Print Clear

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Missouri Doctors Mutual Insurance Company (NAIC #11964)

Individual Professional Liability Application - NP, PA, CRNA

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
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): Independent Employee

4 Practice Profile

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

5 Practice Address

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

Is entity to be listed on policy? Yes☐ No☐

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	

Supervising Information

7 **Supervising Physician(s)** (Attach Collaborative Practice Agreement if applicable) ▶

8 Do all physicians with whom you practice or collaborate or to whom you refer patients have professional liability limits equal to or greater than those you are applying for? Yes ☐ No ☐

9 Do you have any medically related duties that are insured by another company or for which you do not desire MoDocs coverage? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

Practice Profile

continued…

10 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. ▼

Paramedical Personnel Census

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

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

_____ Anesthesiologist Assistant◆	_____ Nurse practitioners◆	_____ Physician assistant◆
_____ Certified nurse midwives	_____ Nurses—LPN	_____ Counseling Professionals
_____ Licensed Clinical Social Worker	_____ Nurses—RN	_____ Other
_____ Nurse anesthetists—CRNA's	_____ Optometrists	

Professional Profile

11–33

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

11 Have you ever been denied board certification or recertification? Yes ☐ No ☐

12 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 ☐

13 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 ☐

14 Have you ever been indicted or convicted of a crime other than a minor traffic violation? Yes ☐ No ☐

15 Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)? Yes ☐ No ☐

16 Has your membership in any professional society or association ever been refused, censured, suspended or revoked? Yes ☐ No ☐

17 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 ☐

18 Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice? Yes ☐ No ☐

19 Do you or does your business entity own, operate, manage or participate in any medical enterprise or business? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

20 Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? Yes ☐ No ☐

21 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 ☐

22 Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? Yes ☐ No ☐

23 Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

24 If you perform surgery is it?

- ▶ Surgery with less than 10 hours per week in trauma.
- ▶ Surgery with greater than 10 hour per week in trauma.
- ▶ N/A

▼

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Professional Profile
continued…

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

25 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? ____

26 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 ☐

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

Hospital Non-hospital facility Office

28 Are you responsible for obstetrical procedures for the labor or delivery of a fetus? Yes ☐ No ☐

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

Hours per month? _____

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

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

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

33 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 ☐

Procedures Profile

34 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	☐ Automated lamellar keratoplasty (ALK)	☐ Cataract surgery
☐ Abortions, therapeutic	☐ Balloon valvuloplasty	☐ Cervical diskectomy
☐ Accupuncture	☐ Bariatric surgery	☐ Cervical laminectomy
☐ Amniocentesis	☐ Biopsy: ▼ _____	☐ Chalazion excision from eyelids
☐ Anal Fissurectomy	☐ Blepharoplasty, cosmetic	☐ Cheiloplasty
☐ Anesthesia, general	☐ Blepharoplasty, functional	☐ Chemical face peel
☐ Anesthesia, IV analgesia (surgical)	☐ Blocks, spine	☐ Cholecystectomy
☐ Anesthesia, spinal	☐ Bone grafts	☐ Chorionic gonadotropin for obesity
☐ Angiography, all others	☐ Botox Injections	☐ Chymopapain disc Injection
☐ Angiography, cerebral or coronary	☐ Breast augmentation, cosmetic	☐ Circumcision, adult
☐ Angioscopy	☐ Breast augmentation, resconstructive	☐ Circumcision, pediatric
☐ Appendectomy	☐ Capsulorrhaphy	☐ CO2 laser
☐ Arterial and venous lines	☐ Capsulotomy	☐ Cobalt therapy
☐ Arterial bypass	☐ Cardiac catheterization, left heart	☐ Collagen Injections
☐ Arthroscopy	☐ Cardiac catheterization, right (swan ganz)	☐ Colporrhaphy and perineoplasty
☐ Atherectomy / rotation ablation	☐ Cardioversions	☐ Conization (hot and cold knife)
☐ Autologous fat Injection, penis	☐ Carpal tunnel surgery	☐ Conization of cervix

▼

Procedures Profile
continued…

- ☐ 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
- ☐ Obstetrical procedures, birthing center
- ☐ Obstetrical procedures, home or other
- ☐ Obstetrical procedures, hospital
- ☐ Obstetrics, deliveries, high risk
- ☐ Obstetrics, deliveries, routine
- ☐ Oophorectomy

Procedures Profile
continued…

- ☐ 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
35–40

Teaching/ Faculty Appointments ▼

35 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

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

Name of institution

_____

37 If yes, are you responsible for the supervision of others? — Yes ☐ No ☐

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

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Professional Duties
continued…

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

40 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

41

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

42 Location where services are provided (total must equal 100%) ▼

☐ Community Health Agency	____ %	☐ Patient Home	____ %	☐ Urgent Care Facility	____ %
☐ Doctor's Office	____ %	☐ Prison	____ %	☐ Your Own Premises	____ %
☐ Hospice/Assisted Living Facility	____ %	☐ Rehabilitation Facility	____ %	☐ Other (specify) ▼	____ %
☐ Hospital	____ %	☐ School	____ %		
☐ Nursing Home	____ %	☐ Surgi/Emergi Center	____ %	**Total**	____ %

Licensed to Practice

43 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	☐

◆ 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.

44 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

45 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		☐

Medical Malpractice Insurance
46–61

46 **COVERAGE DESIRED ▼**

Occurrence Coverage Claims Made Coverage

47 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

48 Effective date requested ▶ / / Is prior acts coverage requested? Yes ☐ No ☐

49 Will you be carrying additional professional liability insurance with another company? Yes ☐ No ☐
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.

50 Retroactive date of current insurance ▶ / / Retroactive date requested ▶ / /

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Medical Malpractice Insurance
continued…

Please use the 'notes' section for additional listings.

51 Are you seeking coverage during your retroactive period for any procedures which you did not check in question number 34? *If yes, please list below all procedures for which you seek retroactive coverage that you did not check in question number 34.* ▼ Yes ☐ No ☐

Insurance History

52 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 ☐

53 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 ☐

54 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 ☐

Claims History

55 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 ☐

56 If you have answered yes to Question 53, 54, or 55 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

57 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

58 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 ☐

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 47–59.

59 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

▼

Potential Liability	60	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 ☐
Education		**Attach a copy of your current CV ▶**	

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
		/ /