THE DOCTORS COMPANY

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

For Group Members

AGENT INFORMATION

Agent name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Website: _____

J111568 7/17

185 Greenwood Road Napa, CA 94558 (800) 421-2368 Fax: (707) 226-0107 E-mail: sales@thedoctors.com thedoctors.com

APPLICATION INSTRUCTIONS AND CHECKLIST

Application Instructions and Checklist

Prior to completing the attached application, please read and observe the following instructions. Please verify that all required attachments are included in order to assist us in processing your application promptly and efficiently.

- Please complete this form electronically or print your responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply to you, please write "N/A."
- The Medical Procedures questionnaire must be completed. If the procedures you perform are not mentioned in the questionnaire, please list them 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 six-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.

If you need additional forms or have any questions about the application, please contact your broker/agent, or call The Doctors Company Member Services at (800) 421-2368. To complete an electronic version of this application, please visit www.thedoctors.com/groupmembers-apply.

Required Attachments

Please include a current copy of the following documents with the application:

- ☐ Curriculum Vitae (CV).
- ☐ Declarations Page from your current policy, showing your policy period, limits of liability, retroactive date, and any exclusions that were applied to your policy.
- ☐ Loss runs from all insurance carriers that insured you for the past six years (if applicable).
- ☐ Certificates of training for cosmetic procedures (if applicable).
- ☐ Practice Protocols.

Except to the extent as may otherwise be provided in the policy and its endorsements, the coverage of a claims-made policy is limited generally to liability for only those claims that are first reported in writing 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.

SIGNATURE REQUIREMENT

I authorize the following person to be added to our group policy with The Doctors Company.

SIGNATURE REQUIRED:

X _____ _____

Authorized Officer's Signature | Date

Desired effective date: _____ _____ _____

Month | Day | Year

GENERAL INFORMATION

1. First name: _____ Middle name: _____ Last name: _____ Suffix: _____ Title: _____
2. Date of birth *(MM/DD/YYYY)*: _____ 3. Social Security number: _____ 4. Gender: ☐ Male ☐ Female
5. E-mail address(es): _____
6. National Provider ID no. *(if available)*: _____
7. Policy number of physician or group insured with The Doctors Company: _____
8. Physician or group name: _____
9. Practice address: Please list all office locations and entities for which you are requesting coverage. Please indicate if they are: hospital, medical office, surgery center, nursing home, urgent care center, correctional facility, etc.

   _____

   _____
10. Office phone number: _____ Fax number: _____
11. Home address and telephone number: _____
12. Requested effective date *(coverage start date)*: _____ Requested retroactive date *(prior acts date)*: _____
13. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier?

    ☐ Yes ☐ No *If yes, please provide proof of tail coverage. If no, please explain in the Remarks section.*

PRACTICE INFORMATION

14. List all current clinic practice locations in this section. Include all locations whether or not The Doctors Company insurance is desired at that location. If additional space is required to show more than three practice locations, please photocopy this page.

    Facility Codes: Please indicate all that apply at each location.

    01: Outpatient Office that you own, rent, or lease
    02: Outpatient Office, other (please identify)
    03: Nursing Home
    04: Correctional Facility
    05: Surgery Center
    06: Abortion Clinic
    07: Urgent Care Center
    08: Emergi-Center
    09: Commercial Laboratory
    10: Other (please identify)

    A. Name of location: _____

    Facility code: _____ % of practice: _____

    Street: _____ Bldg./Suite: _____

    City: _____ State: _____ Zip: _____

    County: _____

    Phone: _____ Extension: _____ Fax: _____

    Is The Doctors Company insurance desired for this practice location? ☐ Yes ☐ No

    If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

    _____

B. Name of location: _____

Facility code: _____ % of practice: _____

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Extension: _____ Fax: _____

Is The Doctors Company insurance desired for this practice location? ☐ Yes ☐ No

If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

_____

C. Name of location: _____

Facility code: _____ % of practice: _____

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Extension: _____ Fax: _____

Is The Doctors Company insurance desired for this practice location? ☐ Yes ☐ No

If no, what is the name of your insurance carrier? (If self-insured, please indicate.)

_____

EDUCATION

15. Medical School:

Name: _____

City: _____ State: _____ Country: _____

Degree: _____ Dates *(MM/DD/YYYY)*: _____ *(MM/DD/YYYY)*: _____

16. Additional education: *If you have completed more than two residencies, one fellowship, or other training program, please provide details, including gaps or splits in training, in the Remarks section.*

A. Internship:

Hospital: _____ City: _____ State: _____

Date: From _____ to _____

B. Residency:

Hospital: _____ City: _____ State: _____

Date: From _____ to _____ Type: _____

C. Residency:

Hospital: _____ City: _____ State: _____

Date: From _____ to _____ Type: _____

D. Residency:

Hospital: _____ City: _____ State: _____

Date: From _____ to _____ Type: _____

E. Other Training:

Location: _____ City: _____ State: _____

Date: From _____ to _____ Type: _____

F. Have you participated in any continuing medical education within the last three years?

☐ Yes ☐ No

If yes, how many credit hours? _____

17. If you are a graduate of a non-U.S. medical school, are you certified by the Educational Council for Foreign Medical School Graduates? ☐ Yes ☐ No

SPECIALITY

18. Primary specialty: _____

Percent of practice: _____ Are you board certified? ☐ Yes ☐ No *If yes, date:* _____

Name of board: _____

If not board certified, what is the expiration date of eligibility? _____

If expired, why? _____

19. Secondary specialty: _____

Percent of practice: _____ Are you board certified? ☐ Yes ☐ No *If yes, date:* _____

Name of board: _____

If not board certified, what is the expiration date of eligibility? _____

If expired, why? _____

LICENSES AND AFFILIATIONS

20. Licenses: Specify states where you are or have been licensed:

State: _____ Year: _____ License #: _____ ☐ Permanent ☐ Temporary Status*: _____

State: _____ Year: _____ License #: _____ ☐ Permanent ☐ Temporary Status*: _____

State: _____ Year: _____ License #: _____ ☐ Permanent ☐ Temporary Status*: _____

State: _____ Year: _____ License #: _____ ☐ Permanent ☐ Temporary Status*: _____

**If any of your licenses are or have been inactive, suspended, restricted, or revoked, please explain in the Remarks section.*

21. Affiliations/Associations/Society membership:

A. Are you a member of any national (not specialty) medical societies? ☐ Yes ☐ No

If yes, list: _____

B. Are you a member of any national podiatric medical specialty societies? ☐ Yes ☐ No

If yes, list: _____

C. Are you a member of any state medical society? ☐ Yes ☐ No

D. Are you a member of any county medical society? ☐ Yes ☐ No

PRACTICE HISTORY

22. Are you entering practice for the first time since completing an internship, residency program, preceptorship, or military service?

☐ Yes ☐ No

23. Indicate your number of practice hours per week. Include office hours, administrative activities, direct patient care, surgery, hours on call, hospital rounds, consultation, etc. Please indicate only the practice hours to be insured by The Doctors Company.

_____

24. Estimate the number of patients you see on an average day of clinical practice: _____

25. A. Indicate number of weeks per year you practice (include office hours, administrative activities, direct patient care, surgery, consultation, etc.): _____

B. If less than 26 weeks, are the weeks all consecutive? ☐ Yes ☐ No

C. Maximum number of consecutive weeks out of practice: _____

26. Do you plan to practice outside the scope of your current group's practice? ☐ Yes ☐ No
If yes, please explain and specify if coverage is desired for this practice:

_____

_____

_____

_____

PRIOR PRACTICE LOCATIONS

27. Where have you practiced your profession for the past six years other than your current practice locations?

Please explain any gaps in your practice. *Use Remarks section, to list additional locations.*

Entity Name: _____

Address: _____ City: _____ State: _____ From: _____ to: _____
MM/YY *MM/YY*

Entity Name: _____

Address: _____ City: _____ State: _____ From: _____ to: _____
MM/YY *MM/YY*

Entity Name: _____

Address: _____ City: _____ State: _____ From: _____ to: _____
MM/YY *MM/YY*

Entity Name: _____

Address: _____ City: _____ State: _____ From: _____ to: _____
MM/YY *MM/YY*

Entity Name: _____

Address: _____ City: _____ State: _____ From: _____ to: _____
MM/YY *MM/YY*

TEACHING

28. A. Are you a teaching physician? ☐ Yes ☐ No

If yes, list name and location of school or program: _____

B. Are you responsible for supervision of residents, interns, or fellows? ☐ Yes ☐ No

C. What is your compensation status? ☐ Volunteer *(non-paid)* ☐ Partial Salary ☐ Full Salary ☐ Other

Describe: _____

Your title: _____

D. What percentage of your weekly time is devoted to clinical teaching? _____

E. Does the training institution provide malpractice coverage for you? ☐ Yes ☐ No *If no, explain in Remarks section.*

STAFF PRIVILEGES

29. Are you performing medical director responsibilities or have you contracted to provide patient care at a skilled nursing facility? ☐ Yes ☐ No

If yes, list all facilities, including nonhospital facilities, where you have staff privileges. List principal location first. Use the Remarks section to list additional facilities. Please list the name of the facilities.

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

CHANGES IN PRACTICE

30. Have your practice specialties/procedures, etc., changed in the past six years? ☐ Yes ☐ No

If yes, please explain how the specialty/procedures, etc., have changed and give the dates of changes.

_____

_____

_____

PROCEDURES

31. A. Will you be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, please provide proof of coverage, including name and address of entity.

B. If you are not an anesthesiologist, do you perform:

Intravenous Analgesia?	☐ Yes	☐ No	Spinal?	☐ Yes	☐ No
Anesthesia – General?	☐ Yes	☐ No	Intravenous?	☐ Yes	☐ No

32. Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered? ☐ Yes ☐ No

If yes, list facility.

_____

33. Do you perform elective cosmetic surgery? ☐ Yes ☐ No
If yes, do you perform the following?

Blepharoplasty? ☐ Yes ☐ No

Cosmetic Surgery of the Breast? ☐ Yes ☐ No

Chemical Peel? ☐ Yes ☐ No

If yes, what type? _____

Dermabrasion/Chemabrasion? ☐ Yes ☐ No

Suction-assisted Lipectomy? ☐ Yes ☐ No

If yes, please provide proof of training, copy of consent form, and proof of hospital privileges for this procedure.

34. Do you practice neonatology (treatment of critically ill or premature neonates)? ☐ Yes ☐ No

If yes, percent of practice: _____

35. Do you practice obstetrics? (obstetrics include prenatal care) ☐ Yes ☐ No

Do you perform deliveries other than in a hospital? ☐ Yes ☐ No

If yes, specify facility: _____

Do you perform obstetrical home deliveries? ☐ Yes ☐ No

36. Do you perform abortions? ☐ Yes ☐ No
If yes,

First Trimester? ☐ Yes ☐ No

Second Trimester? ☐ Yes ☐ No

Third Trimester? ☐ Yes ☐ No

List facilities where you perform abortions: _____

Do you receive referrals? ☐ Yes ☐ No

If yes, from whom? _____

Number of abortions per month: _____

37. If you are a pathologist, do you routinely perform frozen sections and gross surgical pathology examinations and then send material to an unrelated group of pathologists for microscopic examination and final signout?

☐ Yes ☐ No

38. Do you perform radial keratotomy? ☐ Yes ☐ No

Sex-reassignment Surgery? ☐ Yes ☐ No

Weight-control Surgery? ☐ Yes ☐ No

39. If you are a cardiologist, do you perform invasive procedures? ☐ Yes ☐ No
If yes, specify the procedure(s):

_____

_____

40. If you are a dermatologist, do you make your own histopathologic diagnoses of pigmented lesions? ☐ Yes ☐ No

41. Do you staff an Emergency Room for purposes other than to maintain hospital privileges? ☐ Yes ☐ No
If yes, please describe location, hours worked, relationship, etc.

_____

42. Do you treat or review treatment of prison inmates? ☐ Yes ☐ No
If yes, please explain in the Remarks section.

MISCELLANEOUS

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

43. Do you treat or consult on patients in any sovereign nation or territory, other than the United States, such as Native American or Alaskan Native lands?

    ☐ Yes ☐ No *If yes, list the location:* _____ *and % of practice:* _____

44. Are you now being—or have you ever been—treated for alcoholism, narcotics addiction, or mental illness?

    ☐ Yes ☐ No

    (If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

45. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?

    ☐ Yes ☐ No

    (If yes, please accompany this application with a letter outlining dates of treatment, results of treatment, and current status. This letter should be from your treating physician or institution.)

46. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible and/or surcharge assessed against you? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**

    ☐ Yes ☐ No

47. Have you ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency, or have either your license to practice or your narcotics license ever been denied, revoked, suspended, or limited in any way?

    ☐ Yes ☐ No *If yes, please provide copies of complaint and disposition documents.*

48. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause other than incomplete charts?

    ☐ Yes ☐ No

49. Have you ever been indicted and/or convicted of a crime other than minor traffic violations?

    ☐ Yes ☐ No

50. Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)?

    ☐ Yes ☐ No

51. Have you been involved in a malpractice claim, suit, or incident in the past six years?

    ☐ Yes ☐ No

    If yes, please complete the attached Claim Information form for each claim/incident.

52. Does the facility use an Electronic Health Record?

    ☐ Yes ☐ No *If yes, please provide the name of the facility's EHR provider:* _____

PREVIOUS INSURANCE

53. To assure that there are no gaps in coverage, please list all previous medical professional liability insurance carried during the past six years, beginning with your current carrier. Use the Remarks section below to list additional carriers.

Attach a copy of the Declarations Page from your most recent policy.

A. Current carrier: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

Limits of liability: _____ Type of policy: _____
Occurrence or Claims-made

B. First prior carrier: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

Limits of liability: _____ Type of policy: _____
Occurrence or Claims-made

C. Second prior carrier: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

Limits of liability: _____ Type of policy: _____
Occurrence or Claims-made

D. Third prior carrier: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

Limits of liability: _____ Type of policy: _____
Occurrence or Claims-made

Have you ever had The Doctors Company coverage in the past?

☐ Yes ☐ No *If yes, what was your policy number?* _____

54. Desired effective date: _____ (Please allow two to three weeks for processing.)
MM/DD/YYYY

55. Current policy expires: _____
MM/DD/YYYY

NOTICE REGARDING RETROACTIVE COVERAGE

If your current policy or any previous policies are claims-made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage) from that carrier, there will be no coverage for any claim from any act or omission that took place during that period of claims-made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures you for claims made against you for incidents that took place while your previous claims-made insurance was in effect, but that were not brought to your attention until after the effective date of The Doctors Company's policy.

Retroactive coverage does not cover claims that have been filed against you and/or reported to the previous insurers prior to the effective date of the policy with The Doctors Company. Any claims and all conduct, circumstances, or incidents that could reasonably be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

I have read and understand the above statement.

SIGNATURE REQUIRED:

X _____ _____

Authorized Officer's Signature | Date

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 from The Doctors Company?* ☐ Yes ☐ No

C. Desired retroactive date: _____ (You must attach a copy of the most recent Declarations Page from your present carrier indicating the original effective date of coverage and the current paid-through date.)

D. Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurer(s)? ☐ Yes ☐ No

E. After reasonable inquiry, are you, as of this date, aware of any conduct, circumstances, or incidents that occurred during the period of coverage listed in the Previous Insurance section that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? ☐ Yes ☐ No

I hereby acknowledge that I have completed the required reporting of claims and incidents to the group's current carrier.

SIGNATURE REQUIRED:

X _____ _____

Authorized Officer's Signature | Date

_____

Print Name and Title

REMARKS SECTION

CLAIM INFORMATION

Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Name of patient: _____

2. Age: _____ 3. Gender: ☐ Male ☐ Female

4. Relationship to patient (e.g., attending physician, consultant, primary surgeon, assistant surgeon):

_____

5. Allegation: _____

6. Date of incident *(MM/DD/YYYY)*: _____ 7. Location: _____

8. Insurance carrier(s): _____

9. Other defendants: _____

10. Present status: ☐ Open claim Indemnity and expenses reserved: _____
☐ Closed claim Loss of: $ _____ Expenses paid: $ _____
Date closed: _____ ☐ Settlement ☐ Judgment

11. Conditions and diagnosis at time of incident:

_____

_____

_____

_____

_____

12. Dates and description of professional services rendered:

_____

_____

_____

_____

_____

13. Condition of patient subsequent to professional services (and dates of follow-up visits, if known):

_____

_____

_____

_____

_____

AGREEMENTS

AGREEMENT: I do hereby affirm the truth of all statements and answers, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for insurance. I have also made a reasonable inquiry, where appropriate, to ensure the responses herein are as complete and accurate as possible. I understand that any erroneous information or material misrepresentation may 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 and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested 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: 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.

AGREEMENT: I agree that this application shall be deemed appended to and a part of, any policy of insurance issued to me based on this application.

AGREEMENT: I further agree that my signature of this application shall be deemed to be a concurrent execution of the attached Subscriber Agreement and Power of Attorney.

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature | Date

NOTICES

INSURANCE FRAUD WARNING

ALABAMA
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 restitution fines or confinement in prison, or any combination thereof.

ARKANSAS
Any person who knowingly presents a false or fraudulent claim for payment for 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.

COLORADO
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.

DISTRICT OF COLUMBIA
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.

FLORIDA
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.

IDAHO
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS
Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

KENTUCKY
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.

LOUISIANA
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.

NOTICES (CONTINUED)

MAINE
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.

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

MINNESOTA
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

MISSOURI
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.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO
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 subject to civil fines and criminal penalties.

NEW YORK
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 five thousand dollars and the stated value of the claim for each such violation.

OHIO
Any person who, with intent to defraud or knowing that he 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.

OKLAHOMA
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.

OREGON
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA
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.

RHODE ISLAND
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.

TENNESSEE
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.

VIRGINIA
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 and civil damages.

WASHINGTON
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.

WEST VIRGINIA
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.

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 and agrees with The Doctors Company 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 Doctors Company Board of Governors.

2. Subscriber designates and appoints the Attorney to be his or her true and lawful agent and Attorney-in-Fact to act in his or her name, place, and stead and in the name of The Doctors Company , 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 Doctors Company and the business of interinsurance. Subscriber adopts and approves the Management Agreement between The Doctors Company 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 Doctors Company authority to negotiate all the terms and conditions of the Management Agreement between The Doctors Company 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 The Doctors Company .

4. Subscriber further delegates to the Board of Governors of The Doctors Company all necessary and proper powers to conduct, manage, and control the affairs and business of The Doctors Company , subject to those retained by law or through the Rules and Regulations of The Doctors Company , 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 the liability insurance policy issued by The Doctors Company 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 Doctors Company .

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 Doctors Company 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, and signature of the Application to which this Agreement is attached shall constitute signature of this Agreement. This Agreement shall continue in full force and effect until revoked by the written request of Subscriber who has signed this document. 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 Doctors Company , including the Subscriber who has signed this document.

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.

This proxy is solicited on behalf of the management of The Doctors Company 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 Doctors Company 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: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into by and between The Doctors Company, including all of its subsidiaries, hereinafter referred to as "we," and "you" in conjunction with the policy of insurance we have entered into with you. This agreement supersedes and replaces any prior Business Associate Agreement ("BAA").

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

This document sets forth the terms, conditions, and obligations pursuant to which Protected Health Information that is provided, created, or received by us from you or on your behalf, will be handled.

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, we may make any uses of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

B. Our Obligations and Activities.

We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

C. In addition to using the Protected Health Information to perform the services set forth above, we may:

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45 C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

D. With regard to our use and/or disclosure of Protected Health Information, we agree to do the following:

(1) Use and/or disclose the Protected Health Information only as permitted or required by this Agreement or as otherwise required by law and then only to the minimum necessary extent to accomplish the intended purpose of the use;

(2) Report to your designated Privacy Officer, in writing, any use and/or disclosure of the Protected Health Information that is not permitted or required by this Agreement of which we become aware as soon as practical and within ten (10) business days of our discovery of such unauthorized use and/or disclosure. Where practical and possible, we will take steps to mitigate the harmful effect of any unpermitted disclosure of PHI;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and take appropriate physical, administrative, and technical safeguards to prevent unauthorized use and/or disclosure of such Protected Health Information;

(4) Require all of our subcontractors and agents that undertake to perform the services that we perform under this Agreement and that receive, use, or have access to Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to us pursuant to this Agreement;

(5) Unless prohibited by attorney-client and other applicable legal privileges or unless it would violate our contractual and other legal obligation to you, make available all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of the United States Department of Health and Human Services for purposes of determining your compliance with the Privacy Regulations;

(6) Upon prior written request, make available during normal business hours at our offices all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to you within five (5) business days for purposes of enabling you to determine our compliance under the terms of this Agreement;

(7) We shall honor any request from you for information to assist in responding to an individual's request for an accounting of disclosures of Protected Health Information to us. However, should you be asked for an accounting of the disclosures of an individual's Protected Health Information in accordance with 45 C.F.R. Section 164.528, such accounting should not include any disclosures to us which are to carry out your healthcare operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Upon termination of this Policy, the protections of this Agreement will remain in force and we shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law;

(9) In those instances when you would be required to honor an individual's request for access and/or amendment of Protected Health Information disclosed to us, we will assist you to comply with your duties under 45 C.F.R. Sections 154.524 and 164.526. However, usually you will not be required to honor such requests because Protected Health Information in our possession is not part of a designated record set as that term is defined by 45 C.F.R. 164.501; and/or because the information is exempt from access and amendment under 45 C.F.R. Sections 164.524(a) and 164.526(a)(2); and/or because access would violate your superseding contractual and other legal rights; and/or because any amendment could be tampering with evidence in a civil or administrative matter;

(10) You may terminate this Agreement by canceling this Policy if we violate a material term of this Agreement;

(11) You agree that we may modify this Agreement as required to comply with applicable laws or regulations.

In witness whereof, The Doctors Company has caused this Agreement to be signed by its Chairman at its Home Office.

Richard E. Anderson, MD
Chairman of the Board of Governors