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FAX

To receive a RapidQuote, please complete and return to us by fax at **(800) 955-1855**
or email completed form to **quote@modocs.org**—*for assistance call* **(816) 901-9950**

WEB

Missouri Doctors Mutual Insurance Company
RapidQuote†

MoDocs®

Physician or Group Name: _____
Group name **or** First name, M.I., Last name

County or Counties of Practice: _____

Contact Person: _____ Phone: ( ) -

Fax: ( ) - Email address: _____

Expiration Date: _____ Current carrier: _____
(Please attach a copy of your current declarations page or certificate of insurance.)

Are you currently licensed or have you ever been licensed to practice Medicine outside of the state of Missouri? Yes ☐ No ☐
If so, please list each state in which you have been licensed: _____

Requested Limits: ☐ 500/1M ☐ 1M/3M ☐ 2M/6M

List each physician and requested information on each:

Physician First name, M.I., Last name	Start Date in Medical Practice	Specialty	Retroactive Date Requested	Hours Worked Per Week	Invasive Surgery? Yes	Invasive Surgery? No
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Claim History:

Have you or any doctor in the group ever had a claim filed against you? Yes ☐ No ☐
If Yes, please complete the following:
(*Claim status means it is either:* **Pending**, **Closed**, **Dismissed**, **Settled** or **Verdict**.)

Physician First name, M.I., Last name	Date of Incident	Claim Status	Amount of Settlement/Verdict
		-- Select -->	$
		-- Select -->	$
		-- Select -->	$
		-- Select -->	$

if you need more space, please attach additional claim history.

Your Signature: _____ **Date:** _____

†This ***RapidQuote*** does not constitute a formal application for insurance. Any premium estimate based upon this request is for general information only and is not binding on Missouri Doctors Mutual Insurance Company (MoDocs). Once a formal application for insurance is received by MoDocs, if a determination is made to offer insurance to the applicant, a firm premium quote will be made at that time.