

Missouri Doctors Mutual Insurance Company

RapidQuote[†]

web

Please complete and return to us by fax at (800) 955-1855—for assistance call (816) 901-9950.

Physician or Group Name: _____
Group name or First name, M.I., Last name

County or Counties of Practice: _____

Contact Person: _____ Phone: (____) ____ - _____

Fax: (____) ____ - _____ Email address: _____

Expiration Date: _____ Current carrier: _____
(Please attach a copy of your current declarations page or certificate of insurance.)

List each physician and requested information on each:

Physician <small>First name, M.I., Last name</small>	Start Date in Medical Practice	Specialty	Retroactive Date Requested	Requested Limits		Part-Time		Invasive Surgery?	
				500/1M	1M/3M	Yes	No	Yes	No
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Claim History:

Have you or any doctor in the group ever had a claim filed against you? Yes No

If Yes, please complete the following:

(Claim status means it is either: **Pending, Closed, Dismissed** or resulted in a **Verdict**.)

Physician <small>First name, M.I., Last name</small>	Date of Incident	Claim Status	Amount of Settlement/Verdict
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____
_____	____/____/____	_____	\$ _____

Your Signature: _____ **Date:** _____

[†] This **RapidQuote** does not constitute a formal application for insurance. Any premium estimate based upon this request is for general information only and is not binding on Missouri Doctors Mutual Insurance Company (MoDocs). Once a formal application for insurance is received by MoDocs, if a determination is made to offer insurance to the applicant, a firm premium quote will be made at that time.