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Missouri Doctors Mutual Insurance Company (NAIC #11964)

Ancillary Personnel Application

601 Francis Street, Saint Joseph, Missouri 64501
Tel (800) 264–5959 Fax (800) 955–1855

MoDocs®

Before you begin

- Please use black ink when completing this application. Type or print complete answers to every question or write "N/A" for *not applicable*. Failure to provide complete information will delay the processing of this application. Use the 'notes' section to amplify your answers or to provide additional remarks. If you are unsure how to answer a question, call our underwriting department at (816) 676–6363 or (800) 264–5959 between 8:30 AM and 5 PM Monday through Friday.
- An attached curriculum vitae will not suffice; this application must be completed.
- This completed application, together with any supplementary information, must be personally reviewed, signed and dated in ink by the applicant.

1 Personal

First name	Middle name	Last name	Suffix (Jr./Sr./III)

Maiden name	Degree (NP, PA, CRNA)	Date of Birth / /	Age in years	Social security number

License number	BNDD number (if applicable)

2 Residential Address

Street	Apt

City	State	Zip	County

Home phone ( ) -	Home email

3 Practice Address

Practice name

Street	Suite

City	State	Zip	County

Office phone ( ) -	Office fax ( ) -	Office email

Contact person	Number of practice locations (If different from # 3 list on notes page)

4 Supervising Information

Supervising Physician(s) (Attach Collaborative Practice Agreement if applicable) ►

5 Do you work for anyone other than this physician/corporation/partnership? Yes ☐ No ☐
If yes, please explain. ▼

6 Do you have any medically related duties that are insured by another company or for which you do not desire MoDocs coverage? Yes ☐ No ☐
If yes, please explain. ▼

▼

Professional Profile

Please use the 'notes' section to explain any "Yes" answers in detail.

7	Have you ever been denied board certification or recertification?	Yes ☐ No ☐
8	Has any hospital or other entity ever refused, limited, restricted, suspended, revoked, or is currently investigating a complaint regarding your clinical or staff privileges?	Yes ☐ No ☐
9	Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your state or federal narcotics license ever been denied, restricted, suspended, revoked, voluntarily surrendered or limited in any way?	Yes ☐ No ☐
10	Have you ever been indicted or convicted of a crime other than a minor traffic violation?	Yes ☐ No ☐
11	Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)?	Yes ☐ No ☐
12	Has any complaint ever been made against you to any licensing board? (If yes, explain in the notes section the final result of any investigation by that board.)	Yes ☐ No ☐
13	Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice?	Yes ☐ No ☐
14	Are you now, or have you ever been, addicted to alcohol, dependent upon narcotic drugs, been afflicted with mental illness, or have you ever received treatment for alcoholism, narcotic addiction or mental illness?	Yes ☐ No ☐
15	Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	Yes ☐ No ☐
16	Do you perform general anesthesia? If "Yes", check as appropriate below. ▼	Yes ☐ No ☐
	☐ Hospital ☐ Non-hospital facility ☐ Office	
17	Do you practice in an emergency room? If you answer "Yes", complete the following: ▼	Yes ☐ No ☐
	Hours per month? _____	
18	Do you provide regular medical or surgical care to professional athletes?	Yes ☐ No ☐

Professional Duties

19	Estimate the total number of hours you work per week in office and clinical practice including direct patient care, consultation, administrative activities, etc.	Hours per week
20	Do you treat or review treatment of prison inmates?	Yes ☐ No ☐
21	Do you provide medical information or advice, interpret files, prescribe medication, or sell any products or services via the internet or other telecommunications system?	Yes ☐ No ☐

Specialty

22	Primary specialty	% of Practice	Years practicing primary specialty
23	Secondary specialty	% of Practice	Years practicing secondary specialty

Licensed to Practice

24 List all states in which you are licensed to practice, primary practice state first. If temporary, submit a copy of your permit. *Please check the box to the far right if you plan to practice in that state in the next year.* ▼

State (primary practice)	License number	Status *see below*◆	% of Practice ☐
State	License number	Status *see below*◆	% of Practice ☐
State	License number	Status *see below*◆	% of Practice ☐

◆ Status is **Temporary** / **Active** / **Inactive** / **Suspended** / **Restricted** / **Revoked**
If anything other than Active, explain in notes. if more that four, list in 'notes' section.

Practice Positions

25 List previous practice positions other than current practice position. Please explain any date gaps in practice positions. ▼

If you need more space, use the 'notes' section.

Entity name	Address / City / State / Type of practice	From	To
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /

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▼

Staff Privileges

26 List all hospitals or other facilities at which you have staff privileges, primary hospital first. *Please check the box to the far right if you wish us to issue a certificate of insurance to this hospital or facility.* ▼

Hospital / facility	Address / City / State	County		
Hospital / facility	Address / City / State	County		☐
Hospital / facility	Address / City / State	County		☐
Hospital / facility	Address / City / State	County		☐
Hospital / facility	Address / City / State	County		☐

Medical Malpractice Insurance

27–38

27 Effective date requested ► / / Is prior acts coverage requested? Yes ☐ No ☐

28 Will you be carrying additional professional liability insurance with another company? If "yes", please show, in the 'notes' section, the name of the company, limits of liability, effective dates, and what aspect of your practice the other insurance covers. Yes ☐ No ☐

29 Retroactive date of current insurance ► / / Retroactive date requested ► / /

Insurance History

30 Insurance history for the preceding five (5) years, begin with current policy (Please indicate whether or not you purchased a tail, and attach a copy of your current declarations page): ▼

Company name	Policy type / Policy number / Liability limits	From	To	Tail bought
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes ☐ No ☐
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes ☐ No ☐
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes ☐ No ☐
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes ☐ No ☐
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes ☐ No ☐

Claims History

31 Has a medical malpractice claim or suit been presented against you, or has any amount of money been paid by you or on your behalf in a claim of medical malpractice? *If "yes", complete an attached 'Claim / Suit Questionnaire' for each case.* Yes ☐ No ☐

32 Are you aware of any circumstances which may result in a malpractice claim or suit being presented against you? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

33 Are you aware of any circumstances which may result in a malpractice claim or suit being presented against any of your partners, members of your professional association or corporation, or your employees? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

34 If you have answered yes to Question 31, 32, or 33 above, are there any claims or suits or circumstances for which you answered yes that you have not reported to your current professional liability insurer? Yes ☐ No ☐

Potential Liability

35 Are you aware of any patient you have treated in the past 24 months who developed any of the following conditions during or after treatment that may have been caused by medical negligence? ***Please check all that apply.*** ▼

- ☐ Brain injury
- ☐ Spinal cord injury and/or damage resulting in significant sensory and/or motor loss
- ☐ Serious burn injury
- ☐ Amputation of a significant portion of a limb(s)
- ☐ Birth trauma
- ☐ Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

36 Are you aware of any patient you have treated in the past 36 months whose condition or treatment resulted in death that may have been caused by medical negligence? Yes ☐ No ☐

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Medical Malpractice Insurance

continued…

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 27–38.

37 Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 24 months by way of consultation, tests, reports, or other medical services who developed any of the following conditions during or after such medical care that may have been caused by medical negligence?
Please check all that apply. ▼

- ☐ Brain injury
- ☐ Spinal cord injury and/or damage resulting in significant sensory and/or motor loss
- ☐ Serious burn injury
- ☐ Amputation of a significant portion of a limb(s)
- ☐ Birth trauma
- ☐ Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

38 Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 36 months by way of consultation, tests, reports, or other medical services whose condition or treatment resulted in death that may have been caused by medical negligence? Yes ☐ No ☐

▼

Notes

Understanding, Authorization and Signature:

Important: This Application must be signed by the Applicant.

As a licensed professional, the undersigned has made application for insurance to Missouri Doctors Mutual Insurance Company (MoDocs), and in connection with said Application has furnished the above information and the information in the 'notes' section attached.

I understand and agree this Application and any and all exhibits and attachments thereto will be made a part of any policy issued, and any such policy will be issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand that these answers and statements are material and agree that failure to provide a true and complete response to the foregoing questions or to supplement as provided above may, at the option of MoDocs, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize MoDocs, through the Missouri Highway Patrol or any other agency, to conduct a criminal history file check or investigation by name and identifiers to determine the existence of any arrest resulting in conviction and furnish a response to MoDocs.

I authorize MoDocs, or any third party, to obtain and/or run a personal credit report on myself and a business credit report on my medical practice/clinic.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including, but not limited to, authorization to every person or entity, public or private, to release to MoDocs, any documents, records, or other information bearing upon the foregoing. I further authorize the use of a copy of this authorization in lieu of its original. I further authorize MoDocs to forward additional information to me by facsimile.

I understand and agree these investigations shall not be confined to information submitted in this Application, but shall include any other sources of information deemed relevant by MoDocs as may be authorized by law.

Signature

Signature in full of Applicant	Please PRINT Name of Signatory	Date
		/ /

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Claim / Suit Questionnaire

Complete a copy of this page for each claim. Please type or print.

Claimant

Claimant's name(s)

Date of Birth	Sex	Date of alleged incident, error or act
/ /		/ /

Reported

Name of insurer to which claim was reported	Date report was made to insurance company
	/ /

Status

This matter is:	If matter is closed, date closed
☐ Open ☐ Closed ▶	/ /

☐ Incident report only ☐ Demand made ☐ Suit dismissed with prejudice

☐ Suit dismissed without prejudice ☐ Suit abandoned no activity from claimant for over 3 years ☐ Suit filed, judgment in your favor

	Total paid	Total paid on your behalf
☐ Suit settled ▶	$	$

	Total paid	Total paid on your behalf
☐ Jury verdict for plaintiff ▶	$	$

☐ Settlement is under consideration, complete the following: ▼

Offer	Demand	Insurer's loss reserve
$	$	$

Additional defendants

Description

Description of claim, include allegation, events leading up to claim, diagnosis and treatment, results of treatment, prognosis, and any other facts pertinent to the case. Continue on a separate sheet as needed.

I UNDERSTAND THAT THE REPRESENTATIONS PROVIDED HERE BECOME PART OF THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE AND AFFIRM THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED.

Signature

Signature in full _____ Please PRINT Name of Signatory _____ Date / /

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Missouri Doctors Conditions of Acceptance

Missouri Doctors Mutual Insurance Company
Conditions of Acceptance

1. Specific coverage is detailed in the Declaration Sheet, the Insurance Policy, and Endorsements. No statement outside these documents, whether written or verbal, shall act to modify the terms and conditions of coverage.
2. This quotation expires after 15 business days or policy effective date, whichever occurs first.
3. This quotation is immediately void if there is any material change in the applicant's status prior to the policy effective date.
4. **There is no coverage for liabilities arising from incidents, claims, or suits which have been, or should have been, reported to prior carriers, occurring after the retroactive date of this policy.** ***If you are aware of any incident that may result in you being named in a lawsuit, you should immediately report that incident to your current carrier. You should report this even if you do not believe that you are in any way negligent***.
5. This quotation reflects an offer of coverage corresponding to the nature, scope, and extent of medical practice as attested to in the application. It is not intended to offer coverage for a scope of practice that exceeds that which has been attested in the application.
6. Any offer of insurance by MoDocs is conditioned upon completion and underwriting approval of a MoDocs application prior to the effective date.
7. Corporate or other practice entity coverage is provided on a shared limits basis with the insured physicians unless otherwise specified in the Declarations, and excludes the acts or omissions of others not named in the Declarations or identified in the Insurance Policy.
8. Any insured physician rated as a part-time practitioner is subject to a time audit.
9. Coverage cannot be bound until payment is received.

_____ _____

Doctor/Nurse Practitioner Acknowledgement Date

Authorized Personnel Form

Print Clear

Authorized Personnel Form

(Authorization for Use or Disclosure of Information regarding my Medical Liability Policy)

1. I hereby authorize the below listed individual(s) to communicate with MoDocs and to make decisions and/or changes regarding my insurance coverage to my MoDocs Medical Liability Policy.
2. I understand that I have the right to revoke or amend this authorization in writing at any time. I understand that a revocation or amendment is not effective to the extent that any person or entity has already acted pursuant to my authorization and MoDocs has acted in reliance on such authorization.
3. This authorization shall remain in force until authorized otherwise in writing.
4. This form revokes all prior Authorized Personnel Forms.

Authorized Individual(s)

_____

_____

_____

_____

_____ _____

Signature of Physician/Nurse Practitioner/Physician Assistant Date

_____

Printed name of Physician/Nurse Practitioner/Physician Assistant

Part Time Affidavit

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AFFIDAVIT – PART TIME

Before me, the undersigned authority, personally appeared _____, who, being by me duly sworn, deposed as follows:

My name is _____, I am capable of making this affidavit, and personally acquainted with the facts herein stated.

I am a practicing physician working 20 hours or less per week at the location(s) covered by MoDocs policy no. _____. I have worked 20 hours or less per week since _____. My intentions are to continue to work 20 hours or less per week for the indefinite future. In the event I choose to increase my work hours in excess of 20 hours per week, I will notify MoDocs' underwriting department prior to such change in practice.

_____
Signature

Witnessed:

I, _____, hereby state that I am 18 years of age or older.
Witness (Printed)

_____
Witness (Signature)

Address of Witness: _____

_____

_____