Missouri Doctors Mutual Insurance Company (NAIC #11964)

Moonlighting Application

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

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 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 Billing Address

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

Billing name		
Street		Suite
City	State	Zip

▼

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Practice Type

5

Mark all that apply:

_____ I am a hospital affiliated physician, employed and insured through the hospital.

_____ I am a retired physician seeking to resume a limited practice.
Warning: Make sure this will not void your Tail Policy.

_____ I want to Moonlight.

_____ I want to be covered for acts as a Good Samaritan.

_____ I am interested in a practice limited to non-invasive General Practice working less than 10 hours per week.

Professional Profile

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

#	Question	Yes	No
6	Have you ever been denied board certification or recertification?	Yes ☐	No ☐
7	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 ☐
8	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 ☐
9	Have you ever been indicted or convicted of a crime other than a minor traffic violation?	Yes ☐	No ☐
10	Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)?	Yes ☐	No ☐
11	Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	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	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 ☐
15	Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities?	Yes ☐	No ☐
16	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 ☐
17	Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	Yes ☐	No ☐
18	Do you provide regular medical or surgical care to professional athletes?	Yes ☐	No ☐

Professional Duties

#	Question	
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 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

21

Primary specialty	% of Practice	Years practicing primary specialty

Licensed to Practice

22

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.

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Practice Positions

23 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
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

Education

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

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

Medical Malpractice Insurance

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

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

27 Effective date requested ► / /

Insurance History

28 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 ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐

Claims History

29 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 ☐

30 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 ☐

31 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 ☐

32 If you have answered yes to Question 29, 30, or 31 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

33 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 26-36.

☐ 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

34 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...

Potential Liability

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 26-36.

35 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

36 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 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

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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: ☐ Open ☐ Closed ▶ | If matter is closed, date 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

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

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

☐ 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 / /