Print Reset

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Missouri Doctors Mutual Insurance Company (NAIC #11964)

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 (MD/DO) / other)	Date of Birth / /	Age in years	Social security number
BNDD number	DEA number		

2 Residential Address

Street	Apt
City	State	Zip	County
Home phone ( ) -	Home email

3 Practice Profile

Type of practice (Check one):
☐ Private practice ☐ Urgent care center ☐ Other *specify*►

4

Practicing as (Check one) If you check corporation or partnership or employed physician, please complete information below
☐ Individual ☐ Corporation▼ ☐ Partnership▼ ☐ Employed physician▼

5 Practice Address

Entity (Corp, LLC, etc.) as registered on the Secretary of State website to include doing business as.

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)

6 Billing Address ▼

Send billing to:
☐ Residence ☐ Practice ☐ Other *complete information below*▼

Billing name	
Street	Suite
City	State	Zip

Practice Profile
continued…

7

Paramedical Personnel Census

In the blank space provided enter the number of personnel employed.

◆ *Attach a copy of the collaborative agreement for these specialties.*

If you or your partnership or corporation will employ any paramedical personnel, please provide the census information requested below. If you are practicing as part of a group practice, only one individual (i.e.Corporate Officer or Partner) is required to complete this section on the master application if the information applies to all in the group. ▼

____ Anesthesiologist Assistan◆	____ Nurse practitioners◆	____ Physician assistant◆
____ Certified nurse midwives	____ Nurses—LPN	____ Psychologists
____ Licensed Clinical Social Worker	____ Nurses—RN	____ Other
____ Nurse anesthetists—CRNA's	____ Optometrists	

Professional Profile
8–34

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

8	Have you ever been denied board certification or recertification?	Yes ☐	No ☐
9	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 ☐
10	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 ☐
11	Have you ever been indicted or convicted of a crime other than a minor traffic violation?	Yes ☐	No ☐
12	Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)?	Yes ☐	No ☐
13	Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	Yes ☐	No ☐
14	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 ☐
15	Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice?	Yes ☐	No ☐
16	Do you or does your business entity own, operate, manage or participate in any medical enterprise or business? (If yes, please describe in the 'notes' section)	Yes ☐	No ☐
17	Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities?	Yes ☐	No ☐
18	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 ☐
19	Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	Yes ☐	No ☐
20	Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia?	Yes ☐	No ☐
21	Do you perform major surgery? (Includes operations in or upon any body cavity including but not limited to, the cranium, thorax, abdomen, or pelvis, or any other operation which, because of the condition of the patient or length of circumstance, presents a distinct hazard to life. It also includes removal of tumors, open fractures, amputation, removal of any gland or organ, plastic surgery, and any other operation done under general anesthesia, and also includes tonsillectomies, adenoidectomies and caesarean sections.)	Yes ☐	No ☐
22	Do you assist–only at surgery? If you answer "Yes", complete the following: ▼	Yes ☐	No ☐
	Number of own patients per year? ____ Number of other patients per year? ____		
23	Do you provide any surgical services to patients in any setting in which another person provides the postoperative follow-up care for that procedure?	Yes ☐	No ☐
24	Do you perform general anesthesia? If "Yes", check as appropriate below. ▼	Yes ☐	No ☐
	☐ Hospital ☐ Non-hospital facility ☐ Office		
25	Do you supervise CRNA's who provide general anesthesia?	Yes ☐	No ☐

▼

1218AppR10

Professional Profile
continued…

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

26 Do you perform obstetrical procedures? Yes ☐ No ☐

27 Do you perform cesarean sections? If "Yes", check as appropriate below. ▼ Yes ☐ No ☐

☐ Elective ☐ Emergency

28 Do you perform abortions? If "Yes", check as appropriate below. ▼ Yes ☐ No ☐

☐ First trimester ☐ Second trimester ☐ Third trimester

29 Do you practice in an emergency room? If you answer "Yes", complete the following: ▼ Yes ☐ No ☐

Hours per month? _____

30 If you are a radiologist:
- ▶ Is your practice limited to diagnostic radiology? Yes ☐ No ☐
- ▶ Do you perform radiation therapy or other invasive procedures such as angiography or arteriography? Yes ☐ No ☐
- ▶ Do you supervise a hospital X-ray lab other than your own? Yes ☐ No ☐

31 Do you provide regular medical or surgical care to professional athletes? Yes ☐ No ☐

32 Have you performed any new procedures during the past year, i.e. procedures not previously performed by you? Yes ☐ No ☐

33 Do you prescribe pain management medications? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

34 Do you provide addiction treatment or services (including, but not limited to: prescription of addiction medications, counseling, etc.)? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

35 Procedures Profile

Please check any of the following procedures you perform or any of the agents you use. Provide any details you consider relevant in the 'notes' section. ▼

☐ Abdominoplasty	☐ Atherectomy / rotation ablation	☐ Cardiac catheterization, left heart
☐ Abortions, therapeutic	☐ Autologous fat Injection, penis	☐ Cardiac catheterization, right (swan ganz)
☐ Acupuncture	☐ Automated lamellar keratoplasty (ALK)	☐ Cardioversions
☐ Amniocentesis	☐ Balloon valvuloplasty	☐ Carpal tunnel surgery
☐ Anal Fissurectomy	☐ Bariatric surgery	☐ Cataract surgery
☐ Anesthesia, general	☐ Biopsy: ▼ _____	☐ Cervical diskectomy
☐ Anesthesia, IV analgesia (surgical)	☐ Blepharoplasty, cosmetic	☐ Cervical laminectomy
☐ Anesthesia, spinal	☐ Blepharoplasty, functional	☐ Chalazion excision from eyelids
☐ Angiography, all others	☐ Blocks, spine	☐ Cheiloplasty
☐ Angiography, cerebral or coronary	☐ Bone grafts	☐ Chemical face peel
☐ Angioscopy	☐ Botox Injections	☐ Cholecystectomy
☐ Appendectomy	☐ Breast augmentation, cosmetic	☐ Chorionic gonadotropin for obesity
☐ Arterial and venous lines	☐ Breast augmentation, resconstructive	☐ Chymopapain disc Injection
☐ Arterial bypass	☐ Capsulorrhaphy	☐ Circumcision, adult
☐ Arthroscopy	☐ Capsulotomy	☐ Circumcision, pediatric

▼

Procedures Profile
continued…

- ☐ CO2 laser
- ☐ Cobalt therapy
- ☐ Collagen Injections
- ☐ Colporrhaphy and perineoplasty
- ☐ Conization (hot and cold knife)
- ☐ Conization of cervix
- ☐ Corneal transplant
- ☐ Coronary stent placement
- ☐ Cosmetic plastic surgery
- ☐ Cricothyrotomy
- ☐ Cryosurgery
- ☐ Culdocentesis
- ☐ Dacryocystotomy
- ☐ Defibrillation
- ☐ Dermabrasion
- ☐ Dilation and curettage
- ☐ Dilation and evacuation
- ☐ Ectopic pregnancy
- ☐ Electroconvulsive therapy (ECT)
- ☐ Electromyography
- ☐ Endometrial biopsy
- ☐ Endoscopy: ▼
  _____
  _____
- ☐ ENT surgery
- ☐ Enucleation
- ☐ Episiotomy
- ☐ Esophageal dilation
- ☐ Excision of breast tumor
- ☐ Facet injections
- ☐ Facial Lifts
- ☐ Fallopian tube removal
- ☐ Fine needle aspiration
- ☐ Fine needle biopsy
- ☐ Fistula repair
- ☐ Forehead lifts
- ☐ Foreign body removal
- ☐ Fracture reduction, closed, other than simple
- ☐ Fracture reduction, closed, simple
- ☐ Fracture reduction, open
- ☐ Frenotomy
- ☐ Gastric lavage
- ☐ Gastric or ileal bypass for obesity
- ☐ Gastric sleeve or bubble for obesity
- ☐ Glaucoma procedures
- ☐ Glycolic peels
- ☐ Hair transplant
- ☐ Hand surgery
- ☐ Heart biopsy
- ☐ Hemorrhoidectomy, ligation only
- ☐ Hemorrhoidectomy, other than ligation
- ☐ Herniorrhaphy
- ☐ Human growth hormone
- ☐ Hydrocelectomy
- ☐ Hymenectomy
- ☐ Hymenotomy
- ☐ Hypophysectomy
- ☐ Hysterectomy, abdominal
- ☐ Hysterectomy, vaginal
- ☐ In vitro fertilization (IVF)
- ☐ Independent medical evaluations
- ☐ Intrabulbar masses
- ☐ Intraocular lens implants
- ☐ Intubation
- ☐ Iridectomy
- ☐ Joint Injection and intra-articular blocks
- ☐ Joint replacement
- ☐ Laparoscopy
- ☐ Laryngography / laryngoscopy
- ☐ Laser hair removal
- ☐ Laser skin resurfacing
- ☐ Laser surgery
- ☐ LASIK
- ☐ Leeps / leetz procedure
- ☐ Lid repair
- ☐ Liposuction surgery
- ☐ Lumbar laminectomy
- ☐ Lumbar puncture
- ☐ Lumpectomy, other
- ☐ Lumpectomy, superficial skin lesion
- ☐ Lymph gland biopsy
- ☐ Lymphangiography
- ☐ Manipulation under anesthesia
- ☐ Mentoplasty
- ☐ Microsurgery
- ☐ Mohs' chemosurgery
- ☐ Myelogram / myelography
- ☐ Myringotomy
- ☐ Nasal polypectomy
- ☐ Nasopharyngeal surgery
- ☐ Needle aspiration
- ☐ Neonatal intensive care
- ☐ Nerve repairs
- ☐ Nerve root injections

1218AppR10 ▼

Procedures Profile
continued…

- ☐ Obstetrical procedures, birthing center
- ☐ Obstetrical procedures, home or other
- ☐ Obstetrical procedures, hospital
- ☐ Obstetrics, deliveries, high risk
- ☐ Obstetrics, deliveries, routine
- ☐ Oophorectomy
- ☐ Orbital bone fracture repairs
- ☐ Orchidectomy
- ☐ Osteopuncture
- ☐ Otoplasty
- ☐ Pacemakers (temporary/ permanent)
- ☐ Pain control / management, medication only
- ☐ Paracentesis
- ☐ Parotidectomy
- ☐ Penile implants
- ☐ Percutaneous endoscopic Gastrostomy
- ☐ Pericardiocentesis
- ☐ Perineal repair
- ☐ Perineorrhaphy
- ☐ Peripheral nerve blocks
- ☐ Permanent lash liner
- ☐ Phlebography
- ☐ Photorefractive keratotomy (PRK)
- ☐ Phototherapeutic keratotomy (PTK)
- ☐ Pleural biopsy, closed
- ☐ Pleural biopsy, open
- ☐ Polypectomy by endoscopy
- ☐ Prenatal care
- ☐ Prolotherapy
- ☐ Pterygium excision
- ☐ Radial keratotomy
- ☐ Radiation therapy
- ☐ Radical neck dissection
- ☐ Radioactive implants
- ☐ Rapid detoxification
- ☐ Rectocele
- ☐ Retinal detachment repair
- ☐ Retrobulbar blocks
- ☐ Rhinoplasty, cosmetic
- ☐ Rhinoplasty, functional only
- ☐ Rhytidectomy
- ☐ Sacroiliac joint blocks
- ☐ Salivary gland surgery
- ☐ Salpingectomy
- ☐ Scalene node biopsy
- ☐ Sclerotherapy
- ☐ Selective nerve root blocks
- ☐ Septorhinoplasty
- ☐ Sex change (transsexual) surgery
- ☐ Small bowel biopsy
- ☐ Sphincterectomy
- ☐ Spinal infusion pump implantation
- ☐ Spinal surgery
- ☐ Sympathectomy
- ☐ Tendon repair
- ☐ Tenotomy
- ☐ Therapeutic radiology
- ☐ Thyroid Surgery
- ☐ Tissue expansion
- ☐ Tonsillectomy
- ☐ Tonsilloadenoidectomy (T & A)
- ☐ Trabeculectomy
- ☐ Tracheostomy
- ☐ Tubal ligation
- ☐ Tympanostomy
- ☐ Ultrasound
- ☐ Uterine suspension
- ☐ Valvuloplasty
- ☐ Vasectomy
- ☐ Vein stripping
- ☐ Venography
- ☐ Ventricular shunt
- ☐ Vertebroplasty
- ☐ Weight control, medications: ▼
- ☐ Wound debridement

Professional Duties
36–42

Teaching/ Faculty Appointments ▼

36 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

37 Do you have teaching or faculty appointments? If yes, name the institution. ▼ — Yes ☐ No ☐

Name of institution

38 If yes, are you responsible for the supervision of residents, interns or fellows? — Yes ☐ No ☐

39 Does the institution provide you with coverage for these responsibilities? — Yes ☐ No ☐

1218AppR10

Professional Duties
continued…

40 Do you have any medical director responsibilities? If yes, name the institution. ▼ Yes ☐ No ☐

Name and address of institution

Medical Director

► Does this institution provide you with insurance coverage? Yes ☐ No ☐

► Or, do you have insurance coverage from any other source? Yes ☐ No ☐

Other

41 Do you treat or review treatment of prison inmates? Yes ☐ No ☐

42 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

43	Primary specialty	% of Practice	Years practicing primary specialty
44	Secondary specialty	% of Practice	Years practicing secondary specialty

Licensed to Practice

45 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 80	
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

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

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

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 / /

Staff Privileges

47 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		☐

Education

48 **Attach a copy of your current CV ►**

49 If you are a foreign medical graduate, are you certified by the Educational Council for Foreign Medical School Graduates? Yes ☐ No ☐

Medical Malpractice Insurance
50–63

50 Limit of liability requested, check one. Limits are per medical incident / annual aggregate. ▼

☐ $100,000 / $300,000 ☐ $200,000 / $600,000 ☐ $500,000 / $1,000,000

☐ $1,000,000 / $1,000,000 ☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $6,000,000

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

1218AppR10

Medical Malpractice Insurance
continued…

52 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 ☐

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

54 Are you seeking coverage during your retroactive period for any procedures which you did not check in question number 35? *If yes, please list below all procedures for which you seek retroactive coverage that you did not check in question number 35.* ▼ Yes ☐ No ☐

Please use the 'notes' section for additional listings.

Insurance History

55 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
		/ /	/ /	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 ☐

56 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 ☐

Claims History

57 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 ☐

58 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 ☐

59 If you have answered yes to Question 56, 57, or 58 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

60 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.*** ▼

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 50–63.

- ☐ 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

61 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 ☐

▼

Medical Malpractice Insurance

continued…

Potential Liability

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 50–63.

62 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

63 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

1218AppR10

Understanding, Authorization and Signature:

Important: This Application must be signed by the Applicant.

As a licensed physician or surgeon, 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
		/ /

1218AppR10

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 ▶	$	$
☐ 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
		/ /

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

Print Clear

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: _____

_____

_____

Opioid Questionnaire

Print Clear

Dear Doctor

Do you prescribe opioids? *Yes* *No*

Do you prescribe methadone? *Yes* *No*

When CONSIDERING long–term opioid therapy, do you?

Set realistic goals for pain and function based on diagnosis (eg. walk around the block).

☐ *Always* ☐ *Never* ☐ *Sometimes*

Check that non–opioid therapies tried and optimized.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Discuss benefits and risks (eg. addiction, overdose) with patient.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Evaluate risk of harm or misuse.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Discuss risk factors with patient.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Check urine drug screen.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Set Criteria for stopping or continuing opioids.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Assess baseline pain and function (eg. PEG scale).

☐ *Always* ☐ *Never* ☐ *Sometimes*

Schedule initial reassessment within 1 — 4 weeks.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Prescribe short–acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

☐ *Always* ☐ *Never* ☐ *Sometimes*

If RENEWAL without patient visit, do you?

Check that return visit is scheduled ≤ 3 months from last visit.

☐ *Always* ☐ *Never* ☐ *Sometimes*

When REASSESSING at return visit, do you?

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Assess pain and function (eg. PEG); compare results to baseline.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Evaluate risk of harm or misuse:

☐ *Always* ☐ *Never* ☐ *Sometimes*

Observe patient for signs of over–sedation or overdose risk.

☐ *Always* ☐ *Never* ☐ *Sometimes*

If yes: Do you taper dose.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Check for opioid use disorder if indicated (eg. difficulty controlling use)

☐ *Always* ☐ *Never* ☐ *Sometimes*

If yes: Do you Refer for Treatment.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Check that non–opioid therapies optimized.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Determine whether to continue, adjust, taper, or stop opioids.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Calculate opioid dosage morphine milligram equivalent (MME).

☐ *Always* ☐ *Never* ☐ *Sometimes*

If ≥ 50 MME/day total (≥ 50mg hydrocodone; ≥ 33mg oxycodone),
Increase frequency of follow–up; consider offering nalozone.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Avoid ≥ 90 MME/day total (≥ 90mg hydrocodone; ≥ 60mg oxycodone),
Or carefully justify; consider specialist referral.

☐ *Always* ☐ *Never* ☐ *Sometimes*

Schedule reassessment at regular intervals (≤ 3 months).

☐ *Always* ☐ *Never* ☐ *Sometimes*

Signature: _____ Date: _____

Print Clear

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: _____

_____

_____