

FAX

To receive a **RapidQuote**, please complete and return to us by fax at **(800) 955-1855**
—for assistance call **(816) 901-9950**

web

Missouri Doctors Mutual Insurance Company
RapidQuote[†]



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.)

Are you currently licensed or have you ever been licensed to practice Medicine outside of the state of Missouri? Yes No

If so, please list each state in which you have been licensed: _____

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		Hours Worked Per Week	Invasive Surgery?	
				500/1M	1M/3M		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"/>

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, Settled** or **Verdict**.)

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

if you need more space, please attach additional claim history.

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.