Summary Judgment in your
Favor | <input type="checkbox"/> Court outcome in your favor |
| <input type="checkbox"/> Court outcome in favor of plaintiff | |
| <input type="checkbox"/> Directed Verdict | Amount of Loss Payment: \$ _____ |

4. **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: \$ _____

Signature: _____

Print Name: _____

Date: _____

**Form A-1 – Supplement to Application
Incident Report**

Please complete this form to report any facts or circumstances relating to any patient care provided by you or others at your request or referral which could possibly result in a claim, even if it is only a remote possibility in your mind, and even if you believe the claim or suit would be without merit. [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 incident, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

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 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 – Supplement to Renewal Application

Supplemental Questionnaire for Collaborative Practice Agreements

1. List the names, titles and employers of the parties to the collaborative practice agreement and/or arrangement referenced in question 6b of this renewal application:

2. List the professional liability carriers, limits, policy numbers, and policy periods for each of the parties to the agreement or arrangement:

Please attach a copy of the declarations page(s) for each to this form.

3. Please provide the following:

Term of the agreement or arrangement: from ____/____/____ to ____/____/____

Signature: _____

Print Name: _____

DATE: _____

Form H - REQUEST FOR PART-TIME COVERAGE

Please complete this form if you are requesting part-time coverage.

- a. Name: _____ M.D. D.O. Other _____
- b. Policy #: _____
- c. I am requesting coverage on a part-time basis effective (m/d/y): _____
- d. Number of hours worked per week for which coverage is being requested: _____
(Practice hours consist of: Hospital rounds, on call hours involving patient contact, communications with other physicians, patient visits, and charting.)
- e. Patient Load Per Week: _____
- f. Specialty for which you are applying for coverage: _____
- g. My practice is reduced due to:
 - Pregnancy or dependent care
 - Semi-retirement: Date of Birth: _____
 - Disability: Type _____ (Please submit explanation from treating physician)
 - Majority of spent in a teaching capacity – Hours per week: _____
Place: _____
 - Majority of employment insured through hospital: Name of Hospital: _____
 - Majority of employment is in another state, which is insured elsewhere; State: _____
 - Majority of practice insured through another carrier, entity or employer.
 - Other (Please provide a description)
- h. How long do you anticipate your coverage will be at these reduced hours? _____
- i. Please submit proof of coverage for any employment listed above which is to be excluded on your MPM Policy.

Signature: _____

Print Name: _____

Date: _____