THE DOCTORS COMPANY

PROTECTING PHYSICIANS SINCE 1976

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Medical Group Practices

NOTICE

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 the medical group's professional services or the use of the medical group's professional office premises, and B) are first made against the group and are reported to the company while the policy is in force.

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

INSTRUCTIONS

Please print responses in ink, and answer all questions in full. If a question does not apply to your group practice, state "none" or "NA" (Not Applicable). Please include a copy of the group's letterhead and all of the group's advertisements with this application. Please indicate any additional responses in the Remarks Section on page 18.

This application consists of A) an application for insurance, including a Remarks Section page and Claim Information Form, B) a Proxy form, and C) a Subscriber Agreement and Power of Attorney. The completed application, together with any supplementary information, must be signed in ink and dated by an authorized officer of the medical group in all spaces indicated. **Failure to provide complete information will delay the processing of the application.**

GENERAL INFORMATION

1. Group Name

Primary Practice Telephone ( ) - Fax ( ) -

E-mail Address

Web Site Address

A. Primary Practice Location

Street Bldg./Suite

City State Zip -

County Owned Leased Sq. Ft. # of Floors

Date Acquired

B. Billing Address (if other than primary practice location)

Street Bldg./Suite

City State Zip -

County

C. Tax I.D. Number

D. Authorized representative for insurance matters:

Name Title

Phone ( ) - Extension

2. Legal Entities

Entity Name

Description

Entity Type (e.g., corporation, partnership, joint venture)

Insurance Requested ☐ Yes ☐ No

Retroactive Date

Mo./Day/Yr.

If there is more than one entity name, please give a name and a description in Remarks Section on page 18.

LOCATIONS

3. Practice Addresses

List all current office or clinic practice locations in this section. Include all locations whether or not The Doctors Company (TDC) 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
02: Nursing Home
03: Correctional Facility
04: Surgery Center
05: Abortion Clinic
06: Urgent Care Center
07: Emergi-Center
08: Commercial Laboratory
09: Other (please identify)

A. Name of Location

Facility Code　　% of Practice

Street　　Ste.

City　　State　　Zip　　-

County

Phone (　　)　　-　　Fax (　　)　　-

Do you own ☐, rent ☐, or lease ☐ this location? If other, please explain on page 18.

Is TDC 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　　Ste.

City　　State　　Zip　　-

County

Phone (　　)　　-　　Fax (　　)　　-

Do you own ☐, rent ☐, or lease ☐ this location? If other, please explain on page 18.

Is TDC 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   Ste.

City   State   Zip -

County

Phone (   ) -   Fax (   ) -

Do you own, rent, or lease this location? If other, please explain on page 18.

Is TDC insurance desired for this practice location? Yes No

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

D. Does group own property that is leased to other entities? Yes No

E. Within the next 12-month period, does the group plan to:

Obtain another group or entity? Yes No

Add to the number of physicians? Yes No

Add to the number of locations? Yes No

If answer is yes to any question above, please describe in Remarks Section, on page 18.

4. Administration

A. Name of Chief Executive Officer

B. Name of Medical Director

C. Name of Administrator/Risk Manager

STAFF

5. Physicians

Please indicate the number of:

A. Current Year

Full-time Physicians	Part-time Physicians	Total

B. First Prior Year

Full-time Physicians	Part-time Physicians	Total

C. Second Prior Year

Full-time Physicians	Part-time Physicians	Total

D. Third Prior Year

Full-time Physicians	Part-time Physicians	Total

E. Fourth Prior Year

Full-time Physicians	Part-time Physicians	Total

F. Fifth Prior Year

Full-time Physicians	Part-time Physicians	Total

G. Please explain any year-to-year change that occurred in excess of 10 percent.

____

____

____

H. Number of Independent Contractors ☐

I. Do you require your independent contractors to maintain professional liability insurance from a carrier rated A(-) or better by A.M. Best?

☐ Yes ☐ No

J. Do you obtain Certificates of Insurance from your independent contractors?

☐ Yes ☐ No

K. Please attach a copy of Declarations Page(s) from your most recent malpractice insurance policy or a typed list to give us the following information. (If you cannot provide a copy of your Declarations Page or a typed list, please complete the following form.)

Please identify all physicians and/or Ancillary personnel that will be insured under the group's professional liability insurance program:

	Name	Specialty	Date of Birth	Board Certified	Medical License No./State	# Hrs/week	Retroactive Date
1				☐ Yes ☐ No			
2				☐ Yes ☐ No			
3				☐ Yes ☐ No			
4				☐ Yes ☐ No			
5				☐ Yes ☐ No			
6				☐ Yes ☐ No			
7				☐ Yes ☐ No			
8				☐ Yes ☐ No			
9				☐ Yes ☐ No			
10				☐ Yes ☐ No			
11				☐ Yes ☐ No			
12				☐ Yes ☐ No			
13				☐ Yes ☐ No			
14				☐ Yes ☐ No			
15				☐ Yes ☐ No			
16				☐ Yes ☐ No			
17				☐ Yes ☐ No			
18				☐ Yes ☐ No			
19				☐ Yes ☐ No			
20				☐ Yes ☐ No			
21				☐ Yes ☐ No			
22				☐ Yes ☐ No			
23				☐ Yes ☐ No			
24				☐ Yes ☐ No			
25				☐ Yes ☐ No			
26				☐ Yes ☐ No			
27				☐ Yes ☐ No			
28				☐ Yes ☐ No			
29				☐ Yes ☐ No			
30				☐ Yes ☐ No			
31				☐ Yes ☐ No			
32				☐ Yes ☐ No			
33				☐ Yes ☐ No			
34				☐ Yes ☐ No			

	Name	Specialty	Date of Birth	Board Certified	Medical License No./State	# Hrs/week	Retroactive Date
35				☐ Yes ☐ No			
36				☐ Yes ☐ No			
37				☐ Yes ☐ No			
38				☐ Yes ☐ No			
39				☐ Yes ☐ No			
40				☐ Yes ☐ No			
41				☐ Yes ☐ No			
42				☐ Yes ☐ No			
43				☐ Yes ☐ No			
44				☐ Yes ☐ No			
45				☐ Yes ☐ No			
46				☐ Yes ☐ No			
47				☐ Yes ☐ No			
48				☐ Yes ☐ No			
49				☐ Yes ☐ No			
50				☐ Yes ☐ No			
51				☐ Yes ☐ No			
52				☐ Yes ☐ No			
53				☐ Yes ☐ No			
54				☐ Yes ☐ No			
55				☐ Yes ☐ No			
56				☐ Yes ☐ No			
57				☐ Yes ☐ No			
58				☐ Yes ☐ No			
59				☐ Yes ☐ No			
60				☐ Yes ☐ No			
61				☐ Yes ☐ No			
62				☐ Yes ☐ No			
63				☐ Yes ☐ No			
64				☐ Yes ☐ No			
65				☐ Yes ☐ No			
66				☐ Yes ☐ No			
67				☐ Yes ☐ No			
68				☐ Yes ☐ No			

	Name	Specialty	Date of Birth	Board Certified	Medical License No./State	# Hrs/week	Retroactive Date
69				Yes No			
70				Yes No			
71				Yes No			
72				Yes No			
73				Yes No			
74				Yes No			
75				Yes No			
76				Yes No			
77				Yes No			
78				Yes No			
79				Yes No			
80				Yes No			
81				Yes No			
82				Yes No			
83				Yes No			
84				Yes No			
85				Yes No			
86				Yes No			
87				Yes No			
88				Yes No			
89				Yes No			
90				Yes No			
91				Yes No			
92				Yes No			
93				Yes No			
94				Yes No			
95				Yes No			
96				Yes No			
97				Yes No			
98				Yes No			
99				Yes No			
100				Yes No			
101				Yes No			
102				Yes No			

SUPPORT STAFF

6. Employees and Contractors
   Please enter the total number of full-time and full-time equivalent employees/contractors by classification.
   Note: Liability coverage for the acts or omissions of any person within the scope of their duties as an employee of the entity is included under this insurance.

   If any employees (shown in Section A) are to be provided separate individual limits for their own acts of a professional nature, indicate yes or no. An additional charge will be applied. A supplemental application must be completed for each person in Section A.

A. Classifications	Number Employed	Number Contracted	Individual Coverage
Midwife			☐ Yes ☐ No
Nurse Anesthetist			☐ Yes ☐ No
Nurse Practitioner			☐ Yes ☐ No
Optometrist			☐ Yes ☐ No
Physician Assistant**			☐ Yes ☐ No
Total Personnel			

B. Classifications (continued)	Number Employed	Number Contracted
Audiologist		
Laboratory Technician		
Nurse (R.N., L.P.N., or L.V.N.)		
Operating Room Technician (Surgical)		
Operating Room Technician (Nonsurgical)		
Paramedic		
Perfusionist		
Psychologist		
Pulmonary Therapist		
Registered Pharmacist		
Scrub Nurse		
Surgeon Assistant**		
X-ray Technician (without therapy)		
X-ray Technician (with therapy)		
Other Miscellaneous Medical Personnel (Please specify and attach list)		
Total Personnel		

** This classification applies to physician or surgeon assistants who have completed an approved course of study leading to university certification, national certification if required by the state, and who perform their duties under the direct supervision of a licensed physician or surgeon, assisting in the clinical and/or research endeavors of the physician or surgeon.

7. Are all physicians, surgeons, dentists, and medical personnel in this group practice duly licensed/certified to practice medicine in your state?

☐ Yes ☐ No If no, please provide an explanation in Remarks Section on page 18.

8. Are any of the named insureds a party to any agreement or contract with any entity/individual that is not a part of this entity?

☐ Yes ☐ No

9. Who is the medical director for the group? Name ______

Do any of the group members have any medical director responsibilities outside of group practice?

☐ Yes ☐ No

If yes, complete the following questions. Use the Remarks Section if needed.

A. Name and location of entity: ______

B. Does the entity provide you with coverage for:

Your administrative responsibilities? ☐ Yes ☐ No Your direct patient care? ☐ Yes ☐ No

If no to either of the above, please provide a copy of the medical director contract and proof of medical professional liability insurance for the entity.

SCOPE OF OPERATIONS

10. Patients

A. Fee for service ______ % B. Prepaid (HMO, PPO) ______ %

C. Other ______ % ______

Please describe

D. Please explain the medical services that are not on a fee-for-service basis:

______

______

E. Number of patients seen each week ______ Percentage of transient patients ______ %

11. Does group attract patients because of reputation in any particular field of medicine? ☐ Yes ☐ No

If yes, please specify: ______

12. Does group provide the following services:

A. Bariatrics ☐ Yes ☐ No

B. Fertility Service ☐ Yes ☐ No

C. Treatment of prison inmates ☐ Yes ☐ No

D. 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 percent of practice: ______ %

E. Perform activities covered by another professional liability policy?

☐ Yes ☐ No

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

TELEMEDICINE

13. Does the group or its physicians provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunications, video, or information systems?

☐ Yes ☐ No If yes, please describe:

14. Does group own, control, or staff one or more of the following? If yes, please describe in the Remarks Section on page 18.

A. Facilities for Overnight Patient Monitor/Care	☐ Yes	☐ No	
B. Hospital	☐ Yes	☐ No	
C. Nursing Home or Long-term Care Facilities	☐ Yes	☐ No	
D. Surgicenter/Clinic Surgical Outpatient Unit	☐ Yes	☐ No	
E. Emergency Room	☐ Yes	☐ No	
F. Birthing Center	☐ Yes	☐ No	
G. Substance Abuse Programs	☐ Yes	☐ No	
H. Radiation and/or Shock Therapy	☐ Yes	☐ No	
I. Laboratory	☐ Yes	☐ No	Annual gross sales ____ Anatomical Annual gross sales ____ Clinical
J. Emergency Vehicles	☐ Yes	☐ No	
K. Pharmacy	☐ Yes	☐ No	Annual gross sales ____
L. Optical Goods Store	☐ Yes	☐ No	Annual gross sales ____
M. Hearing Aid Store	☐ Yes	☐ No	Annual gross sales ____

15. List all facilities, including nonhospital facilities, where group physicians have staff or courtesy privileges. List principal location first. Use the Remarks Section, page 18, to list additional facilities. Please list the name of the facilities and/or provide copies of your contract.

Facility	City	State	Department	% of Practice

16. Is the group engaged in any medical research?

☐ Yes ☐ No If yes, explain type and extent of research activities:

17. Does the group edit or sell publications, video tapes, or other media?

☐ Yes ☐ No If yes, explain:

RISK MANAGEMENT

18. Loss Control

A. Does the group have a loss control program? ☐ Yes ☐ No

If yes, show date of last site inspection: ☐

Also, please describe nature of program in Remarks Section on page 18.

B. Does the group have an arbitration plan? ☐ Yes ☐ No

If yes, please describe details in Remarks Section on page 18.

C. Does a peer review committee exist? ☐ Yes ☐ No

D. Please describe how fee-related complaints are handled:

E. Does the group provide for continuing education programs? ☐ Yes ☐ No

If yes, please describe details in Remarks Section on page 18, indicating if the physician is reimbursed by the group for the program.

F. Are any teaching programs conducted? ☐ Yes ☐ No

If yes, please describe details in Remarks Section on page 18.

G. Is there a credentials committee? ☐ Yes ☐ No

H. Are informed consent forms used? ☐ Yes ☐ No

If yes, when?

19. Material Disposal

A. Describe how you dispose of contaminated materials, human tissue, nuclear materials, or any other hazardous waste:

B. Do you have an EPA registration number? ☐ Yes ☐ No

If yes, attach the RCRA or Super Fund application forms.

C. Are oxygen and other gas cylinders used? ☐ Yes ☐ No

If yes, indicate where stored:

D. Does group use radium or other isotopes? ☐ Yes ☐ No

If yes, describe safety precautions taken in Remarks Section on page 18. (Describe type and frequency of tests for stray x-ray radiation.)

E. Do floor and ceiling of room in which radium and x-ray are used have lead lining or equivalent protection?

☐ Yes ☐ No

20. New Physicians

A. How are qualifications of new physicians checked? (Describe)

B. Are all prospective physicians required to be certified or board eligible? ☐ Yes ☐ No

If no, explain reasons in Remarks Section, page 18.

21. Medical Records Procedures

A. Indicate procedures applicable:

Alphabetic ☐

Centralized ☐

Color Coded ☐

Drug Allergies Noted in Patient File ☐

Fastened Folder ☐

Loose-leaf Binder ☐

Medical Records Committee* ☐

Medical Records Librarian ☐

Medical Records Supervisor ☐

Numerical with Cross-reference File ☐

Progress Notes Typed (signed by dictating physician) ☐

Progress Notes Written (signed and dated by physician) ☐

Terminal Digit ☐

*Indicate how often the medical records committee convenes and to whom it reports:

B. How are record-keeping deficiencies handled?

C. Are all records kept at the main group location? ☐ Yes ☐ No
If no, indicate in Remarks Section on page 18 where and by whom they are kept.

AFFILIATIONS

22. Accreditation

A. Is the medical group a member of a national organization? ☐ MGMA ☐ AGPA ☐ Other

B. Is the entity certified or accredited by any of the following? (Include a copy of the most recent survey, certification, or accreditation.)
☐ AAAHC ☐ ARC ☐ CAP ☐ JCAHO ☐ Other

MISCELLANEOUS

23. After reasonable inquiry, during the preceding 10-year period, has any claim or suit been brought against the group, its physicians, or other employees, or are you aware of any incident that has taken place in the last 10 years that may lead to a claim or suit?
☐ Yes ☐ No
A. Please attach a copy of loss runs from current and prior carrier.
B. For all losses of $50,000 or more, please complete the Claim Information Form on page 21.

24. Has any professional liability and/or general liability carrier ever canceled, declined, or modified coverage (e.g., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any similar coverage? **NOTE: MISSOURI APPLICANTS DO NOT RESPOND.**
☐ Yes ☐ No If yes, explain:

25. Has the group ever been suspended by any government health program (e.g., Medicare or Medicaid)?

☐ Yes ☐ No

26. Has any physician, patient, or insurance plan ever filed a complaint against the group with any medical association, society or foundation, consumer protection agency, chamber of commerce, or better business bureau?

27. Has the group, its physicians, or other employees ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency, or have its licenses to practice or its narcotics license ever been denied, revoked, suspended, or limited in any way?

☐ Yes ☐ No

(If yes, please provide copies of complaint and disposition documents.)

28. Are any of the group's physicians, or other employees now being—or 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 the treating physician or institution.)

29. Has the group become aware of any chronic illness or physical defect that impairs or could impair its physicians' or other employees' ability to practice in their 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 the treating physician or institution.)

30. Has any hospital ever restricted or revoked any group physician's privileges or invoked probation for any cause other than incomplete charts?

☐ Yes ☐ No

31. Has the group, its physicians, or other employees ever been indicted and/or convicted of a crime other than minor traffic violations?

☐ Yes ☐ No

RETROACTIVE COVERAGE

32. If the group's current policy or any previous policies are claims-made and the group cancels 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, your group may apply for a policy with a retroactive date back to the first day of your previous claims-made policy. Retroactive coverage insures the group for claims made 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 were filed against the group 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.

SIGNATURE REQUIRED

I have read and understand the above statement. ________________ Authorized Officer's Signature ________ Date

A. Does your current policy provide extended reporting (tail) coverage for your former employed physicians?

☐ Yes ☐ No

B. Do you intend to purchase an extended reporting endorsement (tail coverage) from your current carrier?

☐ Yes ☐ No

C. If no, do you wish to purchase retroactive coverage from The Doctors Company for your former (departed) employed physicians?

☐ Yes ☐ No

If yes, provide a list of former employed physicians in the Remarks Section on page 18. Include the name, date of birth, retroactive date, specialty, and the last day worked.

(You must attach a copy of the most recent Declarations Page or endorsement evidencing coverage 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 the group, its physicians, or other employees that have not been reported to your present or prior insurer(s)?

☐ Yes ☐ No

E. 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 the group's present or prior insurer(s)?

☐ Yes ☐ No

SIGNATURE REQUIRED

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

Signature ____________________ ____________

Authorized Officer Date

____

Print Name and Title

LIMITS OF LIABILITY

33. Clinic/Group Professional Liability

A. Desired Limits of Liability ______ Each claim ______ Aggregate ______

B. Is retroactive coverage being requested for the entity? ☐ Yes ☐ No

If yes, please indicate retroactive date: ______ Mo./Day/Yr.

C. Desired effective date: ______ Mo./Day/Yr.

D. Current policy expires: ______ Mo./Day/Yr.

34. Retention

A. Deductible ☐ Self-insured Retention ☐ Amount ______

B. Quota Share Deductible ☐

35. Commercial General Liability (CGL)

A. Limit of Liability ☐ Per Claim ☐ Occurence ______

B. Medical Expense Limit of Liability (per person) ______

C. Fire Damage Limit of Liability (any one fire) ______

D. Aggregate Limit ______

36. Does the medical group require umbrella or excess limits? ☐ Yes ☐ No

If yes, please describe in Remarks Section on page 18.

PREVIOUS INSURANCE

37. Medical Professional Liability Insurance Coverage

To ensure that there are no gaps in coverage, please list all previous carriers who have insured the group in the past 10 years. If additional space is required, please use the Remarks Section on page 18. Attach a copy of the Declarations Page from your most recent policy.

A. Current Carrier ______ Policy Number ______ Limits of Liability ______ Type of Policy ______ Occurrence or Claims-made

Deductible or Self-insured Retention ______ Amount ______ Retroactive Date ______ Mo./Day/Yr. Policy Period ______ From Mo./Day/Yr. ______ To Mo./Day/Yr.

B. First Prior Carrier ______ Policy Number ______ Limits of Liability ______ Type of Policy ______ Occurrence or Claims-made

Deductible or Self-insured Retention ______ Amount ______ Retroactive Date ______ Mo./Day/Yr. Policy Period ______ From Mo./Day/Yr. ______ To Mo./Day/Yr.

C. Second Prior Carrier | Policy Number | Limits of Liability | Type of Policy

Occurrence or Claims-made

Deductible or Self-insured Retention | Amount | Retroactive Date | Policy Period

Retroactive Date: Mo./Day/Yr.

Policy Period: From Mo./Day/Yr. To Mo./Day/Yr.

D. Third Prior Carrier | Policy Number | Limits of Liability | Type of Policy

Occurrence or Claims-made

Deductible or Self-insured Retention | Amount | Retroactive Date | Policy Period

Retroactive Date: Mo./Day/Yr.

Policy Period: From Mo./Day/Yr. To Mo./Day/Yr.

E. Has the group or group member ever been insured with TDC in the past?

☐ Yes ☐ No If yes, what was your policy #?

38. The following material must be submitted with this application:

A. Currently valued loss runs from current and prior carriers for six years (valued within 30 days from application date).

B. Current audited financial statements for two years for the group.

C. Copies of all professional liability policies (including Declarations Pages and Endorsements) from the group's previous carriers. The group's application cannot be considered without these documents.

REMARKS SECTION

If additional space is needed, please use the group's letterhead. For question number, please indicate question number and letter (if applicable)—7 and 16B for example.

QUESTION NUMBER **REMARKS**

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 and/or material misrepresentation will cause immediate rescission of the group's insurance coverage.

AGREEMENT: I understand that the policy being applied for does not cover the liability of others that the medical group may have assumed under any contract or agreement.

(Note: The group's 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 the professional conduct and experience of the group. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, and insurance agent to furnish any information concerning the group that the company may request.

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

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 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.

SIGNATURE REQUIRED

Signature

Authorized Officer

Date

Print Name and Title

CLAIM INFORMATION FORM

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. Sex ______

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

5. Allegation

6. Date of Incident Month Day Year

7. Report Date Month Day Year

8. Location

9. Insurance Carrier

10. Other Defendants

11. Present Status

☐ Open Claim Open Indemnity and Legal Expense Reserve $ ☐ Settlement

☐ Closed Claim Date Closed ☐ Judgment

Settlement or Indemnity and Legal Expense $ Paid ☐ Dismissed

12. Condition and diagnosis at time of incident:

13. Dates and description of professional services rendered:

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

This form, along with any supplementary information, is attached to and made a part of your application.

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 the group and in its 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.

SIGNATURE OPTIONAL

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

Authorized Officer

Print Name and Title

Street

City State Zip -

Date

Month Day Year

(If undated, the date of receipt will be inserted by The Doctors Company. Address any question you may have to the Secretary of the Exchange.)

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 group designee subscribes for group membership in The Doctors Company, an Interinsurance Exchange ("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

Executed this ________ day of ________ 20 ____

Signature ________________________

Authorized Officer

____

Print Name and Title

INSURANCE APPLICANT
BUSINESS ASSOCIATE AGREEMENT

This Agreement is entered into by and between The Doctors Company, an interinsurance Exchange (including its subsidiaries, Underwriter for the Professions Insurance Company and Professional Underwriters Liability Insurance Company), hereinafter referred to as "We" and __________________________ (Applicant Name), hereinafter referred to as "You."

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 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 are Your "business associate." We must use and/or disclose information that identifies an individual, relates to health, health treatment, or health care payment ("Protected Health Information") and is maintained in any form (e.g., electronic, paper, verbal) in Our performance of services with respect to Your application for insurance, and We agree to abide by the assurances, terms, and conditions contained herein in the performance of Our obligations.

This Agreement 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 involve the use and disclosure of Protected Health Information as defined by the Privacy Regulation. These Services may include, among others, quality assessment, quality improvement, outcomes evaluation, protocol and clinical guidelines development, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs to improve the skills of health care 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 B(5) below; (ii) as directed by You; 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:

(1) Our **Business Activities.**

We may:

(a) Use the Protected Health Information in Our possession for Our proper management and administration and to fulfill any of Our present or future legal responsibilities provided that such uses are permitted under state and federal confidentiality laws; and

(b) Disclose the Protected Health Information in Our possession to third parties for the purpose of Our proper management and administration or to fulfill any of Our present or future legal responsibilities 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).

(2) Our **Additional Activities.**

In addition to using the Protected Health Information to perform the Services set forth above, We may:

(a) 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 health care 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 explicit authorization; and

(b) 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.

B. Our **Responsibilities.**

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;

(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 within ten (10) business days of Our discovery of such unauthorized use and/or disclosure;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and appropriate 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 or 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 U.S. 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 health care operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Whether or not an insurance policy is issued as a result of this application, 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; and

(9) In those rare 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 superceding contractual and other legal rights; and/or because any amendment could be tampering with evidence in a civil or administrative matter.

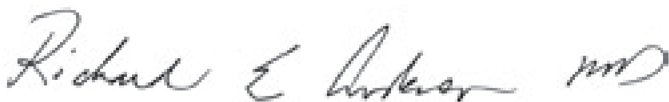
(10) You may terminate this Agreement if We violate a material term of this Agreement.

Date: ______________________________

____
Company Name

By: ____

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



Richard E. Anderson, M.D.
Chairman of the Board of Governors

David B. Troxel
Secretary

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