

TO: MPM Applicant

RE: Application Process

We would like to emphasize how critical it is that this application be filled out completely and accurately, not only for MPM, but for you. Remember that if your application is accepted, you become not only an insured but also a member-owner of MPM. The success of MPM inures to your direct benefit.

The most common reason for processing delays is missing information. We rely on the information provided in the application to fairly and accurately assess your risk classification and fair pricing. The completed application actually becomes part of your policy with MPM. The same is true for all of your co-members. Any false statements or omitted or hidden information may actually negate coverage under the policy. This is only fair to the other members to avoid their subsidizing faulty risk assessment based on false or misleading statements or missing information.

As an owner of MPM, it is also critical that you notify your prior carrier of any potential claims or incidents before accepting the MPM coverage. Remember, these are “claims-made” policies. When you put your prior carrier on notice of an incident or potential claim, in accordance with the reporting requirements, in many cases it becomes their obligation to cover that incident or claim. That is less potential liability that MPM is assuming, and becomes a contributing factor to MPM’s financial success.

We look forward to reviewing and underwriting your application, and welcoming you as a member-owner.

Thank you for your confidence in MPM. Please sign this as an acknowledgement that you have read and understand the above.

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Sincerely,

Timothy H. Trout
Managing Director

Applicant’s Signature

Date

MPM Missouri Physicians Mutual

287 N. Lindbergh Blvd.
St. Louis, Missouri 63141
314-743-4030
Toll Free: (866) 262-4030
www.missouriphysiciansmutual.com

Send Completed Application To:
The Keane Insurance Group, Inc.
10777 Sunset Office Dr. Ste. 200
St. Louis, Missouri 63127
314-966-7733
800-966-7731
Fax: 314-966-7797
www.keanegroup.com

Keane Producer: _____

APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE POLICY

IMPORTANT: You are applying for CLAIMS MADE COVERAGE. For your own protection, report to your CURRENT insurer BEFORE YOUR CURRENT POLICY EXPIRES ANY:
Incident which might lead to a claim;
Request for medical records;
Unfavorable result in treatment;
Knowledge of a patient or family member who might consider bringing a claim against you.

THIS APPLICATION WILL BE ATTACHED TO AND FORM A PART OF ANY POLICY THAT MAY BE ISSUED

- Applicant must personally complete this application.
- Please type or print legibly in black ink.
- You **MUST** attach a curriculum vitae (CV) to this Application or complete Form G and your CV will be incorporated into this application and any policy that may be issued.
- You **MUST** attach the declarations page of your current policy.
- You **MUST** report all circumstances that might reasonably be expected to result in a claim or suit even if you believe that the claim or suit would be without merit.
- Every** question must be answered. If a question does not apply to you, mark it "N/A" (not applicable).
- If space is insufficient for a complete reply, please attach a separate sheet.
- Incomplete answers and/or missing attachments may delay the processing of your application.
- This is an Application only. Completion of this Application or its receipt by MPM or an agent or broker does not bind MPM to issue a policy to you. Before coverage can be bound or a policy issued, this Application must be approved by MPM.

I. GENERAL INFORMATION

1.	Name of Insured	
	Primary Office Address	(First) (Middle) (Last) (M.D./D.O./other)
	Mailing Address	(Number) (Street) (City) (State) (Zip) (County)
	Residential Address	(Number) (Street) (City) (State) (Zip) (County)
	Billing Address	(Number) (Street) (City) (State) (Zip) (County)
	(if different from mailing)	(Number) (Street) (City) (State) (Zip) (County)
	Telephone Numbers	() _____ - _____ () _____ - _____ () _____ - _____
	Email	(Office) (Office Fax) (Residential) _____ @ _____
	Social Security #	_____ - _____ - _____
	Date of Birth	_____ / _____ / _____

II. POLICY OPTIONS

2.	Desired Effective Date	_____ / _____ / _____						
3.	Limit of Liability (circle one) per occurrence/annual aggregate	<table> <tr> <td>\$100,000/\$300,000</td> <td>\$200,000/\$600,000</td> <td>\$500,000/\$1,000,000</td> </tr> <tr> <td>\$500,000/\$1,500,000</td> <td>\$1,000,000/\$1,000,000</td> <td>\$1,000,000/\$3,000,000</td> </tr> </table>	\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000	\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000
\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000						
\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000						
4.	Do you want prior acts coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <p>If your current policy is or any previous policies are claims made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage), there will be no coverage for any claim from any act or omission that took place during that period of claims made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims made policy.</p> <p>Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier. Even if prior acts coverage is written, it will not cover any claims, conduct, circumstances, occurrences, accidents, or medical incidents likely to give rise to a claim which are known to you or which should have been known to you on the date of this application.</p>						
5.	Prior Acts Limit of Liability (circle one)	<table> <tr> <td>\$100,000/\$300,000</td> <td>\$200,000/\$600,000</td> <td>\$500,000/\$1,000,000</td> </tr> <tr> <td>\$500,000/\$1,500,000</td> <td>\$1,000,000/\$1,000,000</td> <td>\$1,000,000/\$3,000,000</td> </tr> </table>	\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000	\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000
\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000						
\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000						

6.	Deductible requested	<input type="checkbox"/> None <input type="checkbox"/> \$20,000 Other _____	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$30,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000
7.	Retroactive Date Requested	_____ / _____ / _____		

III. EDUCATIONAL BACKGROUND

PLEASE ATTACH A COMPLETE COPY OF CURRENT C.V. (with all educational information including but not limited to medical school (s), internships, residency, type of residency, military training and experience If you do not have a current C.V. you may complete FORM G)

6. State(s) where currently licensed:
- a. _____ # _____ % of Practice _____
- b. _____ # _____ % of Practice _____
- c. _____ # _____ % of Practice _____
7. DEA License# _____

PRACTICE HISTORY

8. Present _____ (type of practice) _____ (City and State) from ___/___/___ to ___/___/___
- Prior _____ (type of practice) _____ (City and State) from ___/___/___ to ___/___/___
- Prior _____ (type of practice) _____ (City and State) from ___/___/___ to ___/___/___

9. Please explain any breaks of more than 3 months in your training or practice:

10. **Changes in Practice:** Have your practice procedures, specialty or location changed in the last ten (10) years?
 Yes No If YES, please explain _____

11. How many hours of continuing medical education do you attend annually: _____

12. Foreign medical school graduates:
 Are you certified by Education Commission for Foreign Med School Graduates (ECFMG)? Yes No
 Do you hold the foreign equivalent of board certificates? Yes No
 If YES, please explain _____

BOARD CERTIFICATION (Must be recognized by the American Board of Medical Specialist or the American Osteopathic Association)

13A. Specialty _____ % of Practice _____ Board certified? Yes No

13B. Subspecialty _____ % of Practice _____ Board certified? Yes No

14. If not board certified, are you board eligible? Yes No

If YES, expected date you plan to become board certified ____/____/____

If NO, please explain _____

IV. INFORMATION ABOUT YOUR PRACTICE

15. Type of practice:

- Solo Partnership Employee
- Solo and Professional Assn. Professional Assn. Contractor
- Solo and Professional Corp Professional Corp Resident
- Correctional Institution Nursing Homes

Indicate if you:

- Share professional employees Share calls
- _____ # of physicians, outside your group, you share calls with?
- Common billings Other (describe) _____
- Share profits Other (describe) _____

16. Name of every Corporation, Association, Partnership or Employer you have been associated with or employed by after the date you have requested for your Retroactive Date:

_____ Taxpayer ID # _____ Is this a Missouri entity? Yes No

_____ Taxpayer ID # _____ Is this a Missouri entity? Yes No

17. Do you wish to obtain indemnification for all of the entities described in Question 16? Yes No

If No, which of the entities described in Question 16 do you wish to obtain coverage for:

Additional insured (no separate limit: no additional premium) Yes No

Separate limit of coverage (additional premium required) Yes No

18. Physicians who are part of this entity	Present Insurer	Policy Number	Expires
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

19. How many of the following non-physician employees are employed by you or your group?

- Acupuncture Technicians Nurse Anesthetists (CRNA)* Physician Assistants (PA)*
- Clerks (non-medical) Nurse Midwives (CNM)* Psychologists
- Medical Assistants Nurse Practitioners (NP)* Other _____
- Nurses (not otherwise listed) Optometrists Other _____

* see question #21 below

20. Total Number of Employees: _____

21. List below the name of each employee.

Name	Title
_____	_____
_____	_____
_____	_____

29. Do you provide, or are you subject to providing, emergency care? Yes No
- If YES, is your work for your own patients only? Yes No
- Is your work required for staff privileges? Yes No
- Is there a written contract of agreement? (If YES, attach copy) Yes No
- Is insurance coverage provided by the facility for your work? Yes No

OTHER AFFILIATIONS

30. Do you have any affiliations where you practice medicine or have an ownership interest outside your private office practice listed in questions 16 & 17 (i.e., clinics, laboratories, etc.)? Yes No
- a. If YES, Name of facility _____ Department _____
- Are you: Sole owner Executive officer
 Partial owner Physician with teaching responsibilities
 Medical director Department or ancillary service director
 Administrator
- b. type of contractual agreement: Oral Written (submit copy)
- c. How many hours per week in the capacity(ies) above? hours per week
- d. Is insurance coverage provided by the entity? Yes No
- If NO, is coverage being sought under this policy. If YES, give full details of practice.

PROCEDURES

31. Do you perform any surgery in your office? Yes No
- If yes, please list types of procedures:

- Does your office have emergency resuscitation equipment? Yes No
32. Do you perform surgery in other non-hospital facilities? Yes No
- If YES, facilities: _____ surgical procedures: _____

33. In the course of surgery described above, is general anesthesia administered:
 by you? Yes No
 by others? Yes No
34. Do you personally provide pre-operative examination and post-operative care for all surgical patients? Yes No
 If NO, please explain:

35. Please answer every item and, if necessary, provide explanations on a separate sheet.

a. Hospital Surgery as
Primary Surgeon? Yes No

b. Assisting in Surgery Only Yes No

c. Do you perform spinal surgery? Yes No
If yes, list types and frequency _____

d. Do you perform urological implants? Yes No

e. Obstetrics Yes No

f. Number of Therapeutic Abortions
over the Last 12 Month _____

g. Amniocentesis Yes No

h. Cosmetic/Plastic Surgery* Yes No
Minor Yes No
Major Yes No
Chemical Peels Yes No
Hair Transplants Yes No
Scar Revisions Yes No
Sclerotherapy Yes No
Silicone Injections Yes No
Suction Lipectomy* Yes No

i. Radiation Therapy Yes No

j. Fracture Reductions Yes No
open Yes No
close Yes No

k. Cardiac Catheterization Yes No
right heart Yes No
left heart Yes No

l. Anesthesia Yes No
General Yes No
Nerve Block Yes No
Spinal/Caudal Yes No
Local Yes No

m. Keratotomy Yes No

n. Blepharopigmentation Yes No

o. Coronary Angiography Yes No

p. Electroconvulsive Therapy Yes No

q. Endoscopy Yes No

r. Sigmoidoscopy Yes No

s. Cerebral Angiography Yes No

t. Sex-Reassignment Surgery Yes No

u. Weight Control Yes No
Surgery Yes No
Drugs [List below] Yes No

Percent of Practice _____%

v. Laser [List types & procedures below]** Yes No

w. Laparoscopy Yes No

x. Needle Biopsy of Internal Organs Yes No

y. Paracentesis Yes No

z. Dental Related Fields Yes No
[if yes, complete **Form C**]

aa. Other Procedures not customary to
your specialty Yes No

If Yes, list : _____

* If other than a board certified or board eligible Plastic Surgeon provide proof of training

** Provide proof of training if received outside of your residency

36. **ANESTHESIOLOGISTS**
 (Please complete **Form F**)

37. **FAMILY PRACTITIONERS/GENERAL PRACTITIONERS** – Provide a complete written description of your practice, including all procedures. (also, please complete **Form E**)

38. **GENERAL, THORACIC, VASCULAR and CARDIAC SURGEONS**
 Do you perform organ transplants? Yes No

39. **OBSTETRICIANS AND GYNECOLOGISTS**
 (Please complete **Form B**)

40. **OPHTHALMOLOGISTS** – Provide a complete written description of your practice, including all procedures. (Also, please complete **Form D**)

VI. CLAIM, INCIDENT AND INSURANCE HISTORY

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability.

41. List professional liability insurers for the past 5 years:

Company	Policy Number	Limits	From	To	Type of coverage form?	
					Occurrence	Claims Made
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

42. **Whether or not you are applying for retroactive coverage, please provide a copy of your current policy including all endorsements; state the annual premium amount; and provide a copy of the declaration page.**

43. **Have you ever:**

- a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, non-renew or revoke your privileges? Yes No
- b. Has your membership in any professional society or association ever been suspended or revoked? Yes No
- c. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? Yes No
- d. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? Yes No
- e. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? Yes No
- f. been evaluated, treated or hospitalized for any of the following: Yes No
 - alcoholism central nervous system stimulants or depressants
 - mental or emotional disorders drug addiction
- g. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? If YES, please submit a letter from your treating physician addressing your state of health and Yes No

- whether any condition exist which could adversely affect the practice of your medical specialty
- h. had Medicare/Medicaid fraud charges filed against you? Yes No
- i. signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? (If so, please note that MPM is not a party to Indemnification or hold harmless agreements under it's policies and, accordingly, will not be responsible for any liability incurred under such agreements) Yes No
- j. Have you ever been refused board certification? Yes No
- k. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? Yes No

If YES, complete Form A-claim/incident report for each incident.

44. Have you **ever**:
- a. Been a party to a lawsuit alleging medical malpractice or negligence? Yes No
- b. Had a claim for medical malpractice settled on your behalf with or without the filing of a lawsuit? Yes No
- c. Received a letter from an attorney wherein the attorney states that you may have committed malpractice or acted negligently in the treatment of a patient? Yes No
- d. Received a letter from a patient or relative of the patient wherein the patient or relative of the patient claims that you committed malpractice or acted negligently in the treatment of a patient? Yes No
- e. Given a deposition in a lawsuit where you were not a party in the lawsuit but your employer was a party to the lawsuit and the lawsuit alleged medical malpractice? Yes No

If any of the questions a-e were answered YES, complete Form A-claim/incident report for each affirmative answer.

45. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

- a. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- b. A letter communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? Yes No
- c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? Yes No
- d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
- i. Cardiac arrest Yes No
- ii. Postoperative coma Yes No
- iii. Postoperative neurological deficits Yes No
- iv. Unexpected death within 48 hrs. postoperatively Yes No
- v. All others _____ Yes No
- e. A request for the medical records of a patient who was deceased? Yes No

f. A request for medical records of a patient who was admitted to a hospital as a result of an adverse reaction to medicine that you prescribed? Yes No

If YES, complete Form A-claim/incident report for each incident.

46. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? Yes No

If YES, complete Form A-claim/incident report for each incident.

47. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT) that have not been reported to your current OR prior professional liability carrier? Yes No
If yes, please explain.

If YES, complete Form A-claim/incident report for each incident.

48. Was each incident reported to your professional liability insurance carrier? Yes No
If the incident was not reported to your professional liability insurance carrier, include an explanation.

If YES, complete Form A-claim/incident report for each incident.

49. Other than the incidents, events and claims disclosed on Form A attached hereto, since the retroactive date requested, there are no circumstances, acts, errors or omissions, known to me or of which I should reasonably be aware, prior to the effective date of the policy for which I am applying, which could result in a professional liability claim against me or against any entity of which I am an employee, equity holder, officer or director.

Signature: _____ **Date:** _____

Coverage will not be provided by Missouri Physicians Mutual for incidents which should have been disclosed to MPM as described above.

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF YOUR POLICY.

I hereby represent the truth of my statements and reasons mentioned in this application and any attachments, and that I have not withheld any information that is reasonably likely to influence the judgment of the company in considering this application for professional liability insurance. Up to the effective date of the policy for which I am applying, I agree to immediately notify Missouri Physicians Mutual ("Company") of any information, fact or circumstance that amends, modifies or changes any information contained in this application. I further agree to be bound by the underwriting guidelines of Missouri Physicians Mutual.

In accordance with the provisions of Section 383.035, RSMo, I hereby state that I acknowledge and understand that the Company has published standard rates for coverage and that due to underwriting, marketplace, type of practice, area of practice and past history reasons I may not be charged such rate by the Company for coverage and may be charged an increased rate. I hereby acknowledge and consent to such increased rate to be charged by the Company for medical malpractice coverage under the Company Policy.

I hereby authorize the present and prior professional liability insurance carriers and any and all attorneys who have represented me in connection with any claim of professional liability to release to the Company upon its request for information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

By signing this application, I agree to indemnify, defend, and hold any entity named as Indemnified Organization under my Policy harmless against any and all Damages actually incurred in connection with

Claims made during the Policy Period against such Indemnified Organization that result from an Incident occurring after the Retroactive Date subject to all conditions, limits, and exclusions of the Policy. This indemnification is limited to coverage actually provided by the Policy. Capitalized terms in this paragraph shall have the meanings ascribed to them in the Policy.

I also authorize all medical associations and medical societies in which I am or have been a member, all hospitals in which I now hold or have held staff privileges, the State Board of Medical Examiner for the State of Missouri and any other State in which I have practiced, or resided, and any and all entities and physicians having information regarding me, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I hereby release and agree to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I hereby acknowledge that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to me. I agree that I shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and I hereby expressly waive any right I may have to compel such disclosure.

I further agree that the Company and all persons and organizations described above may rely upon a photostatic copy of the foregoing authorization, which shall be of equal validity with the signed original.

Acceptance of advance payment does not bind the Company to provide insurance.

I acknowledge that I am responsible for payment of all unpaid assessments and premiums regardless of whether anyone has agreed to pay premiums on my behalf.

I authorize release and exchange of information involving past and future underwriting and claims matters, including but not limited to investigations for material information on my reputation and fitness to practice medicine.

I understand and acknowledge upon acceptance of this application by the Company, this application shall become a part of the Policy and operate as a contract between the insured and the Company. I consent to the arbitration/mediation provisions set out in the Policy. I understand and acknowledge that my failure to abide by the arbitration provisions in the Policy, including the participation in and cooperation with the Company will, in the discretion of the Company, result in the exclusion of that Claim from coverage under the Policy including the Company not paying Damages and not providing a defense to a Claim. In addition, such failure to consent and failure to cooperate may result in cancellation of the Policy.

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application – regardless of whether or not I am granted insurance – and for the duration of the insurance which may be issued to me: To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees, Missouri Professional Management, L.L.C., its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant for insurance, and that my application will be evaluated by authorized management personnel and/or the

