

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



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.

Personal	1	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			
Residential Address	2	Street				Apt
		City	State	Zip	County	
		Home phone () -	Home email			
		Type of practice (Check one): <input type="checkbox"/> Private practice <input type="checkbox"/> Urgent care center <input type="checkbox"/> Other <i>specify</i> ▶				
Practice Profile	4	Practicing as (Check one) If you check corporation or partnership or employed physician, please complete information below <input type="checkbox"/> Individual <input type="checkbox"/> Corporation ▼ <input type="checkbox"/> Partnership ▼ <input type="checkbox"/> Employed physician ▼				
	5	Practice name				
Practice Address		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)	
Billing Address	6	Send billing to: <input type="checkbox"/> Residence <input type="checkbox"/> Practice <input type="checkbox"/> Other <i>complete information below</i> ▼				
		Billing name				
		Street				Suite
		City	State	Zip		

Practice Profile

continued...

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 Assistant♦	_____ Nurse practitioners♦	_____ Physician assistant♦
_____ Certified nurse midwives	_____ Nurses—LPN	_____ Psychologists
_____ Licensed Clinical Social Worker	_____ Nurses—RN	_____ Other
_____ Nurse anesthetists—CRNA's	_____ Optometrists	

Professional Profile

8-32

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

8	Have you ever been denied board certification or recertification?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
11	Have you ever been indicted or convicted of a crime other than a minor traffic violation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12	Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13	Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
15	Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
17	Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
19	Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20	Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
22	Do you assist—only at surgery? If you answer "Yes", complete the following: ▼ Number of own patients per year? _____ Number of other patients per year? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>
24	Do you perform general anesthesia? If "Yes", check as appropriate below. ▼ <input type="checkbox"/> Hospital <input type="checkbox"/> Non-hospital facility <input type="checkbox"/> Office	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25	Do you supervise CRNA's who provide general anesthesia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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

Procedures Profile

33

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. ▼

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

Procedures Profile
continued...

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

Procedures Profile
continued...

- | | | |
|---|--|---|
| <input type="checkbox"/> Orbital bone fracture repairs | <input type="checkbox"/> Radial keratotomy | <input type="checkbox"/> Tendon repair |
| <input type="checkbox"/> Orchidectomy | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Tenotomy |
| <input type="checkbox"/> Osteopuncture | <input type="checkbox"/> Radical neck dissection | <input type="checkbox"/> Therapeutic radiology |
| <input type="checkbox"/> Otoplasty | <input type="checkbox"/> Radioactive implants | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Pacemakers (temporary/permanent) | <input type="checkbox"/> Rapid detoxification | <input type="checkbox"/> Tissue expansion |
| <input type="checkbox"/> Pain control / management, medication only | <input type="checkbox"/> Rectocele | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Paracentesis | <input type="checkbox"/> Retinal detachment repair | <input type="checkbox"/> Tonsilloidectomy (T & A) |
| <input type="checkbox"/> Parotidectomy | <input type="checkbox"/> Retrobulbar blocks | <input type="checkbox"/> Trabeculectomy |
| <input type="checkbox"/> Penile implants | <input type="checkbox"/> Rhinoplasty, cosmetic | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Percutaneous endoscopic Gastrostomy | <input type="checkbox"/> Rhinoplasty, functional only | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Pericardiocentesis | <input type="checkbox"/> Rhytidectomy | <input type="checkbox"/> Tympanostomy |
| <input type="checkbox"/> Perineal repair | <input type="checkbox"/> Sacroiliac joint blocks | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Perineorrhaphy | <input type="checkbox"/> Salivary gland surgery | <input type="checkbox"/> Uterine suspension |
| <input type="checkbox"/> Peripheral nerve blocks | <input type="checkbox"/> Salpingectomy | <input type="checkbox"/> Valvuloplasty |
| <input type="checkbox"/> Permanent lash liner | <input type="checkbox"/> Scalene node biopsy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Phlebography | <input type="checkbox"/> Sclerotherapy | <input type="checkbox"/> Vein stripping |
| <input type="checkbox"/> Photorefractive keratotomy (PRK) | <input type="checkbox"/> Selective nerve root blocks | <input type="checkbox"/> Venography |
| <input type="checkbox"/> Phototherapeutic keratotomy (PTK) | <input type="checkbox"/> Septorhinoplasty | <input type="checkbox"/> Ventricular shunt |
| <input type="checkbox"/> Pleural biopsy, closed | <input type="checkbox"/> Sex change (transsexual) surgery | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Pleural biopsy, open | <input type="checkbox"/> Small bowel biopsy | <input type="checkbox"/> Weight control, medications: ▼

_____ |
| <input type="checkbox"/> Polypectomy by endoscopy | <input type="checkbox"/> Sphincterectomy | <input type="checkbox"/> Wound debridement |
| <input type="checkbox"/> Prenatal care | <input type="checkbox"/> Spinal infusion pump implantation | |
| <input type="checkbox"/> Prolotherapy | <input type="checkbox"/> Spinal surgery | |
| <input type="checkbox"/> Pterygium excision | <input type="checkbox"/> Sympathectomy | |

Professional Duties
34-40

34	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
35	Do you have teaching or faculty appointments? If yes, name the institution. ▼ Name of institution _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
36	If yes, are you responsible for the supervision of residents, interns or fellows?	Yes <input type="checkbox"/> No <input type="checkbox"/>
37	Does the institution provide you with coverage for these responsibilities?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Teaching/
Faculty
Appointments

315A.pprf9 ▼

Professional Duties

continued...

38 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

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
42 Secondary specialty	% of Practice	Years practicing secondary specialty

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 <i>see below</i> ♦	% of Practice <input type="checkbox"/>
State	License number	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>
State	License number	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>

♦ Status is **Temporary / Active / Inactive / Suspended / Restricted / Revoked**
 If anything other than Active, explain in notes. if more than 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	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	<input type="checkbox"/>

Education

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

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

Medical Malpractice Insurance

48-61

48 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

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

Medical Malpractice Insurance
continued...

50 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.

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

52 Are you seeking coverage during your retroactive period for any procedures which you did not check in question number 33? *If yes, please list below all procedures for which you seek retroactive coverage that you did not check in question number 33.* ▼ Yes No

Please use the 'notes' section for additional listings.

Insurance History

53 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 <input type="checkbox"/> No <input type="checkbox"/>
		/ /	/ /	Yes <input type="checkbox"/> No <input type="checkbox"/>
		/ /	/ /	Yes <input type="checkbox"/> No <input type="checkbox"/>
		/ /	/ /	Yes <input type="checkbox"/> No <input type="checkbox"/>

54 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

55 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

56 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

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

58 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

59 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 48-61.

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

