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St. Louis, Missouri 63141
314-587-8000
Toll Free: 866 262-4030
Fax: 314-587-8001
www.mpmmins.com

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

Keane Producer: _____

ANCILLARY PERSONNEL APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE POLICY

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

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

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

I. GENERAL INFORMATION

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

II. POLICY OPTIONS

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

III. MEDICAL BACKGROUND

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

8. Medical Education

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

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

9. State(s) where currently licensed:

- a. # _____ Type of License _____ Date of License _____ Expiration _____ % of Practice _____
b. # _____ Type of License _____ Date of License _____ Expiration _____ % of Practice _____
c. # _____ Type of License _____ Date of License _____ Expiration _____ % of Practice _____

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

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

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

If YES, please explain: _____

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

If YES, please explain: _____

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

If YES, do you: Observe Assist Other: _____

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

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

16. Do you ever work in an emergency room? Yes No

If YES, do you: Observe Assist Other: _____

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

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

19. Do you have an employment contract in any capacity involving the practice of medicine? Yes No

If YES, please provide a copy

IV. PRACTICE HISTORY

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

21. Entity Name & Address: _____ from ___/___/___ to ___/___/___

22. Entity Name & Address: _____ from ___/___/___ to ___/___/___

23. Entity Name & Address: _____ from ___/___/___ to ___/___/___

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

V. CLAIM INCIDENT AND INSURANCE HISTORY

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

Contact Name: _____
 Title: _____
 Telephone Number: _____

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

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

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

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

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

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

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

30. Have you ever:

- a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, nonrenew or revoke your privileges? Yes No
- b. Has your membership in any professional society or association ever been suspended or revoked? Yes No
- c. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? Yes No
- d. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? Yes No
- e. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? Yes No
- f. been evaluated, treated or hospitalized for any of the following: Yes No
 - alcoholism central nervous system stimulants or depressants
 - mental or emotional disorders drug addiction
- g. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? If YES, please submit a letter from your treating physician addressing your state of health and whether any condition exist which could adversely affect the practice of your medical specialty. Yes No

- h. had Medicare/Medicaid fraud charges filed against you? Yes No
- i. signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? (If so, please note that MPM is not a party to Indemnification or hold harmless agreements under its policies and, accordingly, will not be responsible for any liability incurred under such agreements) Yes No
- j. Have you ever been refused board certification? Yes No
- k. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? Yes No

l. been contacted by any hospital committee or group (other than an official peer review committee) that has reviewed (i) any issue regarding your delivery of medical services which you know or should have reason to know was of significant concern to a hospital where you have privileges, or (ii) any issue which arose out of any unexpected occurrence involving death or serious physical or psychological injury?

- Yes No

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

- 31. Have you **ever**:
 - a. Been a party to a lawsuit alleging medical malpractice or negligence? Yes No
 - b. Had a claim for medical malpractice settled on your behalf with or without the filing of a lawsuit? Yes No
 - c. Received a letter from an attorney wherein the attorney states that you may have committed malpractice or acted negligently in the treatment of a patient? Yes No
 - d. Received a letter from a patient or relative of the patient wherein the patient or relative of the patient claims that you committed malpractice or acted negligently in the treatment of a patient? Yes No
 - e. Given a deposition in a lawsuit where you were not a party in the lawsuit but your employer was a party to the lawsuit and the lawsuit alleged medical malpractice? Yes No

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

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

- a. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- b. A letter communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? Yes No
- c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? Yes No
- d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
 - i. Cardiac arrest Yes No
 - ii. Postoperative coma Yes No
 - iii. Postoperative neurological deficits Yes No
 - iv. Unexpected death within 48 hrs. postoperatively Yes No
 - v. All others _____ 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 you answered YES to any of the above questions #32a through 32f please complete Form A-claim/incident report for each affirmative answer.

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

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

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

Yes No

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

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

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

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

Signature: _____ **Date:** _____

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

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

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

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

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

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

I hereby release and agree to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I hereby acknowledge that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to me. I agree that I shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and I hereby expressly waive any right I may have to compel such disclosure.

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

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

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

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

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

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me: To the fullest extent 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

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

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

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

Section I.

Use this section for reporting a Claim.

1. Name of Patient: _____

Age: _____ Sex: _____

Address: _____

City/State/Zip: _____

2. Date Reported to Insurance Company: _____

3. Name of Insurance Company: _____

4. Date of Claim: _____

5. Location of Claim: _____

6. Description of Claim: _____

7. Extent and Nature of the Injury: _____

8. Present Condition of the Patient: _____

9. Extent, Nature and Type of Claim: _____

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

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

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

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

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

13. **Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this Claim?**

Yes No

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

Suit threatened, no action taken

Suit 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 your
Favor

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

Awaiting court action
Reserve Amount: _____

Court outcome in your 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 your case:** _____

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

Yes No

If "yes," list settlement amount: \$ _____

17. **Please provide any other relevant information:** _____

Signature: _____

Print Name: _____

Date: _____

Section II.

Use this Section for reporting an Incident.

1. Name of Patient: _____

Age: _____ Sex: _____

Address: _____

City/State/Zip: _____

2. Date Reported to Insurance Company: _____

3. Name of Insurance Company: _____

4. Date of Incident: _____

5. Location of Incident: _____

6. Description of Incident: _____

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 – Educational Information

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

Medical School: _____ from ___/___/___ to ___/___/___

Internship: _____ from ___/___/___ to ___/___/___

Residency: _____ from ___/___/___ to ___/___/___

Type of Residency: _____ Completed: ___ Yes ___ No

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

Name and type: _____ from ___/___/___ to ___/___/___

Name and type: _____ from ___/___/___ to ___/___/___