If previously covered with Medical Protective or MedPro RRG Risk Retention Group, please enter the policy number: _____

MedPro RRG
a MedPro/Berkshire Hathaway solution

PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Instructions

A. If additional space is needed, please complete Section XI. Supplemental Information with a reference to the question.

B. Additional documentation needed - (1) Claim history reports (loss runs) from all prior insurance carriers, (2) copy of current declarations page from your current insurance carrier, (3) copy of current license, (4) Curriculum vitae.

C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

I. General Information

A.

Last Name _____

First Name (Full) _____

Middle Name _____ Suffix _____ Date of Birth MM/DD/YYYY ____ / ____ / _____ ☐ Male ☐ Female

Social Security Number (Optional) ___ - ___ - _____ National Provider Identifier Number _____

Business Phone ___ - ___ - _____ Business Fax ___ - ___ - _____ Residence/Cell Phone ___ - ___ - _____

Email address: _____

B. If you have a web address, please provide the website address (URL): _____

C. Residence Address:

Number & Street _____ Apartment # _____

City _____ State _____ Zip Code _____ - _____

County _____

D. Practice Locations: (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

_____ **% of practice** **1.** ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name _____

Number & Street _____

Suite _____ City _____ State _____ Zip Code _____ - _____

County _____ Start Date: ____ / _____ MM YYYY

_____ **% of practice** **2.** ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name _____

Number & Street _____

Suite _____ City _____ State _____ Zip Code _____ - _____

County _____ Start Date: ____ / _____ MM YYYY

_____ **% of practice** **3.** ☐ Office ☐ Hospital ☐ Other If other please explain: _____

Practice/Hospital Name _____

Number & Street _____

Suite _____ City _____ State _____ Zip Code _____ - _____

County _____ Start Date: ____ / _____ MM YYYY

I. General Information (continued)

E. List all facilities or organizations where you have practiced or have had staff or courtesy privileges for your profession since graduation. (Explain any periods of inactivity.)

Facility Name and Location	Department	Type of Privileges	Dates From / To

F. Do you admit patients to any of the above hospital locations? ☐ Yes ☐ No

If no, please explain your protocol to admit patients to a hospital if the circumstance would arise: _____

G. Billing and Correspondence Address:

☐ Location # (from Question D above): ____ ☐ Residence ☐ Other (Please enter below)

Number & Street _____ Suite _____

City _____ State _____ Zip Code _____ - _____

II. Educational Background

A. Medical School:

Name of School _____ Degree _____

City _____ State _____ **Completed from:** ____ / ____ **To:** ____ / ____

MM YYYY MM YYYY

Country _____

If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program? ☐ Yes ☐ No

If no, please explain: _____

B. Residency: List all Residency training programs.

Please enter each specific specialty.

1. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in training **From:** ____ / ____ **To:** ____ / ____

MM YYYY MM YYYY

2. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in training **From:** ____ / ____ **To:** ____ / ____

MM YYYY MM YYYY

C. Have you participated in any additional training? (i.e. Fellowship, etc.) ☐ Yes ☐ No

1. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in training **From:** ____ / ____ **To:** ____ / ____

MM YYYY MM YYYY

2. Name of Hospital/Facility/Program _____

City _____ State _____ Country _____

Specialty Type _____

Completed? ☐ Yes ☐ No ☐ Still in training **From:** ____ / ____ **To:** ____ / ____

MM YYYY MM YYYY

II. Educational Background (continued)

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

E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 credit hours. _____

F. Have you completed a risk management education course within the last twelve (12) months? ☐ Yes ☐ No

III. Practice Information

A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, Telemedicine or Internet Medicine? ☐ Yes ☐ No

(If this is covered by another professional liability insurance policy, complete Section IV., Question H.)

If yes, which state(s): _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____ , _____

B. States in which you hold a license to practice medicine: (Exclude state abbreviation from license number.)

Please check the appropriate box to indicate the status of your license.

			Active	Inactive	Temporary	Pending
1. State _____	License # _____		☐	☐	☐	☐
2. State _____	License # _____		☐	☐	☐	☐
3. State _____	License # _____		☐	☐	☐	☐
4. State _____	License # _____		☐	☐	☐	☐

C. Do you have previous practice location(s)? If yes, list all location(s) within the past 10 years. If your requested retroactive date is greater than 10 years, provide locations back to the retroactive date. Please list most recent location first. ☐ Yes ☐ No

1. _____
Name of Practice

_____ _____ _____
City State Country

_____ **From:** ____ / ____ **To:** ____ / ____
Specialty MM YYYY MM YYYY

2. _____
Name of Practice

_____ _____ _____
City State Country

_____ **From:** ____ / ____ **To:** ____ / ____
Specialty MM YYYY MM YYYY

D. Please explain the following gaps if they occurred in the last 10 years:

1. Gaps greater than 1 year between your medical school, residency, other training or first time in practice. _____

2. Gaps greater than 6 months between practice locations. _____

E. To which Medical Societies or Associations do you belong? _____

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.
****Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.****

F. What is your present specialty? _____ _____ **% of total practice**

What is your sub-specialty? _____ _____ **% of total practice**

G. Are you permanently retired from the practice of clinical medicine? ☐ Yes ☐ No

H. American Board Certified? ☐ Yes ☐ No

_____ ____ / ____
Specialty Board Date most recently certified

_____ ____ / ____
Specialty Board Date most recently certified

If not American Board Certified, are you board eligible? ☐ Yes ☐ No If yes, when do you plan on taking your boards? ____ / ____ MM YYYY

If not American Board Certified, have you ever taken a specialty board or licensing examination and failed to pass? ☐ Yes ☐ No

If yes, how many times? ____

If yes, please explain: _____

I. List procedures you perform that are not typical to the specialty in which you received your residency or fellowship training. None ☐

_____

_____

_____

J. List any procedures you perform in the office setting for which you are not privileged to perform in a hospital. None ☐

_____

_____

K. Indicate the estimated average weekly numbers, under each of the following categories, for which you require MedPro RRG Risk Retention Group coverage.

Hours per week _____ Patients seen per week _____ None ☐ Unscheduled walk-in patients per week _____ None ☐

III. Practice Information (continued)

L. Please check any of the following procedures you will perform:

- ☐ Abdominoplasty - Tummy Tuck
- ☐ Abortions- Elective _____ % of total practice
- ☐ Abortions- Therapeutic _____ % of total practice
- ☐ Acupuncture - Therapeutic/Local Anesthetic
- ☐ Anesthesia General/Spinal/Caudal
- ☐ Angiography
- ☐ Angioplasty
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assisting in major surgery - own patients only
- ☐ Assisting in major surgery - own & other than own patients
- ☐ Bariatric Surgery - Laparoscopic
- ☐ Bariatric Surgery - Non-Laparoscopic
- ☐ Biopsy - Endoscopic
- ☐ Blepharopigmentation - _____ % of total practice
- ☐ Blepharoplasty - Cosmetic _____ % of total practice
- ☐ Blepharoplasty - Reconstruction _____ % of total practice
- ☐ Botox _____ % of total practice
- ☐ Brachioplasty
- ☐ Breast Implants - Cosmetic _____ % of total practice
- ☐ Breast Implants - Reconstruction
- ☐ Breast Reduction - Cosmetic
- ☐ Bronchoscopy
- ☐ Bronco-esophagology
- ☐ Buttock Implants
- ☐ Calf Implants
- ☐ Cataract Surgery
- ☐ Catheterization - Left Heart
- ☐ Catheterization - Right Heart (other than CVP lines)/ Swan Ganz
- ☐ Cheek/Chin/Lip Implants
- ☐ Chelation Therapy
- ☐ Chemical Peels - Superficial / Medium
- ☐ Chemical Peels - Deep _____ % of total practice
- ☐ Cleft Lip Surgery - Reconstructive
- ☐ Cleft Palate Surgery - Reconstructive
- ☐ Colonoscopy
- ☐ Cryosurgery (Cervical)
- ☐ Cryosurgery (non-external lesions)
- ☐ D & C
- Discectomy
  - ☐ Open
  - ☐ Other Than Open
- ☐ Electromagnetic Therapy
- ☐ Electroconvulsive/Shock Therapy
- ☐ Embolization
- ☐ ERCP
- ☐ Face Lifts
- ☐ Face Lifts Mini (done with laser) ___ % of total practice
- ☐ Gastrointestinal Endoscopy
- ☐ Gynecology - Major Surgery
- ☐ Hair Transplants - Follicular Unit Transplantations
- ☐ Hair Transplants - Other
- ☐ HVLA on the cervical spine on patients younger than 18 years of age
- ☐ Intraoperative Monitoring ____% of total practice
- ☐ Intrathecal Pumps
- ☐ Kyphoplasty
- ☐ Laporoscopic Cholecystectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Laser Therapy (Endoscopic)
- ☐ Laser Therapy (Non-Endoscopic)
- ☐ Lipoinjection ____% of total practice
- Liposuction
  - ☐ Other Than Tumescent Technique
  - ☐ Tumescent Technique Only ____% of total practice
- ☐ Lithotripsy
- ☐ Lymphangiography
- ☐ Mammograms
- ☐ Myelography
- Nerve Blocks
  - ☐ Facet
  - ☐ Lumbar Epidural Steroid
  - ☐ Myofascial
  - ☐ Occipital
  - ☐ Paraspinal/Paravertebral
  - ☐ Peripheral
  - ☐ Sciatic
  - ☐ Triggerpoint Injection
- ☐ Oxidation Therapy
- ☐ Pacemakers - Epicardial
- ☐ Pacemakers - Endocardial
- ☐ Pacemakers - Temporary
- ☐ Peritoneoscopy
- ☐ Phlebography
- ☐ Pneumoencephalography
- ☐ Polypectomy

Prenatal /Gynecological Practice

- ☐ Prenatal Practice - 1st & 2nd Trimester
- ☐ Prenatal Practice - to term, no delivery
- ☐ Prenatal Practice - to term, and delivery
- ☐ Normal Deliveries - total per year ____
- ☐ Cesarean Deliveries - total per year ____

- ☐ Prolotherapy
- ☐ Radial/Laser Keratotomy
- ☐ Radiation/X-Ray Therapy
- ☐ Rectal Ozone Therapy
- ☐ Rhinoplasty _____ % of total practice
- ☐ Sigmoidoscopy - 60 cm or less
- ☐ Sigmoidoscopy - greater than 60 cm
- ☐ Silicone Injections _____ % of total practice

Skin Flaps/Grafts

- ☐ Cosmetic _____ % of total practice
- ☐ Reconstruction _____ % of total practice

- ☐ Spinal Cord Stimulators
- ☐ Thigh Lift
- ☐ Tubal Ligations
- ☐ Upper GI Endoscopy
- ☐ Vasectomies - own patients
- ☐ Vasectomies - own & other than your own patients
- ☐ Weight Control Medication _____ % of total practice
- ☐ Other Medical Techniques

List Procedures (do not restate your specialty)

_____

_____

_____

M. Please indicate the percentage of your total practice performing the following surgical activities:

_____ % Cardiac	_____ % Orthopedic (including back)	_____ % Thoracic
_____ % Gynecology	_____ % Orthopedic (not including back)	_____ % Traumatic
_____ % Hand	_____ % Otolaryngology	_____ % Urology
_____ % Neurosurgery	_____ % Plastic (cosmetic enhancement only)	_____ % Vascular
_____ % Obstetrics	_____ % Plastic (reconstruction only)	_____ % Other (Describe) _____
_____ % Ophthalmology		_____

N. In the last 10 years,

1. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity? ☐ Yes ☐ No

If yes, list procedures/activities, reason for discontinuing, and date discontinued. Date: ____ / _____ (MM / YYYY)

_____

_____

2. Have you performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No

a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?
☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ Never prescribed weight control medication

b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?
☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ Never performed weight control surgery

O. Do you have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

If yes, what is the name of the weight control clinic with which you are affiliated? _____

P. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.) ☐ Yes ☐ No

1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) _____ hrs

2. On average how many of the above hours are you working in order to fulfill staff privilege requirements? _____ hrs

(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Section IV, Question H.)

III. Practice Information (continued)

Q. Please use the space below for any comments you feel will help MedPro RRG Risk Retention Group better understand any special circumstances concerning your practice.

_____

_____

_____

_____

IV. Additional Professional Information

Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the question.

(For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)

A. Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates. _____ hrs None ☐

B. Indicate the average hours per week devoted to treating non-federal prison inmates. _____ hrs None ☐

C. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes. _____ % None ☐

D. Indicate the percentage of your practice devoted to working in a nursing home facility. _____ % None ☐

E. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? ☐ Yes ☐ No

If yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

F. Do you practice as a medical director? ☐ Yes ☐ No

Type and name of facility: _____

If yes, what percentage of your practice is devoted to this activity? _____ %

Briefly describe your responsibilities: _____

G. Do you devise or review plant/employer safety standards? ☐ Yes ☐ No

What products are manufactured by the company? _____

Company Name: _____

Location: _____

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

If yes, are you a(n): ☐ Employee ☐ Independent Contractor ☐ Resident/Fellow ☐ Faculty

Practice Name: _____

Location: _____

Name of Insurer: _____

I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / _____ (MM / YYYY) _____

J. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / _____ (MM / YYYY) _____

K. Has a complaint against you ever been submitted to any state Medical Board or are you currently under investigation by any regulatory authority? ☐ Yes ☐ No

L. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

If yes, please indicate the date(s) and explain: Date: ____ / _____ (MM / YYYY) _____

M. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? ☐ Yes ☐ No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)

If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: _____

_____

Date(s) of treatment(s): **From:** ____ / _____ (MM / YYYY) **To:** ____ / _____ (MM / YYYY) ☐ Currently in treatment

Name of treating physician(s): _____

Address(es): _____

_____

V. Loss Information (Important! Please fully complete.)

Please complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below that has NOT been covered by a MedPro RRG Risk Retention Group Policy. *Previous carrier loss runs are required.*

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? _____ None ☐

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:

► Amputation ► Death ► Loss of major organ function ► Loss of vision ► Permanent neurological injury

If **yes**, how many? _____ None ☐

C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?

If **yes**, how many? None ☐

D. Are you aware of any circumstance, act, error or omission that could possibly result in a professional liability claim against you? ☐ Yes ☐ No

VI. Practice Organization Information

Please provide the number of practice organizations of which you are an employee, shareholder/partner or independent contractor: _____

Please provide details below for your primary practice organization. If you indicated more than one organization above, please complete a Practice Organization Supplement for each one.

A. Type of Legal Entity: (Check only one box)

☐ Solo Unincorporated/Sole Proprietor ☐ Solo Incorporated

☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company ☐ Other-please explain: _____

B. Employment status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date joined: ____ / ____ / _____
MM DD YYYY

C. Type of Organization:

☐ Standard Medical Practice
☐ Hospital
☐ State Licensed Medical Surgery Center
  ☐ For use by other physicians
  ☐ Your patients only
☐ Other-please explain: _____

D. Entity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)

_____

E. If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)

_____

F. Is this entity or employer currently insured with MedPro RRG Risk Retention Group? ☐ Yes ☐ No

If yes, please provide MedPro RRG Risk Retention Group policy or group number, if known.

Policy #: _____ Group #: _____

G. Do you desire coverage for this entity? ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ Shared Policy Limits ☐ Separate Policy Limits

(To request Separate Limit Entity coverage, please contact your agent or MedPro RRG Risk Retention Group Service Representative to complete an application for consideration.)

H. Do you anticipate any changes in staff or services provided in the next year? ☐ Yes ☐ No

If yes, please explain: _____

_____

I. If the purpose of the entity noted above is other than a medical office practice, please explain:

_____

_____

_____

VI. Practice Organization Information (continued)

J. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Physicians	_____	Nurse Midwives	_____	Physician Assistants	_____
Dentists	_____	Nurse Midwife Assistants	_____	Physician Surgical Assistants	_____
Aestheticians	_____	Nurse Practitioners	_____	Podiatrists	_____
Case Managers	_____	Nurse Surgical Assistants	_____	Psychologists	_____
CRNAs/RNAs	_____	Occupational Therapists	_____	Respiratory Therapists	_____
Chiropractors	_____	Perfusionists	_____		

K. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services? ☐ Yes ☐ No

If no, do you plan to do so within 12 months of your requested effective date? ☐ Yes ☐ No

If yes, please provide an explanation: _____

VII. Coverage Information

Notes:

1. **Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**
2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired:

☐ Claims-Made coverage without Prior Acts coverage ☐ Occurrence coverage

☐ Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am): **From:** ____ / ____ / _____ **To:** ____ / ____ / _____
Annual policy term will begin and end on the same month and day. MM DD YYYY MM DD YYYY

C. The retroactive date shown on your current Claims-Made policy is: ____ / ____ / _____
(This date is required for Claims-Made with Prior Acts.) MM DD YYYY
Copy of current Declarations Page is required.

D. Desired Limits: Per Occurrence/Per Claim Filed _____ , _____ , _____ Annual Aggregate _____ , _____ , _____

E. List all previous professional liability insurers. Loss runs from all prior carriers are required.

1. Current Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / _____ To: ____ / ____ / _____
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / _____ To: ____ / ____ / _____
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

☐ Occurrence ☐ Claims-Made From: ____ / ____ / _____ To: ____ / ____ / _____
MM DD YYYY MM DD YYYY

F. Please explain any gaps in coverage.

_____

_____

_____

G. Have you ever practiced without professional liability coverage? *If yes, please explain on a separate sheet of paper.* ☐ Yes ☐ No

H. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? ☐ Yes ☐ No

I. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.

☐ An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current insurer's policy. I understand that the policy for which I am applying with MedPro RRG Risk Retention Group, if offered, will not provide Prior Acts coverage.

Initial Here

VIII. Assignment of Right to Cancel Coverage

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds? ☐ Yes ☐ No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-800-398-6726 or sending written notice to MedPro RRG Risk Retention Group, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Initial Here

Name: _____

Street: _____ Suite: _____

City: _____

State: _____ Zip Code: _____ Phone Number: _____

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

IX. Subscriber Agreement

I understand that if my application for insurance is accepted by MedPro RRG Risk Retention Group ("MEDPRO RRG"), I will be a subscriber ("Subscriber") of MEDPRO RRG and, by my signature below, I hereby acknowledge and agree that the below provisions of this Section IX, including the Power of Attorney, ("Subscriber Agreement") constitute the charter of MEDPRO RRG and that the subscribers to MEDPRO RRG from time to time shall together comprise the reciprocal insurer, which shall operate through its Attorney in Fact as provided in this Subscriber Agreement as a risk retention group in accordance with federal law and as a risk retention group in the form of a reciprocal captive insurer in accordance with District of Columbia law.

In consideration of similar agreements executed or to be executed by other subscribers and of the benefits of the exchange of such agreements and of the terms of this Subscriber Agreement, I agree to the following terms and conditions.

1. **Appointment and Powers and Duties of Attorney-in-Fact.** Subscriber agrees to the appointment of MedPro Risk Retention Services, Inc., an Indiana corporation ("Attorney-in-Fact"), as the Attorney-in-Fact for MEDPRO RRG to carry out the purposes and objectives set forth in this Subscriber Agreement and to carry out all business on behalf of MEDPRO RRG and the subscribers thereto. Subscriber also agrees to the appointment of the Board of Directors of the Attorney-in-Fact as the Subscribers' Advisory Committee for MEDPRO RRG. Attorney-in-Fact is vested with all necessary power and authority to act on behalf of MEDPRO RRG and the subscribers thereto, including conducting the affairs of MEDPRO RRG, managing and operating (directly or through contract with third parties (including affiliates of Attorney-in-Fact)) MEDPRO RRG for the benefit of the subscribers, and causing the issuance and exchange of indemnity, insurance or reinsurance contracts with other subscribers.

2. **Limitations of Liability.**

   a. The financial liability of Subscriber shall be limited to the amount of annual premiums on any contracts of indemnity, insurance or reinsurance due from Subscriber, provided, however, that all contracts of indemnity, insurance or reinsurance shall contain a "limit of liability" and in the event it is determined that Subscriber's liability on a claim under said contract of indemnity, insurance or reinsurance exceeds the limit of liability, such excess amount shall be the sole and complete responsibility of Subscriber.

   b. Should any suit, legal proceeding or other action be brought against Attorney-in-Fact resulting from or arising out of Subscriber's obligation on any contract of indemnity, insurance or reinsurance that Subscriber may enter into, then and in that event, any and all judgments entered against Attorney-in-Fact in that capacity shall be deemed a legal judgment against Subscriber.

3. **Maintenance and Distribution of Surplus.**

   Attorney-in-Fact shall cause MEDPRO RRG to maintain surplus in an amount sufficient to provide for the financial integrity of MEDPRO RRG and in an amount satisfactory to the District of Columbia Department of Insurance, Securities and Banking. In no event, however, shall Attorney-in-Fact be required to contribute its own assets or the assets of any affiliate to MEDPRO RRG.

   a. Subscriber authorizes Attorney-in-Fact to accrue for the benefit of MEDPRO RRG and the subscribers net income and savings realized from the exchange of contracts of indemnity, insurance or reinsurance hereunder and the management of MEDPRO RRG and its assets.

   b. Subject to the laws of the District of Columbia, if MEDPRO RRG is dissolved by Attorney-in-Fact, Attorney-in-Fact shall, after the full satisfaction of all liabilities and surplus notes of MEDPRO RRG from MEDPRO RRG's assets, pay each subscriber then insured an equitable share of all remaining assets, which payment shall be in full satisfaction of all rights and interests of such subscribers. Amounts to be paid to subscribers shall be distributed on an equitable basis as determined by Attorney-in-Fact.

4. **Term of Subscriber Agreement**.

   a. This Subscriber Agreement shall have no fixed term and begins with the commencement of the policy period of any contract of indemnity, insurance or reinsurance issued hereunder to Subscriber and ends upon cancellation or other termination of such contract of indemnity, insurance or reinsurance or upon replacement of this Subscriber Agreement by a modified subscriber agreement provided by Attorney-in-Fact. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements.

   b. Subscriber agrees that this Subscriber Agreement is expressly limited to the uses and purposes herein expressed and to no other. This Subscriber Agreement may be terminated by Subscriber or by Attorney-in-Fact upon 30 days written notice. The Subscriber's appointment of Attorney-in-Fact and Subscriber's obligations and authorizations under this Subscriber Agreement shall survive the termination of this Subscriber Agreement until any and all claims involving the indemnity, insurance or reinsurance contracts of the Subscriber and any and all other matters existing between the Subscriber and MEDPRO RRG, the Attorney-in-Fact or with third parties have been settled or satisfied. Subscriber agrees that the Attorney-in-Fact shall have the authority and ability to perform all duties and carry out all obligations during any extended reporting or tail coverage endorsements during the term of this Subscriber Agreement or after termination.

   c. After termination of this Subscriber Agreement, Subscriber shall have no rights to participate in any distribution of assets upon dissolution of MEDPRO RRG.

5. **Replacement of Attorney-in-Fact**.

   Attorney-in-Fact may resign as Attorney-in-Fact upon designation by Attorney-in-Fact of a successor Attorney-in-fact and 60 days written notice to existing subscribers. Any such successor Attorney-in-fact shall have all the powers, rights and duties provided for in this Subscriber Agreement, and this Subscriber Agreement shall remain in full force and effect with such successor Attorney-in-fact.

6. **Principal Office**.

   The principal office of MEDPRO RRG shall be maintained in the District of Columbia or at such other place as designated by Attorney-in-Fact.

7. **Limitation of Liability of Attorney-in-Fact**.

   Subscriber agrees that no officer, director, or employee of Attorney-in-Fact shall be personally liable to MEDPRO RRG or its subscribers for any breach of duty owed to MEDPRO RRG or its subscribers, provided however that this provision shall not relieve an officer, director or employee from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to MEDPRO RRG and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers, directors and employees of Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above.

8. **Nature of MEDPRO RRG**.

   Subscriber acknowledges that MEDPRO RRG is a risk retention group organized in the District of Columbia as a reciprocal captive insurer and as such its contracts of indemnity, insurance or reinsurance are not subject to all state insurance laws and regulations. Further, state insolvency or guarantee funds are not available to risk retention groups, like MEDPRO RRG. Subscriber also acknowledges that MEDPRO RRG is a reciprocal organization under which each subscriber exchanges insurance obligations with the other subscribers through an Attorney-in-fact.

9. **Governing Law**.

   This Subscriber Agreement shall be governed by and interpreted according to the laws of the District of Columbia without giving effect to the conflict or choice of law provisions of that or any other jurisdiction.

X. Notices and Agreements

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments **(hereinafter "Attachments")** for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with MedPro RRG Risk Retention Group (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain any information pertaining to my credentials, background or any claims, lawsuits, or events, involving professional acts or omissions prior to and if issued, after the issuance of a contract of insurance, Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, or my professional practice, partnership, or business organization, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I also consent to the use of my information by the Company and its affiliates in their business of insurance. I expressly release and discharge from liability any party providing or receiving any such information.

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.

_____ Date Signed: ____ / ____ / _____
Applicant/Subscriber's Signature MM DD YYYY

_____
Print Name

XI. Supplemental Information

The Medical Protective Company

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

B. Patient/Claimant Information:

Last Name _____ First Name _____ Age _____

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. MM / YYYY

D. Date of notice received, if applicable. MM / YYYY

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer: MM / YYYY

Current or former insurer name: _____

If no, please explain: _____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ _____

If closed:

1. Date of closing: MM / YYYY

2. Was a payment made? ☐ Yes ☐ No

   a. If yes, did you consent to the settlement? ☐ Yes ☐ No

   b. Total amount of settlement or award: $ _____

   c. Total amount of settlement or award paid on your behalf: $ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

_____

_____

_____

The Medical Protective Company

Practice Organization Information Supplement

A. Type of Legal Entity: (Check only one box)

☐ Solo Unincorporated/Sole Proprietor ☐ Solo Incorporated

☐ Multi-Shareholder Corporation, Partnership, Limited Liability Company ☐ Other-please explain: _____

B. Employment status:

☐ Employee ☐ Shareholder/Partner ☐ Independent Contractor ☐ Other Date joined: ___ / ___ / ____
MM DD YYYY

C. Type of Organization:

☐ Standard Medical Practice
☐ Hospital
☐ State Licensed Medical Surgery Center
  ☐ For use by other physicians
  ☐ Your patients only
☐ Other-please explain: _____

D. Entity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)

E. If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)

F. Is this entity or employer currently insured with The Medical Protective Company? ☐ Yes ☐ No

If yes, please provide The Medical Protective Company corporation or partnership policy or group number, if known.

Policy #: Group #: Sub-group #:

G. Do you desire coverage for this entity? ☐ Yes ☐ No

If yes, please select the type of entity coverage desired:

☐ Shared Policy Limits ☐ Separate Policy Limits

(To request Separate Limit Entity coverage, please contact your agent or MedPro Service Representative to complete an application for consideration.)

H. If the purpose of the entity noted above is other than a medical office practice, please explain:

I. Indicate the number of each of the following who provide services in your office (please exclude yourself):

Physicians		Nurse Midwives		Physician Assistants	
Dentists		Nurse Midwife Assistants		Physician Surgical Assistants	
Aestheticians		Nurse Practitioners		Podiatrists	
Case Managers		Nurse Surgical Assistants		Psychologists	
CRNAs/RNAs		Occupational Therapists		Respiratory Therapists	
Chiropractors		Perfusionists			

J. Do you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or contract for services? ☐ Yes ☐ No

If no, do you plan to do so within 12 months of your requested effective date? ☐ Yes ☐ No

If yes, please provide an explanation: _____