

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers.

Corporation/Partnership Name: _____

Principal Address: _____

Mailing Address (if different from above): _____

Telephone: _____ Email: _____ Fax: _____

Office Contact Name and Phone Number: _____ Taxpayer ID No: _____

If applicable, please write web site address related to your practice: _____

Underwriting and Rating Information

Please submit a copy of current declarations page. Please use the REMARKS section below to provide further explanation or details.

1.	Requested effective date: _____ Requested retroactive date: _____ Requested limits of insurance: _____				
2.	The legal entity named above is: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">a. Professional Service Corporation</td> <td style="width: 50%;">c. Other Corporation</td> </tr> <tr> <td>b. Partnership</td> <td>d. Other _____</td> </tr> </table> Years in business: _____ Organized in the state of: _____	a. Professional Service Corporation	c. Other Corporation	b. Partnership	d. Other _____
a. Professional Service Corporation	c. Other Corporation				
b. Partnership	d. Other _____				
3.	Describe the principal activity of this organization (give detailed description if other than usual specialty). _____				
4.	Are any owners non-physicians? Yes No If yes, list names and percentage of ownership: _____ _____				
5.	Are you affiliated with, or do you anticipate forming alliances with any other clinics, practice associations, hospitals or private equity firms? Yes No If yes, which are you planning to associate with? _____				
6.	List all practice locations of the organization: _____ _____				

7. Does your Partnership/Corporation own or operate any of the following? Yes No
 Surgery Center
 Commercial Laboratory
 Extended Hours Walk-In Clinic
 Sleep Laboratory
 If yes, indicate name and location of entities: _____

If yes, are any of the above-marked entities staffed by physicians who are not members of your group? Yes No
 If yes, are any of these facilities **NOT** staffed by a physician? Yes No
 If no, please explain who staffs the facility: _____

8. Does your group operate any practice activities under a name other than the partnership/corporation's? Yes No
 If yes, please provide names: _____

9. Please complete the below for those physicians who are stockholders, partners, employees or independent contractors who are applying for coverage with Physicians Insurance RRG.
 For those who are **NOT** applying for coverage, please submit a copy of Certificate(s) of Insurance.

Physician	Specialty	Limits

10. Does your group have any contracts with individual physicians (other than those listed)? Yes No
 If yes, please list the name(s) and provide a copy of the contract: _____

11. Do your group employ, subcontract with, supervise or sponsor any physicians, nurse anesthetists, nurse midwives, nurse practitioners or physician assistants? Yes No
 If yes, and they are applying for coverage with Physicians Insurance RRG, please complete the below.
 For those who are **NOT** applying for coverage, please submit a copy of Certificate(s) of Insurance.

Provider Name	Specialty

12. Does your group employ (issue W-2s) any non-physicians? Yes No

13. Are you aware of any incidents or circumstances 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? Yes No
 If yes, has it been reported to your prior carrier(s)? Yes No

14. Does your group use an electronic medical record? Yes No

15. Does your group use a problem list in your charts?	Yes	No
16. Are allergies clearly documented in medical charts?	Yes	No
17. Please describe the protocol for managing telephone calls from patients asking for advice: _____		
18. What is the protocol for lab work? _____ _____		
19. Who is responsible for communicating results of lab work to patients? _____		
20. Please list all major medical equipment you lease or own: _____ _____		
Is there a service agreement in place for each piece of equipment?	Yes	No
21. Does the group have an incident response plan for cyber security? If yes, does the incident response plan address how the group would respond to a ransomware and other cyber incidents?	Yes	No
22. Do you have any professional service agreements with any of the following: Assisted Living Facility Juvenile Detention Center Correctional Facilities Skilled Nursing Home If yes, please supply a copy of the contract(s) and Certificate of Insurance if covered by another carrier.	Yes	No

REMARKS:

APPLICANT'S REPRESENTATION (Please Read Carefully)

The undersigned authorized Clinic Manager of the applicant declares that the statements set forth herein are true. The undersigned authorized Clinic Manager agrees that if the information supplied on this application changes between the date of this application and the effective date of coverage, he/she will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant nor the insurer to complete the insurance, but it is agreed that this shall be the basis of the contract should a policy be issued, and will be attached to and become a part of the policy.

APPLICANT AUTHORIZATION AND RELEASE (Please Read Carefully)

I acknowledge that as a condition precedent to acceptance of this application, an inquiry and investigation of my professional background, qualification and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance Risk Retention Group or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers or professional associates and Physicians Insurance Risk Retention Group or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance Risk Retention Group, its duly authorized representatives and the members or consultant of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance Risk Retention Group or its duly authorized representatives.

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.

CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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 WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATED AGENCIES.

DISTRICT OF COLUMBIA 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.

MAINE APPLICANTS: THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL. IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), 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 APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW HAMPSHIRE APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS

INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

OKLAHOMA APPLICANTS: WARNING: ANY PERSON, WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OREGON 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 MAY HAVE COMMITTED A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, 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.

WASHINGTON APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN WASHINGTON UNLESS THE INSURED(S) OR SOMEONE ACTING ON BEHALF OF THE INSURED(S) INTENTIONALLY CONCEALS OR MISREPRESENTS A MATERIAL FACT OR CIRCUMSTANCE RELATING TO THIS INSURANCE. 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.

ALABAMA, ALASKA, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, NEW MEXICO, NEW YORK, OHIO, RHODE ISLAND, TENNESSEE, TEXAS, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Clinic Manager Signature

Date

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.

I understand that signature of this application does not bind the company to complete this insurance.

(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)

PHYSICIANS

INSURANCE **PIRRG**

Re: Appointment of Proxy

Dear PIRRG Member:

Physicians Insurance Risk Retention Group, Inc. (“PIRRG”) is a member-owned and directed insurance company. As such, the focus is always on you, the member, and not stockholders or third-party investors. It also means you have a direct voice in the affairs of PIRRG.

As required by law, PIRRG must annually hold member meetings and bring various business elements to the membership for a vote. You can exercise your governance rights by appointing a proxy to vote on your behalf at future member meetings. Your proxy appointment helps ensure that PIRRG obtains the quorum of members necessary to take any important corporate action.

PIRRG will provide advance notice of all future member meetings. You can decide to attend a meeting and exercise your right to vote in person even if you provided a proxy.

Sincerely,

Physicians Insurance Risk Retention Group, Inc.

phyins.com

Physicians Insurance Risk Retention Group, Inc. Serviced by Physicians Insurance Member Services, LLC
601 Union Street, Suite 500
Seattle, WA 98101 | (800) 962-1399



PROXY

I appoint the President and Corporate Secretary of Physicians Insurance Risk Retention Group, Inc. (“PIRRG”), and each of them, agents and attorneys with powers of substitution in each of them, my lawful proxy to vote and act for the member policyholder and in its name at all annual, regular, and special meetings of the members of PIRRG.

This proxy is solicited on behalf of PIRRG and will empower the holders to vote on the member policyholder’s behalf for the election of directors of the Board of Directors and such other business as may properly come before any annual, regular or special meeting of members.

This proxy, unless revoked or replaced by substitution, shall remain in force for three years from the date stated below. If undated, the date of receipt will be inserted by PIRRG.

I may revoke this proxy by giving PIRRG written notice of my revocation before the day of any annual, regular, or special meeting at which such proxy is to be exercised. If I attend a meeting, I may revoke this proxy if I choose to vote in person.

DATE and SIGN your name. The proxy must be signed to be valid.

Policyholder Name: _____

Signature: _____ Date: _____

Print Name: _____

Print Title: _____

Email Address: _____

By providing my email address I opt-in to receive future electronic member communications from PIRRG

Thank you for your assistance in this important matter.