PHYSICIANS INSURANCE RRG

PHYSICIAN AND SURGEON PROFESSIONAL LIABILITY APPLICATION

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.

Name (First, Middle, Last): ____ M.D. D.O. Other ____________

Mailing Address: ____

Principal Office Address (if different than mailing address): ____

Home Address (if different than mailing address): ____

Telephone: __________________________ Fax: _______________________ Email: ______________________________________

Office Contact Name: _________________________________Office Phone Number: _____________________________________

Office Email (if different from email above):____

Other current practice locations (if applicable): ____

____

Coverage Information:

1. Requested Effective Date: ______________________________ Requested Retroactive Date: __________________________
2. Requested Limits of Insurance: ____
3. Name of Solo Corporation (if applicable): ____
4. Medical Specialty: ______________________________________ Subspecialty (if applicable): ___________________________
5. Specialty Board Certification(s): ____________________________________ Date of certification(s): ______________________

   If not board certified, are you eligible? Yes No Anticipated date of taking exam: _________________________
6. Average number of patients per week: _________________________ Number of hours per week: _________________________

   If you are practicing part-time, please provide the date on which you began practicing in that capacity: __________________
7. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage for? Yes No

   If yes, please provide a copy of the Certificate of Insurance.

8. Please list all states you are licensed:

State	License Number	Active/Inactive

9. All hospitals and surgery centers at which you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each:

Name	City	State	Type of privileges	% of admissions

10. All medical societies, medical associations, or other related professional societies, to which you belong:

11. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation Date

If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? Yes No

If yes, date certified: ________________ If no, please explain: ____

12. All internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Month/Year Completed
Internship:		
Residency:		
Fellowship:		
Fellowship:		

13. All previous practice locations within the last 10 years:

14. Please indicate below your best estimate of the number of the following procedures you expect to perform, or in which you will participate, in the next year, beginning with the date of your requested coverage (additional underwriting questions may apply):

Abortions - first trimester:
____________ Hospital
____________ Clinic
____________ Office
Abortions - after first trimester:
____________ Hospital
____________ Clinic
____________ Office
____________ Acupuncture
____________ Adenoidectomies
____________ "Alternative Medicine" or "complementary medicine" procedures (as viewed by most physicians)
Please describe: ____
Anesthesia - obstetrical:
____________ General
____________ Spinal
____________ Epidural
Anesthesia - non-obstetrical:
____________ General
____________ Spinal
____________ Epidural
____________ Anesthesia (other) - Please describe:
____________ Angiographies
____________ Angioplasty
____________ Arteriographies
____________ Assisting in major surgery - own patients
____________ Assisting in major surgery - other than own patients
____________ Breast implants
____________ Breast reductions
Catheterizations:
____________ Cardiac
____________ Arterial
____________ Other - Please describe: ____
____________ Chelation therapy
____________ Chemabrasion
____________ Chemical Peels
____________ Chemotherapy
____________ Colonoscopies
____________ Cosmetic implantation or injection of silicone or other materials - Please describe: ____________________
____
____________ Cryosurgery - Please describe: ____
____________ D & C's
Deliveries:
____________ Vaginal
____________ Cesarean
____________ Vaginal after Cesarean
____________ Discograms

____________ Electromyography
____________ Endoscopy (other than proctoscopy or sigmoidoscopy) - Please describe: ____________________________
____________ Eyeliner pigmentation
____________ Fracture reductions - closed
____________ Fracture reductions - open
____________ Hair transplants, or other hair growing or replacement techniques
Hemorrhoidectomies:
____________ Internal
____________ External
____________ Herniorrhaphies
Ketamine Therapy:
____________ Intravenous
____________ Non-intravenous
Laparoscopy:
____________ Diagnostic - Please describe: ____________________________
____________ Surgical - Please describe: ____________________________
____________ Laser Surgery - Please indicate type of surgery: ____________________________
____________ Liposuction
____________ Lumbar punctures
____________ Manipulation therapy
____________ Myelography
____________ Needle aspirations
____________ Needle biopsies
____________ Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts - Please indicate type of surgery: ____________________________

____
____________ Pacemaker insertion
____________ Pain management - Please indicate type: ____________________________
____________ Pre-natal care
____________ Radial keratotomies
____________ Radiation - diagnostic
____________ Radiation - therapeutic
____________ Sclerotherapy (choose one) <1mm >1mm
____________ Shock therapy
____________ Spinal Surgery
____________ Tattoo removal
____________ Thoracentesis
____________ Tonsillectomies
____________ Total joint replacements
____________ Tubal ligations
____________ Vasectomies
____________ Venography
____________ Weight control by means other than diet or exercise - Please describe: ____________________________
____________ Any other procedure you reasonably believe will be of interest to a medical professional liability insurer – Please describe: ____________________________

I DO NONE OF THESE PROCEDURES

15. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of major surgery:

___________ Abdominal	___________ Ophthalmological
___________ Bariatric	___________ Orthopedic – including spinal surgery
___________ Cardiac	___________ Orthopedic – without spinal surgery
___________ Colon/rectal	___________ Plastic - cosmetic
___________ General	___________ Plastic - reconstructive
___________ Gynecologic	___________ Thoracic
___________ Hand	___________ Traumatic
___________ Head and Neck	___________ Urologic
___________ Neurosurgical	___________ Vascular
___________ Obstetrical	I DO NONE OF THESE

16. Please describe, and provide dates for, any major changes in your practice in the last ten years, such as changes of specialty, or significant procedures initiated or no longer perform:

____

____

In responding to questions 17 through 41, please explain any "yes" response with further explanation or details in the REMARKS section below.

Question		
17. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society?	Yes	No
18. Has any state ever refused your license to practice medicine?	Yes	No
Has any state ever restricted, suspended, or revoked your license to practice medicine?	Yes	No
Have you ever voluntarily surrendered a license to practice medicine?	Yes	No
Has any state agency ever placed you on probation or restricted your practice?	Yes	No
Have you ever been investigated by any governmental agency?	Yes	No
19. Has any hospital ever denied, restricted, reduced, or suspended your privileges or invoked probation?	Yes	No
20. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?	Yes	No
21. Are you now being, or have you ever been, treated for, or suffered from, alcoholism, chemical dependency or mental illness?	Yes	No
22. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs or could impair your ability to practice medicine?	Yes	No
23. Have you ever been investigated for or had any sexual misconduct or battery allegations filed against you?	Yes	No
24. Have you ever been convicted or are you currently under investigation for a crime other than a traffic offense?	Yes	No
25. Have you ever been refused board certification?	Yes	No

		Yes	No
26.	Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or had renewal refused?	Yes	No
	To your knowledge is any such action under consideration by any current medical professional liability insurer?	Yes	No
27.	Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office?	Yes	No
28.	Are you an employee of, or do you do contract work for, any government agency? If so, please provide name: ____	Yes	No
29.	Do you have any professional agreements with any of the following: Assisted Living Facility Juvenile Detention Center Correctional Facilities Skilled Nursing Home If yes, please provide a copy of the contract(s) and Certificate of Insurance if covered by another carrier.	Yes	No
30.	Are you a sports team physician for any college, university, or professional team?	Yes	No
31.	Do you participate in any clinical trials or pharmaceutical testing programs?	Yes	No
	If yes, is it (are they) FDA approved?	Yes	No
32.	Please indicate the number of people you employ by the following categories: _________ Lab or X-ray Technicians _________ Nurse Practitioners _________ Medical Assistants _________ Physicians or Surgeons _________ Nurses _________ Physician Assistant _________ Nurse Anesthetists _________ Surgical Assistants _________ Nurse Midwives _________ Other (please specify)		
	If you have staff, are they certified in CPR?	Yes	No
33.	Do you admit patients for other physicians?	Yes	No
34.	Do you engage in any "moonlighting" activity, apart from your practice?	Yes	No
35.	Do you work in an emergency room?	Yes	No
	If yes, how many hours on average per week? ______________		
	For what institution? ____		
	If coverage is to be provided by another carrier, please provide evidence of other coverage.		
36.	Do you use a collection agency?	Yes	No
	If yes, does the collection agency have authority to file collection suit at its discretion?	Yes	No
37.	Do you work with a blood bank?	Yes	No
38.	If you are NOT a radiologist:		
	Do you take and/or interpret your won X-rays or other imaging procedures?	Yes	No
	If yes, estimated number per year: ______________		
	Does a radiologist over-read your X-rays?	Yes	No
	If yes, by whom and with what training? ____		

39. Do you perform invasive pain management procedures? Yes No
If yes, please list the procedures you perform and indicate if each is done in a hospital or office:
____
Do you provide fluoroscopic guided procedures? Yes No
Do you use sedation? Yes No
Do you place permanent pumps or stimulators? Yes No

40. Do you practice as a Hospitalist? If yes, please complete all applicable below. Yes No
a) Individual (solo practice)? Yes No
Name and Federal ID of solo corporation or service corporation:
____
b) Employee? Yes No
Name of employer: ____
c) Independent contract? Yes No
Name of hiring party to contract: ____
d) Partner/shareholder? Yes No
Name of corporation/partnership: ____

41. If you practice as a partner in a partnership or shareholder in a multi-shareholder professional corporation, is corporation coverage desired? Yes No
If yes, an additional application will be required. This coverage is not available unless all partners, shareholders and employed physicians/surgeons are insured by the Company.

REMARKS:

42. Beginning with your most recent, or current, insurer please list all professional liability insurers for the past ten years.
Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Occurrence or Claims-made)	Policy Number	Policy Period

Question	Yes	No
43. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension ("tail" coverage) be purchased from your current insurer? Please provide a copy of the Declarations Page and any reporting period extension of your current coverage.	Yes	No
44. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation, or partnership to which you belong or have belonged?	Yes	No
If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?	Yes	No
45. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rending of or failure to render professional services which may give rise to a claim?	Yes	No
If yes, has such incident(s) been reported to a prior professional liability insurer?	Yes	No
46. Have you had a request for medical records of a patient which has been reported to your current carrier?	Yes	No
47. Have you served as an expert witness or have you been deposed as an expert in any case of medical malpractice? If yes, please supply copies of your deposition or testimony if available.	Yes	No

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance Risk Retention Group in considering this application have been omitted. I agree that this shall be the basis of the locum tenens coverage provided to me and that I will notify Physicians Insurance Risk Retention Group of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (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 COMMITED 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.

______________________________	______________________________
Applicant's 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 RRG

RETROACTIVE COVERAGE FORM

(This form must be completed, signed and dated. Use the remarks section below if additional information is necessary.)

Name (First, Middle, Last) ____ M.D. D.O. Other ____________

If you **do not** wish to apply for retroactive coverage, please check the box, sign and date below

If you do wish to apply for retroactive coverage, please complete the following:

1.	Requested retroactive coverage date: ________________________ Limits of liability requested: _________________________			
2.	Did you practice as part of a partnership or corporation during the prior acts period? If yes, name(s) of corporation/partnership __________________________________		Yes	No
3.	Was the nature of your practice different during any of the prior acts period than it is now? If yes, please describe: ____		Yes	No
4.	Did you practice in another state during the prior acts period? If yes, please list states: ____		Yes	No
5.	Did you function as a Medical Director for any facility during the prior acts period? If yes, please name the facility and dates of Medical Directorship: ____		Yes	No
	If yes, do you admit patients to the above facility?		Yes	No
6.	Are you a hospitalist? If yes, please state the name of the facility: ____		Yes	No
7.	Did you treat patients at a skilled nursing home, assisted living facility, juvenile detention center or correctional facility during the prior acts period? If yes, please provide name and approximate work dates of facility: ____ Please note, additional underwriting questions may apply.		Yes	No
8.	Have you reported all incidents or potential claims, outcomes that have resulted in death, permanent damage/disability or any other outcomes that could result in a claim to a prior carrier during the prior acts period? If yes, please provide details in the remarks section below or additional page(s).	Yes	No	N/A

REMARKS:

I understand that, if granted prior acts coverage by the carrier, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. **Any claim which has been reported to another insurance carrier prior to the effective date.**
2. **Any claim known to the insured at the effective date which has not been reported to a prior carrier.**
3. **Any claim which may arise out of an incident which has been reported to another insurance carrier prior to the effective date.**
4. **Any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.**

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge, and that I know of no other relevant facts which might affect the underwriter's judgment when considering this application or which might be material to the underwriter's risk. I further authorize the release of any underwriting or claim information from all prior and current insurers, professional societies or association, or hospitals to the carrier.

No coverage will be bound until after the Company has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment in advance of review of the application is not an expression of the Company's intent to provide coverage. If coverage is refused by the Company, any advance payment will be returned.

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

______________________________ ______________________________

Applicant's 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.)

SUPPLEMENTAL CLAIM INFORMATION FORM

(This form must be completed, signed and dated. Please attach additional pages if necessary)

Name (First, Middle, Last) ____ M.D. D.O. Other ____________

If you have **never** had any claims/incidents opened, paid, or closed, please check the box, sign and date below

If you have had any claims/incidents opened, paid, or closed, please complete the following or provide detailed loss history documentation:

Patient information (name, age, other):
Date of first consultation:
Physical condition and diagnosis at the above date:
Nature and dates of treatment provided:
Date of incident or occurrence from which claim resulted:
Date of claim:
Allegations made against you:
Present status or disposition of claim including amount of settlement or judgement:
Subsequent condition or health of patient:
Names of other providers, hospitals or other entity, if any, involved in the claim or suit:
To whom may we refer for further information about this claim?
Was this claim reported to your insurance carrier? Yes No If yes, please list the name of carrier and policy number: ________________________________

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

______________________________ ______________________

Applicant's 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.)

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.

PHYSICIANS
INSURANCE RRG

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.