

# **CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION**

For Health Care Professionals  
(Physicians & Surgeons)

**PROTECTING  
PHYSICIANS  
SINCE 1976**

## **Questions?**

**call Bob DeSimone ...**

**(800)464-2986**

**(858)452-2986**

**fax (858)452-2907**

**email [apps@tdia.com](mailto:apps@tdia.com)**

**mail**

**5151 Shoreham Place ste.180  
San Diego, CA, 92122**

## APPLICATION INSTRUCTIONS & CHECKLIST

We have provided the following checklist to assist you in completing your application. Please verify all required information to assist us in processing your application promptly and efficiently. This application for insurance consists of two parts: A and B, plus a Remarks Section, Claims/Incident Supplement Form, Agreements & Notices, Part 1–Proxy, and Part 2–Subscriber Agreement and Power of Attorney.

- Complete Part A once per medical group, and Part B per health care professional.
- All questions must be answered. If you do not know the answer to a particular question, please note that in the Remarks Section.
- If you wish to explain any of your answers, please use the Remarks Section. If you need additional space, please continue your answers on your letterhead and attach it to the application.
- Claims information should be provided for a 10-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current company loss runs.
- Be sure that all documents are signed and dated where indicated.
- Please enclose a copy of the following:
  - a) Your letterhead and advertisements for each physician and ancillary.
  - b) The Declarations page from your current policy, showing your existing policy number and policy period. (Please note: This document is not the same as your Certificate of Insurance.)
  - c) Curriculum vitae (CV) for each physician and ancillary.
  - d) Loss runs from your current professional liability carrier.

**If you need additional forms or have any questions about the application process, please call The Doctors Insurance Agency at (800) 464-2986.**

This is an application for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional service, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or coverage summary, together with any endorsements that may apply, has been issued to the first named insured.

**MEDICAL GROUP DETAILS**

Entity/Medical Group name (or physician name and personal corporation/DBA if solo): \_\_\_\_\_

Requested coverage effective date as at 12:01 A.M. (MM/DD/YYYY): \_\_\_\_\_

Request is to join a physician or group with policy number: \_\_\_\_\_

Complete Part B of this application per health care professional.

**OR**

New request. Complete Part A once per medical group and Part B per health care professional.

**ENTITIES AND PRACTICE TYPES**

**FIRST:** Entity Name (or physician name and personal corporation/DBA if solo): \_\_\_\_\_

National Provider Identifier \_\_\_\_\_ Federal Taxpayer Identification Number \_\_\_\_\_

Sole Proprietorship       Partnership       Individual (Solo) Corporation       Multi-person Corporation

Multi-person Association (please describe): \_\_\_\_\_  Other (please describe): \_\_\_\_\_

Coverage requested for this entity?     Yes     No    If yes:     Separate Limit    or     Shared Limit

Requested Retroactive Date (MM/DD/YYYY) \_\_\_\_\_

**SECOND:** Entity Name (or physician name and personal corporation/DBA if solo): \_\_\_\_\_

National Provider Identifier \_\_\_\_\_ Federal Taxpayer Identification Number \_\_\_\_\_

Sole Proprietorship       Partnership       Individual (Solo) Corporation       Multi-person Corporation

Multi-person Association (please describe): \_\_\_\_\_  Other (please describe): \_\_\_\_\_

Coverage requested for this entity?     Yes     No    If yes:     Separate Limit    or     Shared Limit

Requested Retroactive Date (MM/DD/YYYY) \_\_\_\_\_

**LOCATIONS**

**PRIMARY LOCATION:** Name \_\_\_\_\_

Number and Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

**TYPE OF LOCATION**

Outpatient Office       Urgent Care Center       Freestanding Surgery Center       Nursing Home       Hospital

Skilled Nursing Facility       Independent Laboratory       Correctional Facility       Abortion Clinic

Other (please explain) \_\_\_\_\_

What month/year did professional services begin at this location? (MM/YYYY) \_\_\_\_\_

Is medical professional liability insurance desired for professional services at this location?     Yes     No

If no, what is the name of the insurance carrier for this location? \_\_\_\_\_

## LOCATIONS

**ADDITIONAL LOCATIONS:** Name \_\_\_\_\_

Number and Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

### TYPE OF LOCATION

Outpatient Office       Urgent Care Center       Freestanding Surgery Center       Nursing Home       Hospital

Skilled Nursing Facility       Independent Laboratory       Correctional Facility       Abortion Clinic

Other (please explain) \_\_\_\_\_

What month/year did professional services begin at this location? (MM/YYYY) \_\_\_\_\_

Is medical professional liability insurance desired for professional services at this location?       Yes       No

If no, what is the name of the insurance carrier for this location? \_\_\_\_\_

## BILLING ADDRESS

Number and Street \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## NON-COVERED MEDICAL STAFF

Please list names of all non-covered physician or podiatrist partners who are not applying for coverage with The Doctors Company, stockholders, associates, independent contractors, and employed physicians or podiatrists associated with the entity(ies), and indicate the category that applies to each with the current insurance carrier.

**A. Name** \_\_\_\_\_ Professional Designation:       MD       DO       DPM

Category:       Physician Partner       Stockholder       Associate       Independent Contractor

Insurance Carrier \_\_\_\_\_

Limits:      Per Claim \$ \_\_\_\_\_      Aggregate \$ \_\_\_\_\_

Entities with which the physician is associated: \_\_\_\_\_

Locations at which the physician practices: \_\_\_\_\_ % of practice: \_\_\_\_\_

\_\_\_\_\_ % of practice: \_\_\_\_\_

**B. Name** \_\_\_\_\_ Professional Designation:       MD       DO       DPM

Category:       Physician Partner       Stockholder       Associate       Independent Contractor

Insurance Carrier \_\_\_\_\_

Limits:      Per Claim \$ \_\_\_\_\_      Aggregate \$ \_\_\_\_\_

Entities with which the physician is associated: \_\_\_\_\_

Locations at which the physician practices: \_\_\_\_\_ % of practice: \_\_\_\_\_

\_\_\_\_\_ % of practice: \_\_\_\_\_

## NON-COVERED MEDICAL STAFF

**C. Name** \_\_\_\_\_ Professional Designation:  MD  DO  DPM  
Category:  Physician Partner  Stockholder  Associate  Independent Contractor  
Insurance Carrier \_\_\_\_\_  
Limits: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_  
Entities with which the physician is associated: \_\_\_\_\_  
Locations at which the physician practices: \_\_\_\_\_ % of practice: \_\_\_\_\_  
\_\_\_\_\_ % of practice: \_\_\_\_\_

## NON-COVERED ALLIED PERSONNEL

Please list names of all other allied personnel who are not applying for coverage with The Doctors Company, whether employed or independent contractors associated with the entity(ies), and indicate the category that applies to each with the current insurance carrier.

**A. Name** \_\_\_\_\_  
Professional Designation:  Certified Nurse Midwife  Certified Registered Nurse Anesthetist  
 Nurse Practitioner  Optometrist  Physician Assistant  
Insurance Carrier \_\_\_\_\_  
Limits: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_  
Entity with which the health care professional is associated \_\_\_\_\_  
Locations at which the health care professional practices: \_\_\_\_\_ % of practice: \_\_\_\_\_  
\_\_\_\_\_ % of practice: \_\_\_\_\_

**B. Name** \_\_\_\_\_  
Professional Designation:  Certified Nurse Midwife  Certified Registered Nurse Anesthetist  
 Nurse Practitioner  Optometrist  Physician Assistant  
Insurance Carrier \_\_\_\_\_  
Limits: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_  
Entity with which the health care professional is associated \_\_\_\_\_  
Locations at which the health care professional practices: \_\_\_\_\_ % of practice: \_\_\_\_\_  
\_\_\_\_\_ % of practice: \_\_\_\_\_



**PERSONAL INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_

Social Security Number \_\_\_\_\_ National Provider Identifier \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Gender  Male  Female Professional Designation  MD  DO  DPM

Home Address - Number and Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Category:  Physician Partner  Stockholder  Associate  Independent Contractor

Entities with which the physician is associated: \_\_\_\_\_

Locations at which the physician practices: \_\_\_\_\_ % of practice: \_\_\_\_\_

\_\_\_\_\_ % of practice: \_\_\_\_\_

**REQUESTED COVERAGE**

1. Are you entering private practice for the first time?  Yes  No

2. Current policy expires on (MM/DD/YYYY) \_\_\_\_\_

3. Please indicate limits of liability requested: (Not all limits may be available in all states.)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> \$100,000/\$300,000     | <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$3,000,000/\$3,000,000                 |
| <input type="checkbox"/> \$200,000/\$600,000     | <input type="checkbox"/> \$1,000,000/\$5,000,000 | <input type="checkbox"/> \$3,000,000/\$5,000,000                 |
| <input type="checkbox"/> \$250,000/\$500,000     | <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000                 |
| <input type="checkbox"/> \$250,000/\$750,000     | <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000                 |
| <input type="checkbox"/> \$500,000/\$1,000,000   | <input type="checkbox"/> \$2,000,000/\$5,000,000 | <input type="checkbox"/> Other (limits set by your state, etc.): |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 | Indicate amount: _____   |

4. A. Do you intend to purchase an extended reporting endorsement (tail coverage) from your current carrier?  Yes  No

B. If no, do you wish to purchase retroactive coverage?  Yes  No

C. If you wish to purchase retroactive coverage, please indicate your retroactive date. (MM/DD/YYYY) \_\_\_\_\_

**MEDICAL SPECIALTY**

Please indicate your medical specialty(ies):

A. **Primary Specialty** \_\_\_\_\_ % of practice \_\_\_\_\_

Are you ABMS or AOA board certified?  Yes  No If yes, date of certification or recertification (MM/YYYY) \_\_\_\_\_

If certificate is time limited, date of certificate expiration (MM/YYYY) \_\_\_\_\_

Name of Board \_\_\_\_\_ or  Not board certified

Eligible/qualified for board certification Enter eligibility/qualification expiration date (MM/YYYY) \_\_\_\_\_

Certification expired—please explain: \_\_\_\_\_

## MEDICAL SPECIALTY

Please indicate your medical specialty(ies):

**B. Secondary Specialty** \_\_\_\_\_ % of practice \_\_\_\_\_

Are you ABMS or AOA board certified?  Yes  No If yes, date of certification or recertification (MM/YYYY) \_\_\_\_\_

If certificate is time limited, date of certificate expiration (MM/YYYY) \_\_\_\_\_

Name of Board \_\_\_\_\_ or  Not board certified

Eligible/qualified for board certification Enter eligibility/qualification expiration date (MM/YYYY) \_\_\_\_\_

Certification expired—please explain: \_\_\_\_\_

\_\_\_\_\_

## EDUCATION

Please provide information regarding your medical education.

### MEDICAL SCHOOL:

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_ DEGREE/CERTIFICATION: \_\_\_\_\_

Are you certified by the Education Council for Foreign Medical School Graduates?  Yes  No

### INTERNSHIP:

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_

### RESIDENCY:

Specialty \_\_\_\_\_

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_

Was residency completed?  Yes  No If no, please give details in the Remarks Section.

### RESIDENCY:

Specialty \_\_\_\_\_

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_

Was residency completed?  Yes  No If no, please give details in the Remarks Section.

## EDUCATION

### FELLOWSHIP:

Specialty \_\_\_\_\_

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_

### OTHER TRAINING (if any):

Training Program \_\_\_\_\_

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Start Date (MM/YYYY) \_\_\_\_\_ Finished Date (MM/YYYY) \_\_\_\_\_

## AFFILIATIONS

Are you a member of any national, state, or county medical societies?  Yes  No

If yes, complete the following: National Professional Society: \_\_\_\_\_

State Medical Society: \_\_\_\_\_ County Medical Society: \_\_\_\_\_

Other medical specialty societies to which you belong:

American Academy of Otolaryngology—Head and Neck Surgery

American Association of Neurological Surgeons

American College of Physicians

American College of Surgeons

American Society of Plastic Surgeons®

California Society of Pathologists

Other medical societies: \_\_\_\_\_

Independent Physicians Association (IPA): \_\_\_\_\_

## LICENSES

Please indicate your medical licenses:

A. License State \_\_\_\_\_ Number \_\_\_\_\_

License Status:  Inactive  Restricted  Revoked/Suspended  Active  Temporary

B. License State \_\_\_\_\_ Number \_\_\_\_\_

License Status:  Inactive  Restricted  Revoked/Suspended  Active  Temporary

C. License State \_\_\_\_\_ Number \_\_\_\_\_

License Status:  Inactive  Restricted  Revoked/Suspended  Active  Temporary

## PRACTICE PROFILE

1. Indicate your average number of practice hours per week. (Include office hours, administrative activities, direct patient care, surgery, consultation, etc., with the exception of hours on call.) \_\_\_\_\_
2. A. Estimate number of patients seen in clinical practice on an average weekly basis. \_\_\_\_\_  
B. How many surgical procedures do you perform each week? \_\_\_\_\_
3. Do you have any medical director responsibilities?  Yes  No  
If yes:  
A. Name and location of facility(ies): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
B. Does the facility provide you with coverage for your administrative responsibilities?  Yes  No  
C. Does the facility provide you with coverage for your direct patient care at the facility?  Yes  No
4. Do you perform medical-legal evaluations?  Yes  No  
If yes, for whom? \_\_\_\_\_
5. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary office locations (including but not limited to telemedicine or Internet medicine)?  Yes  No  
A. If yes, indicate all states where you see patients or where the patients being treated reside:  
State \_\_\_\_\_ State \_\_\_\_\_ State \_\_\_\_\_ State \_\_\_\_\_ State \_\_\_\_\_ State \_\_\_\_\_  
If additional states, please list in the Remarks Section.  
B. Are you licensed to practice in each of these states?  Yes  No  
C. What percentage of your total practice does this extra-state activity constitute? \_\_\_\_\_%
6. Are you employed full time or part time by the federal, state, or local government, or are you on active military duty?  Yes  No  
If yes, please explain the nature of your employment and why you desire coverage: \_\_\_\_\_  
\_\_\_\_\_
7. Do you advertise your medical practice?  Yes  No  
If yes, provide copies of advertisements that you are currently using or have placed in periodicals, yellow pages, on flyers, handouts, Internet advertising, etc.  
Web Site Address \_\_\_\_\_ Web Site Address \_\_\_\_\_
8. Are you a teaching physician?  Yes  No  
If yes, list the name and location of school or program: \_\_\_\_\_  
A. Are you responsible for clinical supervision?  Yes  No  
B. What percentage of your weekly time is devoted to clinical teaching? \_\_\_\_\_%  
C. Does the training institution provide malpractice coverage for you?  Yes  No
9. Are you a sports team physician for any college, university, semi-professional, or professional team?  Yes  No  
If yes, please explain: \_\_\_\_\_
10. A. Do you practice as a hospitalist or intensivist?  Yes  No  
B. Do you work in any emergency room?  Yes  No  
If yes, is it required solely to maintain staff privileges?  Yes  No  
C. Do you provide any locum tenens services?  Yes  No  
D. Do you "moonlight" at any other facilities?  Yes  No  
E. Do you provide any services at a hotel, spa, or health club?  Yes  No  
If yes, please explain: \_\_\_\_\_

## PRACTICE PROFILE

11. Do you perform any procedures or practice activities not routinely performed by other physicians practicing in your specialty or subspecialty?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

12. Have there been any changes in your specialty or practice activities (including but not limited to the addition or deletion of procedures, change in number of hours per week you practice, in entity name, and in health care provider staff) within the past five (5) years?  Yes  No

Please note: Former employed health care providers, entity names, and discontinued procedures are not automatically covered under the policy. If coverage is desired, please indicate in your explanation below.

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

13. Do you anticipate any changes in your specialty or practice activities (including but not limited to the addition or deletion of procedures, change in number of hours per week you practice, in entity name, and in health care provider staff) in the next year?  Yes  No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

14. Do you have staff privileges?  Yes  No

If yes, please list all facilities, including non-hospital facilities, where you have staff privileges. List principal location first: If additional facilities need to be listed, please note them in the Remarks Section.

A. Facility Name \_\_\_\_\_ Facility type:  Hospital  Non-hospital  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Department \_\_\_\_\_ % of your practice \_\_\_\_\_

B. Facility Name \_\_\_\_\_ Facility type:  Hospital  Non-hospital  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Department \_\_\_\_\_ % of your practice \_\_\_\_\_

15. Do you practice in any office surgical facility or freestanding surgery center?  Yes  No

If yes, list the facilities and certifications:

**FIRST:** Facility Name \_\_\_\_\_

Certified by (check all that apply):  AAAASF  AAAHC  NCQA  Joint Commission  Medicare  None  
 Do the available services at this facility include an overnight stay?  Yes  No

If yes, please explain: \_\_\_\_\_  
 Is anesthesia administered in this facility?  Yes  No

	YOU	ANESTHESIOLOGIST	CRNA	OTHER
Minimal Sedation (anxiolysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Sedation/Analgesia (conscious sedation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Sedation/Analgesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List the surgical procedures you perform in this facility: \_\_\_\_\_  
 \_\_\_\_\_

## PRACTICE PROFILE

**SECOND:** Facility Name \_\_\_\_\_

Certified by (check all that apply):  AAAASF  AAAHC  NCQA  Joint Commission  Medicare  None  
Do the available services at this facility include an overnight stay?  Yes  No

If yes, please explain: \_\_\_\_\_  
Is anesthesia administered in this facility?  Yes  No

	YOU	ANESTHESIOLOGIST	CRNA	OTHER
Minimal Sedation (anxiolysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Sedation/Analgesia (conscious sedation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Sedation/Analgesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List the surgical procedures you perform in this facility: \_\_\_\_\_  
\_\_\_\_\_

## PRACTICE HISTORY

Please indicate your complete practice history.

I have had no prior practice.

A. Entity Name \_\_\_\_\_  
Number and Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Office Phone \_\_\_\_\_  
Start Date (MM/YYYY) \_\_\_\_\_ End Date (MM/YYYY) \_\_\_\_\_

B. Entity Name \_\_\_\_\_  
Number and Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Office Phone \_\_\_\_\_  
Start Date (MM/YYYY) \_\_\_\_\_ End Date (MM/YYYY) \_\_\_\_\_

C. Entity Name \_\_\_\_\_  
Number and Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Office Phone \_\_\_\_\_  
Start Date (MM/YYYY) \_\_\_\_\_ End Date (MM/YYYY) \_\_\_\_\_

## INSURANCE HISTORY

I have had no prior insurance.

To ensure that there are no gaps in coverage, please list previous medical professional liability insurance carried during the past ten (10) years, beginning with your current carrier. Attach a copy of the Declarations page from your most recent policy.

A.  Claims Made  Occurrence Was extended reporting coverage (tail) purchased?  Yes  No  
Policy Period: From (MM/DD/YYYY) \_\_\_\_\_ To (MM/DD/YYYY) \_\_\_\_\_  
Insurer \_\_\_\_\_  
Limits: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_

## INSURANCE HISTORY

- B.  Claims Made     Occurrence                      Was extended reporting coverage (tail) purchased?     Yes     No
- Policy Period: From (MM/DD/YYYY) \_\_\_\_\_ To (MM/DD/YYYY) \_\_\_\_\_
- Insurer \_\_\_\_\_
- Limits:            Per Claim    \$ \_\_\_\_\_                      Aggregate    \$ \_\_\_\_\_
- C.  Claims Made     Occurrence                      Was extended reporting coverage (tail) purchased?     Yes     No
- Policy Period: From (MM/DD/YYYY) \_\_\_\_\_ To (MM/DD/YYYY) \_\_\_\_\_
- Insurer \_\_\_\_\_
- Limits:            Per Claim    \$ \_\_\_\_\_                      Aggregate    \$ \_\_\_\_\_

## ELIGIBILITY

If you answer yes to any of the following questions, **please give full details in the Remarks Section of the application.** Include dates and copies of related documents.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you ever been evaluated for, recommended for treatment of, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, or any mental illness, including but not limited to depression and/or chronic fatigue? <i>(If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? <i>(If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status.)</i>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? <b>NOTE MISSOURI APPLICANTS DO NOT RESPOND.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever appeared before, been investigated by, entered into any consent agreement with, or do you have an investigation currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental or regulatory agency? <i>(If yes, please provide copies of complaint and disposition documents.)</i>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has any physician, patient, or insurance plan ever filed a complaint against you with any medical association/society or foundation, consumer protection agency, Chamber of Commerce, or Better Business Bureau?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has your participation in any governmental or nongovernmental health program (e.g., Medicare, Medicaid, HMO, PPO, and/or any managed care program) ever been suspended, placed on probation, terminated, or limited in any way?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have your staff privileges at any hospital or health care facility ever been suspended, revoked, voluntarily surrendered, placed on probation, or in any way restricted, or do you have an investigation relative to your staff privileges pending or in progress at any hospital or health care facility?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been refused hospital or health care facility staff privileges?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your membership in any professional society or association ever been refused, censured, suspended, placed on probation, or revoked?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been convicted of, pled guilty to, or entered into a plea agreement for a violation of any law or ordinance (including driving while under the influence of alcohol or any other substance) other than traffic offenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever been accused of sexual misconduct of any kind in your professional capacity?   | <input type="checkbox"/> | <input type="checkbox"/> |

## ELIGIBILITY

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 13. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors, or public health insurance payors, including but not limited to Medicare or Medicaid?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever failed any professional licensing or board certification examinations?<br>If yes, how many times? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you been a party to a malpractice claim, suit, or incident in the past 10 years? An incident is a circumstance involving your professional services that you know or believe, or by diligent inquiry you would have a reasonable basis to know or believe, may give rise to a claim. <i>(If you answer yes, please provide complete details on the Claims/Incident Supplement Form. Complete a separate form for each claim.)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Other than the claims/suits/incidents indicated in question 15 above, are you aware, after reasonable inquiry, of any of the following circumstances in the past 10 years that might reasonably lead to a claim or suit being brought against you even if you believe that claim or suit would be without merit, including:  |                          |                          |
| A. A request for records from a patient and/or attorney related to an adverse outcome?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. A letter from an attorney regarding your medical treatment of a patient?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Patient or family member expressed dissatisfaction with or complained about the outcome of a procedure, treatment, or diagnosis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any other circumstances that might be reasonably expected to lead to a claim or suit?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are there any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have not been reported to your current or prior medical professional liability carrier?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you or any ancillary personnel contracted, either now or in the past, to treat patients or review treatment at correctional facilities?<br>If yes, please explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/>  |                          |                          |
| 19. Do you or any ancillary personnel provide medical services at any long-term care facility, skilled nursing facility, or nursing home? If yes:  | <input type="checkbox"/> | <input type="checkbox"/> |
| A. How many patients do you treat per month, on average? _____   |                          |                          |
| B. Are you or any ancillary personnel under contract to provide medical services at any long-term care facility, skilled nursing facility, or nursing home?  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Do you serve as a medical director of any long-term care facility, skilled nursing facility, or nursing home?   | <input type="checkbox"/> | <input type="checkbox"/> |

## MEDICAL PROCEDURES

**Please check all procedures that you perform:**

**COSMETIC PROCEDURES** *(If not applicable, please skip this section.)*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abdominoplasty  | <input type="checkbox"/> Autologous Fat Injection  | <input type="checkbox"/> Autologous Fat Injection into the Penis or Breast |
| <input type="checkbox"/> Blepharoplasty  | <input type="checkbox"/> Breast Augmentation   | <input type="checkbox"/> Breast Reduction                                  |
| <input type="checkbox"/> Coronal Lift  | <input type="checkbox"/> Endoscopic-Assisted Forehead Lift   | <input type="checkbox"/> Facial Laser Resurfacing                          |
| <input type="checkbox"/> Hair Implant  | <input type="checkbox"/> Implants Other than Breast  | <input type="checkbox"/> "Lifestyle" Lift                                  |
| <input type="checkbox"/> Large Volume Liposuction<br><i>(over 5,000 cc aspirate)</i> | <input type="checkbox"/> Large Volume Liposuction<br><i>(over 5,000 cc aspirate) Performed in a</i>              | <input type="checkbox"/> Liposuction<br><i>(under 5,000 cc aspirate)</i>   |
| <input type="checkbox"/> Penile-Related Cosmetic<br>Procedures                       | <input type="checkbox"/> Large Volume Liposuction<br><i>Freestanding Surgery Center or Office Surgical Suite</i> |  |
| <input type="checkbox"/> Sex Reassignment Surgery                                    | <input type="checkbox"/> Rhinoplasty <i>(cosmetic)</i>   | <input type="checkbox"/> Rhytidectomy                                      |
|  | <input type="checkbox"/> Thread Lift <i>(contour threads)</i>  |  |

## MEDICAL PROCEDURES

### COSMETIC PROCEDURES (continued) *(If not applicable, please skip this section.)*

Please indicate if you or any of your staff perform the following procedures:

	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collagen Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Tattooing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Wrinkle Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Micro-Dermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent Make-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### PRIMARY CARE *(If not applicable, please skip this section.)*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> A & P Repair<br><input type="checkbox"/> Analgesia, IV for Conscious Sedation<br><i>(moderate sedation)</i><br><input type="checkbox"/> Circumcision <i>(pediatric only)</i><br><input type="checkbox"/> Colonoscopy <i>(up to 65 cm)</i><br><input type="checkbox"/> Dilation and Curettage<br><input type="checkbox"/> Endometrial Biopsy<br><input type="checkbox"/> Hemorrhoidectomy <i>(other than ligation)</i><br><input type="checkbox"/> Insertion of IUDs<br><input type="checkbox"/> Nasal Polypectomy<br><input type="checkbox"/> Orchidectomy<br><input type="checkbox"/> Scalene Node Biopsy<br><input type="checkbox"/> Therapeutic Abortion<br><input type="checkbox"/> Vasectomy | <input type="checkbox"/> Adenoidectomy<br><input type="checkbox"/> Anesthesia <i>(spinal)</i><br><input type="checkbox"/> Cesarean Section Delivery<br><input type="checkbox"/> Closed Reductions <i>(other than simple)</i><br><input type="checkbox"/> Cryotherapy and LEEPs<br><input type="checkbox"/> Ectopic Pregnancy<br><input type="checkbox"/> Endoscopic Procedures<br><input type="checkbox"/> Hydrocelectomy<br><input type="checkbox"/> Laparoscopy<br><input type="checkbox"/> Normal Vaginal Delivery<br><input type="checkbox"/> Prenatal and Postnatal Care<br><input type="checkbox"/> Sigmoidoscopy <i>(flexible only to 65 cm)</i><br><input type="checkbox"/> Tonsillectomy<br><input type="checkbox"/> Vein Stripping | <input type="checkbox"/> Anal Fistulectomy<br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Cholecystectomy<br><input type="checkbox"/> Colonoscopy <i>(above 65 cm)</i><br><input type="checkbox"/> Culdocentesis<br><input type="checkbox"/> Elective Cardioversion<br><input type="checkbox"/> Hemorrhoidectomy <i>(ligation only)</i><br><input type="checkbox"/> Hysterectomy <i>(vaginal, abdominal)</i><br><input type="checkbox"/> Myringotomy<br><input type="checkbox"/> Oophorectomy<br><input type="checkbox"/> Salpingectomy<br><input type="checkbox"/> Tendon Repair <i>(nonelective)</i><br><input type="checkbox"/> Tubal Ligation<br><i>(open and laparoscopic)</i> |
|--|--|---|

### CARDIOLOGY *(If not applicable, please skip this section.)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Coronary Angiography | <input type="checkbox"/> Coronary Angioplasty/Stents |
|--|---|--|

### OPHTHALMOLOGY *(If not applicable, please skip this section.)*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Medical Procedures Only   | <input type="checkbox"/> All Surgical Procedures  |   |
| <input type="checkbox"/> Limited Surgical Procedures—limited to minor surgical procedures, including:                              |   |   |
| <ul style="list-style-type: none"> <li>• Assisting in Surgery</li> <li>• Laser Iridotomy</li> <li>• Suture Tarsorrhaphy</li> </ul> | <ul style="list-style-type: none"> <li>• Laser Ablation of Corneal Lesion</li> <li>• Laser Punctal Closure</li> <li>• Thermage</li> </ul> | <ul style="list-style-type: none"> <li>• Laser Capsulotomy</li> <li>• Laser Trabeculoplasty</li> <li>• Wedge Resection for Noncancerous Tumors</li> <li>• Laser Iridoplasty</li> <li>• Marginal Adhesion Tarsorrhaphy without Incision into Tarsus</li> </ul> |

### PHYSICAL MEDICINE & REHABILITATION/PAIN MANAGEMENT *(If not applicable, please skip this section.)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cryoanalgesia                                  | <input type="checkbox"/> Dorsal Column Stimulator Implants/Reprogramming                               |  |
| <input type="checkbox"/> Intra-Articular Block <i>(joint injection)</i> | <input type="checkbox"/> Intradiscal Electrothermal Therapy  | <input type="checkbox"/> Myofascial Trigger Point Injections |
| <input type="checkbox"/> Nerve Root Injections                          | <input type="checkbox"/> Spinal Infusion Pump Refilling and Reprogramming                              | <input type="checkbox"/> Spinal Stimulation Programming      |
| <input type="checkbox"/> Stellate Ganglion Block                        | <input type="checkbox"/> Block <i>(spine and non-spine, with exception of stellate ganglion block)</i> |  |
| <input type="checkbox"/> Epidural or Spinal Catheter                    | <input type="checkbox"/> Radio Frequency Nerve Ablation  | <input type="checkbox"/> Rapid Detoxification                |
| <input type="checkbox"/> Spinal Infusion Implant                        | <input type="checkbox"/> Spinal Stimulation Implant  |  |

**Applicable to General Surgeons only:** Do you perform bariatric surgery?  Yes  No

**Applicable to Pathologists only:** Do you interpret Pap tests, or are you the medical director of a laboratory that interprets Pap tests?  Yes  No  
 If no, when did you cease interpreting Pap tests? (YYYY) \_\_\_\_\_

#### Applicable to Obstetricians, Gynecologists, and Endocrinologists only:

- A. If you are an obstetrician, how many deliveries do you perform per year? \_\_\_\_\_
- B. Do you perform in vitro fertilization (IVF)?  Yes  No

**Applicable to Orthopedic Surgeons only:** Do you treat the spine?  Yes  No



## CLAIMS/INCIDENT SUPPLEMENT FORM

This section should be completed only if you answered yes to question 15 on page B•8. Please photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. All questions must be answered or marked Not Applicable (N/A).

Name of Patient \_\_\_\_\_

Age at time of incident \_\_\_\_\_ Gender:  Male  Female

Your relationship to patient (e.g., attending physician, primary surgeon, assistant surgeon): \_\_\_\_\_

Date of Incident (MM/DD/YYYY) \_\_\_\_\_ Date Reported to Carrier (MM/DD/YYYY) \_\_\_\_\_

Location: \_\_\_\_\_

Insurance Carrier(s): \_\_\_\_\_

Other Defendants: \_\_\_\_\_

Defense Counsel: \_\_\_\_\_

*City State Telephone*

Plaintiff's Counsel: \_\_\_\_\_

*City State Telephone*

Present Status:  Incident Only  Pending Suit  Closed with Settlement  
 Closed with Judgment  Closed with No Indemnity Payment

Please explain status: \_\_\_\_\_

Date Closed (MM/DD/YYYY) \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_

To your knowledge, was any settlement or judgment paid by another party involved (i.e., your P.A., P.C., partners, employees, hospital, etc.)?  Yes  No

If yes, amount of settlement or judgment \$ \_\_\_\_\_

Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_

Applicant's response to allegation(s): \_\_\_\_\_

Conditions and diagnosis at time of treatment: \_\_\_\_\_

Dates and description of treatment rendered: \_\_\_\_\_

Condition of patient subsequent to treatment (include dates and follow-up treatment): \_\_\_\_\_

Were there any issues regarding altering or directing others to alter (whether changing, clarifying, updating, completing, or destroying) any patient or business records pertaining to this claim?  Yes  No

If yes, please explain: \_\_\_\_\_

Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: \_\_\_\_\_

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

**X**  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## AGREEMENTS & NOTICES

**AGREEMENT:** I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information or material misrepresentation will cause immediate rescission of my insurance coverage.

**AGREEMENT:** I understand that no coverage will be bound by the company until such time as I have signed the application—in ink—and returned the original to the company with the required payment.

(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

**AGREEMENT:** I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

**AGREEMENT:** I understand that in connection with this application for insurance, the company may review my credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. The company may use a third party in connection with the development of my insurance score.

**AGREEMENT:** Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

**Notice to Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Notice to District of Columbia Applicants:** **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Notice to Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Notice to Kentucky Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Louisiana Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Maine Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Notice to Missouri Applicants:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application you should not respond.

**Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New Mexico Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Notice to New York Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 (five thousand dollars) and the stated value of the claim for each such violation.

**AGREEMENTS & NOTICES**

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. The absence of such a statement shall not constitute a defense in any prosecution.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance benefits, and civil damages.

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**SIGNATURE REQUIRED:**

**X** \_\_\_\_\_  
Signature Date

**PART 1 – PROXY**

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them, my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving the Exchange written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

**SIGNATURE OPTIONAL:**

**X** \_\_\_\_\_  
Signature Date

Type or Print Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**PART 2 – SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY**

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company, an Interinsurance Exchange (“the Exchange”), and agrees with the Exchange and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company (“the Attorney”) to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by the Exchange’s Board of Governors.

2. Subscriber designates and appoints the Attorney to be its true and lawful agent and Attorney-in-Fact to act in its name, place, and stead and in the name of the Exchange, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of the Exchange and the business of interinsurance. Subscriber adopts and approves the Management Agreement between the Exchange and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of the Exchange authority to negotiate all the terms and conditions of the Management Agreement between the Exchange and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or Exchange.

4. Subscriber further delegates to the Board of Governors of the Exchange all necessary and proper powers to conduct, manage, and control the affairs and business of the Exchange, subject to those retained by law or through the Rules and Regulations of the Exchange, or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of a claims-made insurance policy issued by the Exchange and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of the Exchange.

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to “Attorney” shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of the Exchange and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word “Subscriber” is used, it refers to all members of the Exchange, including the Subscriber who has signed this document.

**SIGNATURE REQUIRED:**

**X**  
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Executed this day of

Type or Print Name \_\_\_\_\_