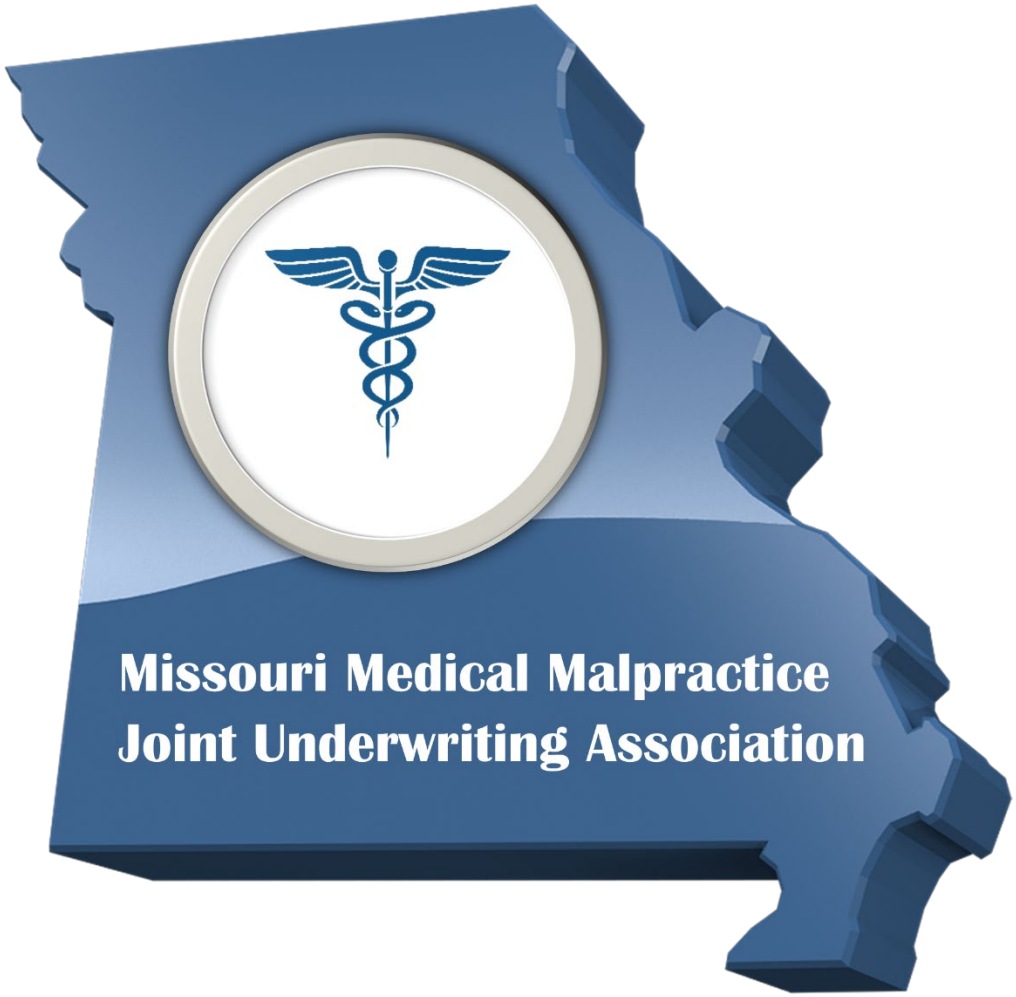

Missouri Medical Malpractice Joint Underwriting Association

Operations and Rating Manual

4700 Country Club Drive
Jefferson City, MO 65109
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Website: MMMJUA.com

I. Plan Overview

A. Purpose of Missouri Medical Malpractice Joint Underwriting Association

The Missouri Medical Malpractice Joint Underwriting Association (hereinafter the "Association") was established to provide medical professional liability insurance that is not otherwise reasonably available in the voluntary market and began issuing policies effective June 2004.

B. Eligibility

Any health care provider shall be entitled to apply to the association for medical malpractice liability insurance. For the purposes of this Operations and Rating Manual (hereinafter the "Manual"), the term "Applicant", whether in the singular or plural, shall refer to applicants, policyholders, named insureds and additional insureds. Such application may be made on behalf of an Applicant by a broker or agent authorized by the Applicant.

However, in order to be eligible for coverage the provider shall:

- Be duly licensed or registered as a health care provider under Missouri Law and meet the definition of a Health Care Provider as stated in RSMo 383.150: "physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination";
- Have a professional health care practice which is located in whole or in part within the state of Missouri;
- Be seeking professional liability or related coverages, through the Association, only for Missouri activities or premises;
- Have been unable to obtain such coverage through the voluntary market for the period of time for which coverage is requested at comparable cost;
- Provide proof of similar coverages for all professional activities rendered and premises situated in other states;
- Pay the premium or portion thereof required under the underwriting manual of the Association;
- Have no unpaid, uncontested premium due for prior insurance;

- Agree to participate in any loss control steps or programs required by the Association; and

- Conform to any other reasonable underwriting guidelines in the underwriting manual.

- Not participate in the certification of patients for the medical use of marijuana.

II. Operations Overview

A. Servicing Company's Authority

The Board grants operational and underwriting authority to the Servicing Company. The Operations and Rating Manual provides a consistent and structured framework for the Servicing Company to equitably manage the Association. The guidelines established are subject to change as the Association evolves. Upon Board approval, the Manual will be amended to incorporate changes. The commemoration of changes in this manual is not required for the changes to take effect.

B. Policy Forms

The Association will provide professional liability insurance under policy forms and applications as approved by the Board and the Missouri Department of Insurance. A list of approved policy forms and applications is contained on Appendix A and available for review on the Association's website at www.mmmjua.com.

C. Manual Rules

The Association adopts by reference the loss cost prepared, published and filed by the Insurance Services Office, Inc. (the "ISO"). Coverage will be underwritten in accordance with ISO guidance, as modified by the rules and exceptions as set forth in this manual.

Health care providers applying for coverage may have characteristics that indicate a different exposure than that presented by others in the same rating classifications. These differences in exposure shall be recognized through the application of credits/debits as set forth in this Manual.

If at any time rules in this manual conflict with one another, or circumstances arise that are not covered by manual rules, the servicing carrier will obtain approval from the General Counsel to the board of the Association for revisions to the manual or forms, or submittal of Consent to Rate filings to the Department of Insurance.

D. Distribution System

Eligible health care providers may apply for professional liability insurance through an agent authorized to place casualty insurance under subdivision 1 (4) of Section 375.018, RSMo., or direct to the Association. Commissions shall not be paid or premiums shall not be reduced if a policy is purchased direct from the Association.

The Association will not license or have any agent or broker representation. The Servicing Company will not recommend insurance agents to health care providers. If the Board approves a list of agents for recommendation to Applicants who request assistance in obtaining agent representation, the Servicing Company will provide the list of agents to such Applicants. If the Servicing Company determines that an agent has made material misrepresentations with respect to any Applicant or that such agent has acted in any way to deceive or defraud the Association, it will report this information to the Board and request authority to remove such agent from the approved list of agents.

Commissions will be paid to authorized agents on a sliding scale as follows:

Annual Premium	Commission (as a % of annual premium)
First $25,000	8%
Next $75,000	5%
Over $100,000	3%

Agents are not authorized to withhold their commission from payments made to the Association. In order for the Association to proceed with payment of commission to an agent, a copy of their current license, and a W-9 form must be on file with the Servicing Company. The Servicing Company will pay commissions to the agents by the last day of the month after the effective date of each policy or the last day of the month after the month in which payment is received and posted by the accounting department, from the insured for a policy, endorsement or installment billing, whichever is later. Commissions will not be paid on installment billings until after the installment payments are received and posted by the Servicing Company.

The Servicing Company will remit premiums collected less commissions paid or payable to the Association in accordance with its contract.

In the event of cancellation of a policy, the Servicing Company will return any return premium due to the insured, less any other balances due to the Association. Any commission due back from the agent for premium returned to the insured will be deducted from the agent's commission in the next month commissions are processed. If no commission is due to the agent, the agent will be billed for the unearned commission.

For any premium financing company approved by the Servicing Company, the Servicing Company will remit return premiums to the finance company in accordance with the provisions of the approved finance agreements. If the Servicing Company returns the entire unearned premium, including agent's commissions, to the finance company, the Servicing Company will have the right to offset any amount of commission paid by the Servicing Company from any other amounts due to the agent, or bill the agent directly for such unearned commission. The Servicing Company will also then forward a separate billing to the insured for any remaining amount due for the Additional First Year Charge, per the Promissory Note signed by the insured. The Association reserves the right not to accept a finance agreement from a finance company not previously approved, and/or if a copy of the signed finance agreement is not submitted with the binding information.

Requests to change agents received, in writing from an insured, will be honored immediately, in regard to servicing of the account. The agent who submitted the application will receive commissions through the end of the policy term.

E. Additional First Year Charge

Pursuant to Missouri Statute 383.165 RSMo, each policyholder shall pay to the Association in the first policy year, in addition to premium payment due for insurance through the Association, an amount equal to said premium payment. Such charge shall be stated in the policy.

Effective December 12, 2006, for quotes for new insureds, the full amount of the Additional First Year Charge will be considered fully earned at binding, however, the Additional First Year Charge may be paid using the Association's installment plan.

F. Right of Appeal

Any Applicant for insurance coverage, any person insured by the Association or their representatives, or any affected insurer, agent or agency aggrieved with respect to any ruling, action, or decision by or on behalf of the Association, including by its staff, any committee thereof or any servicing companies hired by the Board, regarding matters within the discretion of such persons or entities under the relevant provisions of Chapter 383, RSMo., the Plan of Operation, or the manuals of the Association, or any other matters agreed to specifically by the Board after a formal vote, may submit a grievance in writing to the Board for its review. The submission of the grievance to the Board shall be made within thirty (30) days following notice of such ruling, action or decision. The Board may limit its review to the written submission or, in its sole discretion, permit the grievant to present oral argument to the Board. The Board shall provide its decision on the appeal in writing within thirty (30) days of the submission of the grievance or within thirty (30) days of the oral argument, if permitted.

Only decisions of the Board on appeals may be appealed to the Director of Insurance, provided however, that decisions regarding underwriting and rating shall not be appealable to the Director. Any appeal that is permitted to be made to the Director shall be made in writing within thirty (30) days from the decision of the Board.

In accordance with Section 383.190, RSMo, any person aggrieved by any decision of the Director on any such appeal may, within ten (10) days after notice thereof, file a petition in the Circuit Court of Cole County for a review thereof.

III. Underwriting Procedures

A. Application and Quoting Process

Each Health Care Provider is required to submit the appropriate application(s) in order to be considered for coverage with the Association. Applications can be obtained from the Servicing Company, authorized agent, or from the Association's web-site at www.MMMJUA.com.

New Applications should be returned to the Association at least 60 days prior to the requested effective date of coverage to ensure ample time to complete the underwriting review process. The Servicing Company will endeavor to provide a firm quotation at least 30 days prior to the requested effective date on complete submissions received at least 60 days prior to the requested effective date. Applications signed more than 90 days prior to the effective date of coverage (120 days for renewals), must be re-signed and dated prior to binding.

Complete submissions received less than 60 days prior to the requested effective date of coverage will receive a firm quotation upon completion of the underwriting review.

Applicants with incomplete submissions will receive a letter summarizing the items necessary to make the submission complete. Premium indications, which are subject to change, may be released if the underwriting information needed to release a premium indication has been provided. No firm premium quotation may be given before a fully completed application has been submitted.

A complete submission for physicians, surgeons, dentists and allied health care providers includes the following:

- Application with original signature and date;
- Every question completed (use N/A, when appropriate) and detailed explanations provided, when requested;
- Five-Year Claims History from current and/or previous insurance carriers;
- Supplementary Loss Form completed for each medical malpractice case;
- Expiring Declaration Page from current/expiring insurance coverage;
- Business letterhead;
- Verification of Claims-Made Reporting Coverage from expiring insurance carrier;
- Application for each allied health care provider for which coverage is requested;
- Curriculum Vitae; and
- Copy of Missouri Medical License
- Completed, Signed Authorization to Release Information

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In addition to the above, health care facilities need to provide:

- Application for each employed physician, surgeon, and dentist for which coverage is requested;
- Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies;
- Copy of medical staff by-laws; (not required prior to binding)
- A.H.A. Survey of hospitals;
- Risk Management and Quality Improvement Plan;
- Verification of professional liability coverage for all contracted services; and
- All hold harmless agreements.

In reviewing an application form, the Association and/or Servicing Company may seek such additional information as is reasonable to verify the information on the application or otherwise determine the Applicant's loss history or exposure to claims.

Applicants shall endeavor to obtain coverage through the voluntary market. Only where an Applicant or their agent certifies on an application approved by the Department that the Applicant and/or agent has been unable to obtain such coverage for the Applicant through the voluntary market for the period of time for which coverage is requested, at comparable cost, shall such coverage be available to the Applicant with the Association. If the Applicant is applying for coverage through an agent, the certification regarding the Applicant's inability to obtain coverage through the voluntary market shall be made by the Applicant's agent.

Renewal Applications will be mailed to insureds 120 days prior to their expiration date/renewal date. Renewal Applications should be returned to the Association at least 60 days prior to the expiration date/renewal date.

Firm Quotations and Premium Indications expire 7 days after the requested effective date or 30 days from the release date, whichever is less.

B. Refusal to Issue

The Association's right to refuse to issue coverage in response to an initial application for coverage is not limited to but may include one or more of the following reasons:

- Applicant does not meet the Association's eligibility requirements;
- Any concealment, misrepresentation or fraud on the part of the Applicant concerning the Applicant's medical practice, the application for insurance, or otherwise;
- Unacceptable or unsupportable loss severity or loss frequency based upon the Applicant's loss history;
- Applicant has unpaid, uncontested premium due for prior insurance;
- Unwillingness or inability to conform to reasonable underwriting standards.

C. Binding of Coverage

The Association shall rely on the information developed from the application and underwriting review process for the purposes of determining the required premium. Coverage may not be bound (made effective) until the submission is complete including any additional information requested by the Servicing Company, the necessary investigation is completed, and the required premium is paid (including cash deposit and signed promissory note, or full cash payment, of the Additional First Year Charge). The Servicing Company will issue a written binder based upon the Applicant's request in accordance with a proposal made to the Applicant, after premium and Additional First Year Charge has been received per the premium payment guidelines of the Association. The binder will remain in effect for the term shown on the binder or until a policy is issued to replace the binder, whichever is sooner. Binders may be extended where necessary.

In circumstances where state licensure is pending, coverage may be accepted by the Association pending issuance and confirmation of the license. The Association will issue a binder upon receipt of all information including a copy of the license. If all other required information and payment have been received, the Association may backdate coverage to the effective date of the state issued license.

D. Coverage

If approved, the Applicant is offered coverage based on the following:

Individual Professional Liability Coverage for eligible individual physicians, dentists, and allied health care providers, written on a Claims-Made form, with limits of liability in the amount of $500,000 each medical incident/$1,500,000 annual aggregate or $1,000,000 each medical Incident/$3,000,000 annual aggregate.

Partnership, Limited Liability Company, Association or Corporation Professional Liability Coverage for physician groups and eligible facilities, written on a Claims-Made form with limits of liability in the amount of $500,000 each medical incident/$1,500,000 annual aggregate or $1,000,000 each medical incident/$3,000,000 annual aggregate.

Commercial General Liability Coverage written on a Claims-Made form with limits of liability of $500,000 each incident/$1,500,000 general aggregate or $1,000,000 each incident/$3,000,000 general aggregate, available to facilities in conjunction with professional liability coverage only.

E. Premium Payment

Premium and Additional First Year Charge payments are expected in advance of binding of coverage. At the discretion of the Association, coverage may not be bound until payment is received by the Association. Payment is considered received on the date payment is sent to the Association, as evidenced by the post-mark date or date shown as received by delivery service for items sent by overnight mail service.

A premium payment plan is available for active policy premiums when the total annual policy premium is at least $10,000. Annual premiums under $10,000 are due in full at the time coverage is bound. The premium payment plan requires a deposit of 40% of the annual premium at binding with 30% due within 60 days of the effective date and the remaining 30% due within 120 days of the effective date. A non-refundable service fee equal to 2.5% of the total financed premium is due at binding, along with the deposit. The premium payment plan is not available for Prior Acts Policy premiums and mid-term endorsements. Those choosing to make full cash payment of the Additional First Year Charge, or making a 25% down or installment payment of the charge, may pay using the premium payment plan, provided they otherwise qualify for the payment plan. Failure to pay a premium installment timely when due will result in cancellation of the policy for non-payment of premium. The full amount of any unpaid balance due for the Additional First Year Charge will be fully due and collectible at the time of cancellation. The Association will retain any unearned premium due the insured due to cancellation for application to any unpaid Additional First Year Charge note balance, after any amounts remaining due to premium finance companies have been paid.

For all policies issued on an installment premium basis, installment billing notices will be sent at least 30 days in advance of the premium due date. Notices of cancellation for non-payment of premium will be sent immediately if payment is not **received on or before the due date**. The notice of cancellation for non-payment provides 10 days plus 3 days mailing, within which payment must be received in order to continue coverage without a lapse. The Association reserves the right to not accept late payments or accept late payments subject to restrictions.

After a policy has been cancelled a second time within a single policy term due to non-payment, the insured must pay the entire account balance within 13 days in order to reinstate coverage. Further, the insured forfeits the option to pay in installments the following renewal term.

If a policy is cancelled due to non-payment, the outstanding amount due for the Additional First Year Charge will be fully due and payable. After payment of any outstanding premium finance company balances, the Association will withhold refund of any unearned premium due the insured in order to apply toward these outstanding amounts.

All premium payments shall be made by check payable to: Missouri Medical Malpractice Association, and mailed to the Association: 4700 Country Club, Jefferson City, MO 65109.

Agency checks are discouraged. Checks will be accepted by Association approved financing companies. A copy of the signed finance agreement is required to be included with the binding request.

F. Certificates of Insurance

The Servicing Company will issue certificates evidencing insurance coverage, to interested parties upon request of the insured. An interested party is considered to be a hospital, nursing home, HMO, PPO, or other practice or managed care program that the Association deems to have a legitimate interest in the coverage of the insured. Agents or brokers are not authorized to issue certificates. Certificates indicating individual named insureds on the policy as the certificate holder will not be issued.

G. Cancellation

The insured may cancel coverage at any time. Cancellation will be effective no earlier than the date that the Association receives written notice of the requested cancellation from the insured.

The Association's right to cancel coverage is not limited to but may include one or more of the following reasons:

- Applicant no longer meets the Association's eligibility requirements;
- Any concealment, misrepresentation or fraud on the part of the Applicant, whether before or after a loss, concerning the Applicant's medical practice, the application for insurance, or otherwise;
- Violations of terms or conditions contained in the policy;
- Applicant has unpaid, uncontested premium due for prior insurance;
- Changes in exposure which have materially increased the risk assumed by the Association;
- Death or disability of the Applicant;
- A material breakdown of the relationship between the Applicant and the Association.

Written notice of cancellation shall be provided by certified United States mail to the first Named insured, at the last mailing address known to us, stating the actual reason for cancellation, giving at least:

- 10 days prior to the effective date of the of cancellation plus 3 days mailing in the case of non-payment of premium;
- 30 days prior to the effective date of the of cancellation plus 3 days mailing in the case of fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder;
- 30 days prior to the effective date of the of cancellation plus 3 days mailing in the case of changes in conditions after the effective date of the policy which have material increased the hazards originally insured; or
- 60 days prior to the effective date of the cancellation for any other reason.

Cancellation requests from premium finance companies for cancellation due to non-payment of premium will be processed upon receipt of the notice from the finance company, and after the Association has provided the insured with the legally required 10 days notice plus 3 days mailing.

Subject to Missouri cancellation requirements, the following provisions apply:

Pro Rata Cancellation is used when a policy is cancelled at the request of the Association, due to death or disability, concealment, misrepresentation or fraud, or for non-payment of premium. Pro rata return premium will be computed and rounded to the next higher whole dollar.

Short Rate Cancellation is used when a policy is cancelled for any reason other than pro rata. Short rate cancellation will be computed at .90 of the pro-rata unearned premium factor and rounded to the nearest dollar.

Proof of mailing by certified United States mail to the first Named insured, at the last mailing address known to us, will be sufficient proof of notice.

Minimum premium will be retained, unless the policy is cancelled flat as of the inception date stated in the declaration page. If the policy is cancelled mid-term, and the full Additional First Year Charge has not been paid, any unpaid balance of the Additional First Year Charge will become fully due and payable at the time of cancellation. The Association will retain unearned premium for application to unpaid Additional First Year Charge balances, after payment of any remaining amounts due to premium finance companies. The Association will notify the insured of the note balance due, and the insured will be given 14 days from the date of the notice in order for payment to be received by the Association. If payment is not received within that time, the file will be turned over for collection.

H. Non-Renewal

The Association's right to non-renew a policy is not limited to but may include one or more of the following reasons:

- Applicant no longer meets the Association's eligibility requirements;
- Any concealment, misrepresentation or fraud on the part of the Applicant, whether before or after a loss, concerning the Applicant's medical practice, the application for insurance, or otherwise;
- Violations of terms or conditions contained in the policy;
- Unacceptable or unsupportable loss severity or loss frequency based upon the Applicant's loss history;
- Applicant has unpaid, uncontested premium due for prior insurance;
- Unwillingness or inability to conform to reasonable underwriting standards;
- Changes in exposure which have materially increased the risk assumed by the Association;
- A material breakdown of the relationship between the Applicant and the Association.

Written notice of non-renewal shall be provided by certified United States mail to the first Named insured, at the last mailing address known to us, stating the actual reason for non-renewal, at least 60 days prior to the effective date of the non-renewal for any reason.

Proof of mailing by certified United States mail to the first Named insured, at the last mailing address known to us, will be sufficient proof of notice.

If the policy is non-renewed by the insured, the Association will immediately bill the insured for the remaining unpaid balance of the Additional First Year Charge. Payment of this charge will be due within 14 days of the date of the invoice or demand letter. If payment is not received within that time, the file will be turned over for collection.

At least 60 days prior to renewal date, each provider will receive a Conditional Non-Renewal Notice from the Association advising that the coverage provided under the policy will end at the policy expiration date, and will not be renewed unless all required renewal information and funds are received prior to the renewal date, as evidenced by U. S. Postal Service postmark on the envelope addressed to the Association.

If the Named Insured cancels or does not renew this policy, or if, for any reason other than nonpayment of premium, the Association cancels this policy or refuses to renew this policy or renews this policy on other than a claims-made basis, the Named Insured may:

1. by giving written notice to the Association no later than thirty (30) days after the effective date of cancellation or nonrenewal of this policy; and

2. by paying promptly when due any additional premium (to be computed in accordance with the Association's rules, rates, rating plans, and premiums effective on the inception date of the policy);

have an endorsement issued providing an Extended Reporting Period following the effective date of the cancellation or nonrenewal of this policy during which Claims otherwise covered by this policy may be reported. Extended Reporting Period Coverage will be offered for a limited term of up to three years. Extended Reporting Period will be charged as a multiplier of the annual premium for departing insureds based on that insured's loss ratio. The Extended Reporting multipliers are as follows:

Extended Reporting Period - 1 Year Option

Loss Ratio (5-Year)	ERP Factor
0%-80%	2.00
81%-100%	3.00
101%-200%	4.00
201%-1000%	5.00
>1000%	6.00

Extended Reporting Period - 2 Year Option

Loss Ratio (5-Year)	ERP Factor
0%-80%	3.00
81%-100%	4.00
101%-200%	5.00
201%-1000%	6.00
>1000%	7.00

Extended Reporting Period - 3 Year Option

Loss Ratio (5-Year)	ERP Factor
0%-80%	4.00
81%-100%	5.00
101%-200%	6.00
201%-1000%	7.00
>1000%	8.00

IV. General Rating Rules

A. Unknown Classification

If there is no classification included in the rate filing for operations applicable to a health care provider, a classification will be assigned that most closely reflects the type of work and relative exposure to loss of the provider's activities compared to activities contemplated by the filed class codes.

B. Multiple Classifications

Health care providers will be classified in accordance with the classification schedule included with the rate filing made by the Association to the Division of Insurance. If more than one classification applies, the classification with the highest base rates will apply.

C. Multiple Territories

If a health care provider's practice involves two or more rating territories, the highest rating territory applies subject to underwriting judgment.

D. Covered Medical Employees

Under the **Physicians, Surgeons & Dentists** form, coverage for medical employees (other than those listed below) will be provided on a shared limit of liability basis, at no additional charge, per the terms and conditions of the policy.

This provision does not apply to physicians, surgeons, dentists, physician assistants, surgeon assistants, certified nurse midwives, certified nurse practitioners, psychologists, emergency medical technicians, perfusionists, chiropractors, certified nurse anesthetists, cytotechnologists, optometrists, podiatrists, residents, interns or any other specialty on file with ISO as additional charge classifications. Separate individual coverage must be evidenced to the Association for these specialties.

Under the **Facility Professional Liability** form, coverage for medical employees (other than those listed below) will be provided on a shared limit of liability basis, at no additional charge, per the terms and conditions of the policy.

This provision does not apply to physicians, surgeons, dentists, chiropractors, podiatrists, anesthetists, certified nurse anesthetists, certified nurse midwives, certified nurse practitioners, physician/surgeon assistants, residents,interns or any other specialty on file with ISO as additional charge classifications. These individuals must meet eligibility requirements and apply for separate coverage subject to the procedures outlined above in Section III – Underwriting Procedures.

E. Policy Terms

Policies will be written for a twelve- (12) month term.

F. Premium Computation

Premiums including endorsement changes will be computed using the rules and rates in effect at the inception of the policy. All changes requiring a change in premium are to be pro-rated for the remaining term. Any changes resulting from decreased exposure may be subject to a onetime extended reporting period charge based on the provisions above.

Whenever factors or multipliers are used to compute the premium, they will be applied consecutively and not added together, except with respect to the scheduled rating plans. Scheduled rating plan debits will be added together then applied in total to the adjusted premium.

The Association reserves the right to adjust a provider's premium effective at policy inception if information is developed during the policy term that differs from the information the provider supplied in the application.

Minimum Premium: The minimum premium per policy period is $500 per individual provider and $2,500 per facility, regardless of the term.

Additional Premium Charges: All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of $15.00 or less will be waived. Return premiums requested by the insured will be granted. Retain the policy minimum premium.

G. Deductibles

Deductible options are not customarily available, however, in lieu of non-renewal or declination of an Applicant, the Association, at its sole discretion, may mandate an indemnity deductible. For mandatory deductibles equal to or in excess of $25,000, the Association may also require a Letter of Credit on file. No premium credits are available for mandatory deductibles.

H. Providers with Multi-State Exposures

Should a provider practice in more than one state, coverage under the Association policy will only apply to professional medical or dental services rendered within the state of Missouri. A limitation endorsement will be attached to the policy, and the endorsement will require an acceptance signature from the insured. In addition, the Association will require proof of ongoing insurance coverage from the provider's insurer for the exposures outside of the state of Missouri. A certificate of insurance including a definitive cancellation clause providing the Missouri Medical Malpractice Association with 30 days written notice prior to cancellation of the other carrier's coverage is required. A provider who does not have proof of current "other states" coverage on file with the Association is no longer eligible for coverage through the Association, and may be subject to cancellation or non- renewal.

I. Lost Cost Adjustment Multiplier

The Association adopts by reference the Lost Cost for the State of Missouri as prepared published and filed by the ISO, with the following Lost Cost Adjustment Multiplier: **6.75**.

J. Claims Made Factors

The Association will utilize the following ISO Claims Made Factors on an accelerated basis:

Company Accelarated Claims Made Factors*	Number of months in Claims Made Program											
Number of Whole Years	0	1	2	3	4	5	6	7	8	9	10	11
0	0.60	0.61	0.62	0.64	0.65	0.66	0.67	0.69	0.70	0.71	0.72	0.74
1	0.75	0.75	0.76	0.76	0.77	0.77	0.77	0.78	0.78	0.79	0.79	0.80
2	0.80	0.80	0.81	0.81	0.82	0.82	0.82	0.83	0.83	0.84	0.84	0.85
3	0.85											

V. Physicians, Surgeons, Dentists, and Allied Health Care Providers Rates and Rating Rules

A. Physician Professional Liability Class Plan

The Association adopts by reference the loss cost prepared, published and filed by the ISO. Coverage will be underwritten in accordance with ISO guidance, as modified by the rules and exceptions as set forth in this manual.

B. Rating Territory Factors

Territory 1 - 1.10
Territory 2 - 1.10
Territory 3 - 1.00

C. Professional Liability Premium Credits

Moonlighting Credit

A 50% Moonlighting Credit is available to healthcare providers whose practice is limited to 20 or less hours per week and who perform covered “moonlighting” activities. This credit is not available to residents in training. This credit may be applied to full-time providers whose Missouri practice is limited to 20 hours or less per week.

Covered “moonlighting” activities include:

- Healthcare providers in active, full-time military service requesting coverage for outside activities.
- Full-time Federal Government employees (such as V.A. Hospital employees) requesting coverage for outside activities.
- Full-time State or County Health Department employees requesting coverage for outside activities.

Practice hours are defined as:

- Hospital rounds
- Charting
- On call hours involving patient contact, whether direct or by telephone,
- Consultations, and
- Patient visits/consultations.

Part-Time/Semi-Retired Credit

A 50% Part-Time Credit is available to healthcare providers whose practice is limited to 20 or less hours per week. This credit is not available to healthcare providers who perform invasive surgical procedures.

Practice hours are defined as:

- Hospital rounds
- Charting
- On call hours involving patient contact, whether direct or by telephone,
- Consultations, and
- Patient visits/consultations.

Practice hours of healthcare providers receiving the Moonlighting Discount or Part-Time/Semi-Retired Credit are subject to random audit by the Association.

Practice Interruption Credit

Individual Health Care Providers whose practice is interrupted are eligible for a one-time Practice Interruption Credit. The purpose of this discount is to “freeze” coverage while allowing the policy to remain in force. Coverage for services rendered during the “frozen” period will cease. Eligible reasons for practice interruption include sabbatical leave, active military duty, maternity leave, disability, or volunteer charitable medical assignments.

This discount is not intended for absence due to vacation, illness, leaves of less than 90 days or that extend longer than one year.

A 30% premium credit will be applied to the period of practice interruption. The discount will be applied upon return to the practice of medicine.

D. Surcharges Loss Evaluation Surcharge

The Loss Evaluation Surcharge is evaluated based on the preceding ten (10) years* of loss history provided by the expiring carriers' loss runs. The Loss Evaluation Surcharge is determined based on the loss information available at the time of the underwriting review for new or subsequent renewal coverage. The debit will apply to all premiums including Prior Acts Policy premiums.

“Loss” is defined as the sum of the indemnity reserve, allocated loss adjustment expenses reserve, paid indemnity, and paid allocated loss adjustment expenses as determined by the expiring carrier. When allocated loss expense is unknown, multiply total incurred indemnity by 1.20. Two losses of $10,000 or less each, including indemnity reserve, allocated loss adjustment expenses reserve, paid indemnity, and paid allocated loss adjustment expenses will be forgiven. In addition, class action and individual drug litigation (i.e. Lotronex, Fen-Phen, Propulsid, Rezulin) will be forgiven and not considered when granting this debit.

The surcharge schedule considers both frequency and severity of cases as outlined below:

	Number of Losses									
	1	2	3	4	5	6	7	8	9	10
Up to and including $100,000	1.00	1.15	1.30	1.45	1.85	2.05	2.20	2.35	2.50	2.65
$100,001 to $250,000	1.15	1.30	1.45	1.60	2.05	2.20	2.35	2.50	2.65	2.80
$250,001 to $500,000	1.30	1.45	1.60	1.70	2.20	2.35	2.45	2.65	2.80	2.95
$500,000 to $750,000	1.45	1.60	1.70	2.20	2.35	2.45	2.60	2.80	2.95	3.10
$750,000 to $1,000,000	1.60	1.75	1.85	2.35	2.50	2.60	2.75	2.95	3.10	3.25
$1,000,000 to $1,500,000	1.75	1.90	2.00	2.50	2.65	2.75	2.90	3.10	3.25	3.40

*Loss information to be considered includes all losses *reported* in the previous ten (10) years.

Scheduled Evaluation Surcharge Criteria

A healthcare provider who is subject to any of the following shall be assessed a premium surcharge equal to 5% of the annual premium, for each offense which occurred within the last five years. If the offense occurred more than five years ago but less than 10 years ago, a surcharge equal to 2.5% of the annual premium for each offense, will apply. The surcharges are applied with the understanding that more than one surcharge may be applied for the same occurrence. (i.e. A healthcare provider reports 1) One year ago entering into a consent agreement with the state licensing board due to 2) treatment for substance abuse with 3) Hospital privileges suspension during the treatment period.) Based on the Scheduled Evaluation Surcharge Criteria the premium calculation would be base premium + .05 + .05 + .05). The surcharge will be capped at a maximum of 25% of annual premium.

These surcharges may be assessed in addition to, and not in place of, any other action taken by the Association based on information received by the Association with respect to the provider's status or standing.

1) A healthcare provider who has practiced without medical malpractice insurance.
2) A healthcare provider whose expiring coverage is with a non-standard, non-admitted carrier for cause.
3) A healthcare provider whose practice patterns or type/nature of practice presents an increased risk including but not limited to prescribing substances that are not FDA approved, performing procedures that are considered experimental, practicing a specialty for which they have not received appropriate training.
4) A healthcare provider whose hospital privileges have been denied, restricted, suspended, or revoked, or against whom probation has been invoked by a hospital.
5) A health care provider who has had their license denied, suspended, restricted or revoked or against whom probation has been invoked by the licensing authority.
6) A healthcare provider who has been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental health.
7) A healthcare provider who has relapsed following alcohol or chemical dependency treatment.
8) A healthcare provider who has been asked to participate in or has volunteered to participate in an impaired healthcare provider program.
9) A healthcare provider against whom a claim for sexual misconduct has been made.
10) A healthcare provider who has had a patient or his representative file a complaint or grievance against them with a hospital committee, state licensing or regulatory agency or other medical review committee (other than complaints determined that no probable cause existed and file closed).
11) A healthcare provider who has been charged with or convicted of a felony and/or misdemeanor including but not limited to mail fraud, and perjury.
12) A healthcare provider who has had an injury, illness, or other event occur that may impair, lessen or diminish their physical or mental ability to practice as a physician, surgeon, dentist or allied healthcare provider.
13) A healthcare provider who has appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical or dental review committee.
14) A healthcare provider who has altered medical records.
15) A healthcare provider who fails to cooperate with Association Risk Management recommendation and/or attend a sponsored Loss Prevention Seminar.
16) Ability to participate with Medicare or Medicaid revoked, suspended, placed on probation or voluntarily surrendered.

E. Locum Tenens Coverage

Coverage for temporary substitute physicians, surgeons, and dentists may be provided for a maximum of 90 days policy term with no additional premium charge. Locum Tenens are defined as physicians, surgeons, and dentists who provide temporary coverage for an insured who is normally scheduled to work but is unable to do so due to vacation, maternity leave, hospitalization, attendance at a professional meeting/seminar, illness, or family emergency. Locum Tenens coverage is not available for allied health care providers.

In order to obtain coverage, the substitute provider must complete an application and receive underwriting approval prior to the dates for which the substitute physician is providing coverage. Applications will be kept on file for one year, then an updated application will be required prior to additional use of the Locum Tenens provider. An endorsement will be issued to the insured's policy adding the substitute provider, and scheduling dates coverage is provided, on a shared limit of liability basis. Additional dates for the same provider may be added, but the Association must be notified in advance, and the policy endorsed for each additional period of time for which coverage is requested.

F. Organization Coverage

Shared Limit

For physicians, surgeons, dentists, or allied health care providers that have formed a corporation or limited liability corporation, the coverage for the organization will be provided at no additional charge, but corporate coverage will be limited to only the acts of the insureds listed on the policy and those covered under Section IV, General Rating Rules, Item D, Covered Medical Employees and the limits of liability will be shared with the treating insured provider.

Separate Limit

Upon approval of the Association, coverage for partnerships, limited liability companies, associations, corporations or other similar entities can be provided with a separate limit of liability on an optional basis for an additional premium.

The rate shall be in accordance with ISO guidance, including a premium equal to 20% of all applicable charges for insured physicians, surgeons, and dentists of the organization.

VI. Health Care Facility Rates and Rating Rules

The Association adopts by reference the loss cost prepared, published and filed by the ISO. Coverage will be underwritten in accordance with ISO guidance, as modified by the rules and exceptions as set forth in this manual.

A. Rating Territory Factors

Territory 1 – 2.00
Territory 2 – 2.00
Territory 3 - 1.00

B. Professional Liability Premium Surcharges

Facility Professional Liability Experience Rating Plan

1. Instructions

The rules of this Plan shall govern the experience rating procedure to be followed in connection with Facility Professional Liability in Missouri.

The rules below will set forth procedures, which describe use of experience.

2. Definitions

A. Risk – The term "risk" as used in this plan shall mean the exposure of any one insured to be rated by the Missouri Medical Malpractice Joint Underwriting Association.
B. Experience – For the purpose of this plan, "experience" shall mean the facility professional liability experience.
C. Experience Period Premium at Present Rates – "Experience period premium at present rates" is the sum of the premiums computed by extending the present exposures for Facility Professional Liability at present rates for limits of $1,000,000 per medical incident or occurrence, $3,000,000 aggregate, regardless of the limits of liability used in rating during the experience period.
D. Incurred Losses – "Incurred Losses" are the sum of (1) all paid and outstanding allocated claim expenses and (2) paid and outstanding indemnity losses limited to $1,000,000/claim for Facility Professional Liability allocated to the experience period in which they occurred. If loss runs do not include Allocated Loss Expense information, a 15% factor will be applied to paid loss amounts to determine claim expense to be included in this calculation.

3. General Provisions

Eligibility Requirements: Any risk developing an annual manual premium of $25,000 or more at $1,000,000/$3,000,000 rates for the Facility Professional Liability exposures shall be subject to the rules of this experience rating plan.

4. Application of Experience Modification

The experience modification developed by this plan for the risk shall be applicable to the total premium for the risk for Facility Professional Liability insurance.

5. Experience to be Used for Rating

A. The experience to be used in this plan shall be the latest available five years' experience incurred by the risk. The experience period shall commence no more than six years prior to the effective date of the experience modification to be established and expire at least one year prior to the effective date of the experience modification to be established.
B. If five years of experience is not available, the experience available shall be used in determining the experience modifications. In no instance will an experience period of less than one year be used in the determination of an experience modification.
C. Experience incurred by companies other than the Missouri Medical Malpractice Joint Underwriting Association or self-insured experience shall be used subject to the periods described above, and given credence in accordance with its apparent reliability.

6. Rating Procedure

A. Premium Subject to Experience Rating shall be the "Experience Period Premium at Present Rates" as defined in Section 2 (C) modified by the following factors:

Number of Years Between The Effective Date of Each Policy in the Experience Period and the Effective Date of the Experience Modification Being Established	Hospital Professional Liability Factor
2	.87
3	.82
4	.76
5	.71
6	.67

B. Incurred Losses Subject to Experience Rating are the sum of:

(1) "Incurred Losses" as defined in 2(D)
(2) Policy Experience:
IBNR and Loss Development determined as a function of expected losses. Facility Professional Liability Losses. Premium Subject to Experience Rating as determined in 6(A) above for Facility Professional Liability for each year of the experience period is multiplied by the Expected Loss Ratio to produce expected losses. The appropriate loss development factor from the following table is multiplied times the expected losses to produce the indicated IBNR and loss development:

Number of Months (N) Between the Loss evaluation Date and the effective date of the latest Policy included in the Experience period	Facility Professional Liability Factor				
	Latest Policy Year (N)	2nd Latest Policy Year (N)+12	3rd Latest Policy Year (N)+24	4th Latest Policy Year (N)+36	5th Latest Policy Year (N)+48
18	.62	.37	.20	.09	.04
21	.55	.32	.17	.07	.03
24	.48	.28	.14	.05	.02
27	.42	.24	.12	.05	.01

C. Actual Loss Ratio. The actual loss ratio for the risk shall be determined by dividing the Incurred Losses subject to Experience Rating by the Premium Subject to Experience Rating for Facility Professional Liability.

D. Credibility. The credibility rating for the risk is displayed on Table B, based on the Premium Subject to Experience Rating for Facility Professional Liability.

E. Experience Modification. The experience modification shall be determined by application of the following formula:

$$\text{Credibility} \times \frac{\text{Actual Loss Ratio} - \text{Expected Loss Ratio}}{\text{Expected Loss Ratio}} = \text{Experience Modification}$$

If the experience modification is negative, it is a credit; if positive a debit.

F. Expected Loss Ratio. The Expected Loss Ratio at limits of $1,000,000/$3,000,000 is equal to .763.

Table B
Credibility
Factors

Premium Subject to Experience Rating		Credibility Factor	Premium Subject to Experience Rating		Credibility Factor	Premium Subject to Experience Rating		Credibility Factor
0 -	16,780	0.01	579,488 -	605,529	0.35	2,392l,945 -	2,507,527	0.69
16,781 -	28,235	0.02	605,530 -	632,391	0.36	2,507,528 -	2,629,885	0.70
28,236 -	39,927	0.03	632,392 -	660,113	0.37	2,629,886 -	2,760,837	0.71
39,928 -	51,864	0.04	660,114 -	688,736	0.38	2,760,838 -	2,901,323	0.72
51,865 -	64,054	0.05	688,737 -	718,306	0.39	2,901,324 -	3,052,422	0.73
64,055 -	76,504	0.06	718,307 -	748,870	0.40	3,052,423 -	3,215,385	0.74
76,505 -	89,224	0.07	748,871 -	780,479	0.41	3,215,386 -	3,391,667	0.75
89,225 -	102,222	0.08	780,480 -	813,188	0.42	3,391,668 -	3,582,971	0.76
102,223 -	115,507	0.09	813,189 -	847,055	0.43	3,582,972 -	3,791,304	0.77
115,508 -	129,089	0.10	847,056 -	882,143	0.44	3,791,305 -	4,019,048	0.78
129,090 -	142,978	0.11	882,144 -	918,519	0.45	4,019,049 -	4,269,048	0.79
142,979 -	157,184	0.12	918,520 -	956,254	0.46	4,269,049 -	4,544,737	0.80
157,185 -	171,719	0.13	956,255 -	995,428	0.47	4,544,738 -	4,850,292	0.81
171,720 -	186,594	0.14	995,429 -	1,036,124	0.48	4,850,293 -	5,190,850	0.82
186,595 -	201,821	0.15	1,036,125 -	1,078,431	0.49	5,190,851 -	5,572,794	0.83
201,822 -	217,413	0.16	1,078,432 -	1,122,449	0.50	5,572,795 -	6,004,167	0.84
217,414 -	233,382	0.17	1,122,450 -	1,168,282	0.51	6,004,168 -	6,495,238	0.85
233,383 -	249,744	0.18	1,168,283 -	1,216,046	0.52	6,495,239 -	7,059,341	0.86
249,745 -	266,512	0.19	1,216,047 -	1,265,865	0.53	7,059,342 -	7,714,103	0.87
266,513 -	283,703	0.20	1,264,866 -	1,317,874	0.54	7,714,104 -	8,483,333	0.88
283,704 -	301,331	0.21	1,317,875 -	1,372,222	0.55	8,483,334 -	9,400,000	0.89
301,332 -	319,414	0.22	1,372,223 -	1,429,070	0.56	9,400,001 -	10,511,111	0.90
319,415 -	337,970	0.23	1,429,071 -	1,488,594	0.57	10,511,112 -	11,886,111	0.91
337,971 -	357,018	0.24	1,488,595 -	1,550,987	0.58	11,886,112 -	13,632,143	0.92
357,019 -	376,577	0.25	1,550,988 -	1,616,463	0.59	13,632,144 -	15,923,810	0.93
376,578 -	396,668	0.26	1,616,464 -	1,685,256	0.60	15,923,811 -	19,066,667	0.94
396,669 -	417,314	0.27	1,685,257 -	1,757,625	0.61	19,066,668 -	23,650,000	0.95
417,315 -	438,537	0.28	1,757,626 -	1,833,855	0.62	23,650,001 -	30,983,333	0.96
438,538 -	460,362	0.29	1,833,856 -	1,914,264	0.63	30,983l,334 -	44,733,333	0.97
460,363 -	482,816	0.30	1,914,265 -	1,999,206	0.64	44,733,334 -	61,400,000	0.98
482,817 -	505,925	0.31	1,999,207 -	2,089,076	0.65	61,400,001 -	80,000,000	0.99
505,926 -	529,719	0.32	2,089,077 -	2,184,314	0.66	80,000,001 -	Infinity	1.00
529,720 -	554,229	0.33	2,184,315 -	2,285,417	0.67			
554,230 -	579,487	0.34	2,285,418 -	2,392,944	0.68			

Schedule Rating Plan

A healthcare facility subject to any of the following, shall be assessed a premium surcharge equal to 5% of the annual premium for each offense that occurred within the last five years. The surcharges apply with the understanding that more than one surcharge may be applied for the same occurrence. Surcharges will be added together, and will be subject to a maximum applicable surcharge of 25% of annual premium.

These surcharges may be assessed in addition to, and not in place of, any other action taken by the Association based on information received by the Association with respect to the provider's status or standing.

1) A healthcare facility or nursing home that has operated without medical malpractice insurance.
2) A healthcare facility or nursing home that fails to maintain Commercial General Liability with limits of liability of at least $500,000 each occurrence/$1,500,000 general aggregate or $1,000,000 each occurrence/$3,000,000 general aggregate.
3) A healthcare facility or nursing home whose expiring coverage is with a non-standard, non-admitted carrier for cause.
4) A healthcare facility or nursing home that fails to obtain Extended Reporting Coverage from previous claims-made carriers or to purchase a Prior Acts Policy from the Association, covering all previous claims-made policy terms.
5) A healthcare facility whose type/nature of operation presents an increased risk including but not limited to administering substances that are not FDA approved or engaging in procedures that are considered experimental.
6) A healthcare facility or nursing home whose licenses, certification or ability to participate with Medicare or Medicaid has been revoked, suspended, placed on probation or voluntarily surrendered.
7) A healthcare facility or nursing home that fails to meet current life safety code requirements as published in Fire Code/Uniform Fire Code.
8) A healthcare facility or nursing home that fails to maintain a written patient transfer plan for all contingencies which includes an audit process and is monitored through committee.
9) A healthcare facility that is not accredited by JCAHO, AHCA, or equivalent accreditation or whose accreditation has outstanding contingencies. (For nursing homes, the state inspection is sufficient to meet this requirement).
10) A healthcare facility or nursing home that fails to perform background checks on all staff who have patient or resident contact (employees, leased workers, students, and volunteers) including criminal history (5 years), felonies, misdemeanors, sexual offenses, abuse, theft, assault, credit history, verification of all education, verification of references, US citizenship status/Visa, substance test, federal database, local database
11) A healthcare facility or nursing home whose employed or contracted physicians fail to maintain individual professional liability coverage with limits of liability equal to the limits selected by the facility.
12) A healthcare facility or nursing home that fails to maintain a written continuing education plan which includes risk management topics for nursing, physicians, administration, governing board and department heads.
13) A healthcare facility or nursing home that fails to cooperate with Association Risk Management recommendation and/or attend a sponsored Loss Prevention Seminar.

(14) Nursing Homes - for each Class I or I/II deficiency (whether corrected or not) as indicated on the most recent State Inspection.
(15) Nursing Homes – for each case of repeated class II/III or III deficiencies (whether corrected or not) as indicated on the most recent three State Inspections.
(16) Nursing Homes without a policy to check on residents every day.
(17) Nursing Homes which do not conduct a nursing assessment for every new resident including evaluation of Skin/Decubiti, Mobility Limitations, Urinary Incontinence, History of Prior Injuries, Required Assistance, Orientation/Cognition, Current Medications, Fall Risk, Wandering Tendencies, Nutritional Needs, and Risk of Provoking or Initiating Abusive Behavior.
(18) Nursing Homes that do not have a policy clearly identifying the types of Dementia residents for whom staff is capable of providing care.
(19) Nursing Homes that accept Dementia/Alzheimer's patients that do not include a secured unit(s) for residents prone to wandering.
(20) Nursing Homes that do not perform fall assessments.
(21) Nursing Homes that do not have and enforce a policy regarding smoking in and around the facility.
(22) Nursing Homes that do not perform and document regular rounds of the physical plant and grounds, to ensure they are in a safe and well maintained condition.
(23) Nursing Homes that do not provide education on wound prevention and treatment to their staff.
(24) Nursing Homes that do not have documented policies and procedures on assisting residents with self-medication and administering medication in place.
(25) Nursing Homes that do not have written protocols in place for notification of resident's health care provider in cases of Acute Change of Condition.
(26) Nursing Homes that do not have a written Emergency Evacuation Plan for the facility.

Schedule Rating Plan

The premium charged to a healthcare facility may be further modified by application of a multiplier reflecting a credit as determined under this plan to recognize any of the following factors which are not otherwise adequately considered in the basic rating plan.

	Max. Credit
1. Loss/Claims History	-25%
2. Quality of Professional Service (Medical Staff, Physicians, Nurses)	-25%
3. Facility Management	-10%
4. Environmental Control	-5%
5. Cooperation with Company in Risk Management and Claims Handling	-10%
6. Unusual Risk Factors	-20%

The maximum modifier that may be applied under this plan is -25%.

C. Commercial General Liability Rating Rules

Commercial General Liability premium shall be calculated by applying a 10% factor to the professional liability premium as determined above. Terrorism coverage is included within the 10% charge. Should a provider wish to reject Terrorism coverage, the premium will be reduced by an amount equal to 1% of the General Liability Premium.
Coverage shall be provided based on limits of $500,000 per occurrence, $1,500,000 annual general aggregate, $1,500,000 annual products/completed aggregate; or $1,000,000 per occurrence, and $3,000,000 annual general aggregate, $3,000,000 annual products/completed operations aggregate, and $100,000 limit for premises damage liability. No Medical Payments coverage is available under this program.

Charges will be made for additional exposures located on the same premises as the insured facility as indicated in the following table:

Description	Rating Basis	Rate at	Rate at
		$500,000/$1,500,000	$1,000,000/$3,000,000
Swimming Pools	Each	$647	$730
Saunas/Hot Tubs	Each	$647	$730
Exercise/Weight Rooms	Each	$647	$730
Gymnasiums	Each	$647	$730
Rental Dwellings	Each	$86	$97
Meeting Rooms	Per 1,000 square feet	$104.65	$112.19
Cafeterias serving food to other than residents for a charge	Per $1,000 receipts	$4.69	$5.08

The Association will not provide General Liability coverage at locations other than the insured facility location(s).

APPENDIX A

Policy Forms and Applications
(as of October 31, 2023)

Approved Policy Forms

Physicians, Surgeons, and Dentists Professional Liability Declarations Page #MMM100P1023
Physicians, Surgeons, and Dentists Professional Liability Supplemental Declarations Page #MMM101P0121
Physicians, Surgeons, and Dentists Professional Liability Coverage Form #MMM120PSD1023
Physicians, Surgeons or Dentists – Missouri Limitation Endorsement #MMM125PSD0604
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Exclusion – Military Service or Federal Government Employee #MMM130PSD1004
Locum Tenens Endorsement #MMM135PSD1023
Leave of Absence or Disability Endorsement #MMM140PSD0506
Provider Extended Reporting Period Endorsement #MMM150F1023
Facility Declarations Page #MMM300F1023
Facility Supplemental Declarations Page #MMM301F0121
Facility Professional Liability Coverage Form #MMM320F1023
Facility Extended Reporting Period Endorsement #MMM350F0121
Allied Health Declarations Page #MMM200A1023
Allied Health Supplemental Declarations Page #MMM201A0121
Allied Health Professional Liability Coverage Form #MMM220A1023
Commercial General Liability Coverage Form #MMM400G1023
Commercial General Liability Terrorism Disclosure Form #MMM401G1023
Commercial General Liability Terrorism Notice Form #MMM405G1023
Commercial General Liability – Additional Insured Endorsement #MMM403GL1023
Commercial General Liability – Additional Insured – Lender Endorsement #MMM406GL0707
Commercial General Liability – Missouri Limitation Endorsement #MMM420GL0604
Commercial General Liability – Designated Premises Exclusion #MMM404GL1023
Exclusion of Certified Acts of Terrorism and Other Acts of Terrorism #MMM402GL0904
General Endorsement #MMM600G0904

Approved Applications

Physicians and Surgeons Professional Liability Application #MMM110PS0121
Physicians and Surgeons Professional Liability Renewal Application #MMM110PSRe0121
Dentist Professional Liability Application #MMM130D0820
Dentist Professional Liability Renewal Application #MMM130Dre0121
Facility Professional Liability Application #MMM310F0121
Allied-Health Professional Liability Application #MMM215A0121
Allied-Health Professional Liability Renewal Application #MMM215Are0121
Locum Tenens Application #MMM125L0116

Certificates of Insurance

Facility Certificate of Insurance #MMMJUAFACCT1023
Physicians and Surgeons Professional Liability Certificate of Insurance #MMMJUAPHYSCT