THE DOCTORS COMPANY
medical ~~mal~~practice insurance

PROFESSIONAL LIABILITY INSURANCE APPLICATION

For Medical Group Practices

AGENT INFORMATION

Agent name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Website: _____

J11889B 4/19

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

APPLICATION INSTRUCTIONS AND CHECKLIST

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process your application promptly and efficiently.

- Please complete this form electronically or print your responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply to you, please write "N/A."
- If you wish to explain any of your answers, please use the Remarks section. If you need additional space, please continue your answers on a separate page and attach it to the application.

The following items must be included with your application:

- ☐ List of all practice locations, including the name of the facility, facility type, percentage of practice, street address, city, state, zip code, county, phone number, and fax number. Also indicate whether the practice location is owned, rented, or leased, and whether insurance from The Doctors Company is desired for the location.
- ☐ List of all providers, including first and last name, date of birth, license number(s), specialty, retroactive date, full-time equivalency, board certification indicator(s), and desired limits of liability.
- ☐ Six years of loss runs including indemnity payments, expense payments, and reserves for all open and closed claims.
- ☐ Currently valued loss runs from current and prior carriers for six years (valued within 30 days from application date).
- ☐ Current audited financial statements for two years for the group.
- ☐ Copies of all professional liability policies (including Declarations Pages and Endorsements) from the group's previous carriers for the past six years. The group's application cannot be considered without these documents.

Claims-made vs. Occurrence:

Claims-made policies generally cover incidents and events that both happen and are reported to us while you have a policy with The Doctors Company. You may request a retroactive date to allow you to report to us claims that arise out of incidents that took place previously while you were insured elsewhere. You can also purchase extended reporting, or tail, coverage which will allow you to report claims that arise out of incidents occurring after your retroactive date but before you ended your policy with us but which are reported after you end your coverage with us.

Occurrence policies cover incidents that happen while you were covered by a policy issued by The Doctors Company, but can be reported anytime (even if you no longer have a policy with us).

In some states we offer a third option claims-made with Pre-paid Extended Reporting Period "Tail". This option works a lot like an occurrence policy and the cost of the tail coverage is included in your claims-made premium.

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

COVERAGE SELECTION

Please indicate coverage type desired:

☐ Claims-made (available in all states)
Covers incidents that take place after the retroactive date and are reported during the policy period.

☐ Occurrence *(Only available in IN, MI, NM, and SC)*
Covers incidents that take place during the policy period regardless of when reported as a claim.

☐ Claims-made with pre-paid ERP *(Only available in MA, MI, and OH)*

GENERAL INFORMATION

1. Group name: _____

Primary practice location telephone: _____ Fax: _____

E-mail address(es): _____

Website address(es): _____

A. Primary practice location:

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____ ☐ Owned ☐ Leased ☐ Rented Sq. Ft.: _____ # of Floors: _____

Date acquired: _____

B. Billing address: ☐ Same as primary practice address

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

C. Mailing address: ☐ Same as primary practice address ☐ Same as billing address

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

D. Tax I.D. number: _____

E. Authorized representative for insurance matters:

Name: _____ Title: _____

Phone: _____ Extension: _____ E-mail address: _____

2. Entities:

Entity name: _____ Description: _____

Entity type (e.g., corporation, partnership, joint venture): _____

Insurance Requested: ☐ Yes ☐ No Retroactive date (if applicable): _____

If there is more than one entity name, please give a name and a description in the Remarks section.

LOCATIONS

3. Practice address(es) other than primary practice address listed above.
Attach a list or use the Remarks section to provide the additional entity names, descriptions, type, and retroactive dates if applicable. Also, include an organizational chart that indicates all entities.

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: Hospital
10: Medi-Spa/Cosmetic Center
11: Other (please identify)

A. Name of location: _____

Facility code: _____ % of practice: _____

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Extension: _____ Fax: _____

Do you own ☐, rent ☐, or lease ☐ this location? If other, please explain in the Remarks section.

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

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

_____

B. Name of location: _____

Facility code: _____ % of practice: _____

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Extension: _____ Fax: _____

Do you own ☐, rent ☐, or lease ☐ this location? If other, please explain in the Remarks section.

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

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

_____

C. Name of location: _____

Facility code: _____ % of practice: _____

Street: _____ Bldg./Suite: _____

City: _____ State: _____ Zip: _____

County: _____

Phone: _____ Extension: _____ Fax: _____

Do you own ☐, rent ☐, or lease ☐ this location? If other, please explain in the Remarks section.

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

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

_____

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

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

Acquire 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 the Remarks section.

4. Administration

A. Name of Chief Executive Officer: _____

B. Name of Medical Director: _____

C. Name of Administrator/Risk Manager: _____

D. Please list all operational and clinical committees in place in your organization, including, but not limited to, peer review, QA, and executive committees (Use Remarks section as necessary.):

_____

_____

E. Are any of your physicians members of a governing committee of the hospitals in which they have privileges? ☐ Yes ☐ No

F. Do any of your physicians have academic/faculty appointments at local medical schools? ☐ Yes ☐ No

STAFF

5. Physicians and/or Ancillary Personnel

Please indicate the number of:

A. Current Year
Full-time: _____ Part-time: _____ Total: _____

B. First Prior Year
Full-time: _____ Part-time: _____ Total: _____

C. Second Prior Year
Full-time: _____ Part-time: _____ Total: _____

D. Third Prior Year
Full-time: _____ Part-time: _____ Total: _____

E. Fourth Prior Year
Full-time: _____ Part-time: _____ Total: _____

F. Fifth Prior Year
Full-time: _____ Part-time: _____ Total: _____

G. Please explain any year-to-year change noted above 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 either a copy of declarations page(s) from your most recent malpractice insurance policy or a typed list to give us the following information, or 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 (if applicable)
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				
35				☐ Yes ☐ No				
36				☐ Yes ☐ No				
37				☐ Yes ☐ No				
38				☐ Yes ☐ No				
39				☐ Yes ☐ No				
40				☐ Yes ☐ No				

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 his or her duties as an employee of the entity is included under this insurance unless otherwise excluded.

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

A. Classifications	**Number employed**	**Number contracted**	**Separate limits**
Doctor of Nursing			☐ Yes ☐ No
Midwife-CNM			☐ Yes ☐ No
Midwife-Other			☐ Yes ☐ No
Naturopathic Doctor			☐ Yes ☐ No
Nurse Anesthetist			☐ Yes ☐ No
Nurse Practitioner			☐ Yes ☐ No
Optometrist			☐ Yes ☐ No
Perfusionist			☐ Yes ☐ No
Psychologist			☐ Yes ☐ No
Physician Assistant**			☐ Yes ☐ No
Total Personnel	0	0	

B. Classifications (continued)	**Number employed**	**Number contracted**
Audiologist		
Laboratory Technician		
Nurse (RN, LPN, or LVN)		
Operating Room Technician (Surgical)		
Operating Room Technician (Nonsurgical)		
Paramedic		
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	0	0

7. Are all physicians, surgeons, dentists, and medical personnel in this group practice duly licensed/certified to practice medicine in the states(s) in which they provide medical services?

☐ Yes ☐ No If no, please provide an explanation in the Remarks section.

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

☐ Yes ☐ No If yes, please provide an explanation in the Remarks section.

9. Do any of the group members have medical director responsibilities for entities outside of the group?

☐ Yes ☐ No If yes, complete the following questions. Use the Remarks section if needed.

A. Name(s) and location(s) of outside entity(ies): _____

_____

B. Does the outside entity provide coverage for:

Administrative responsibilities? ☐ Yes ☐ No

Direct patient care? ☐ Yes ☐ No

If yes to either of the above, please provide proof of medical professional liability insurance for the entity.

** This classification applies to physician assistants or surgeon assistants who have completed an approved course of study leading to university certification and/or 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.

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 the group attract patients because of reputation in any particular field of medicine? ☐ Yes ☐ No

If yes, please specify: _____

12. Does the group provide the following services:

A. Bariatrics ☐ Yes ☐ No

B. Fertility services ☐ Yes ☐ No

C. Aesthetic/Cosmetic procedures ☐ Yes ☐ No

D. Treatment of prison inmates ☐ Yes ☐ No

E. Does the group 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: _____%

F. Does the group perform activities covered by another professional liability policy?

☐ Yes ☐ No If yes, please provide proof of coverage, including name and address of entity.

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 the group own, control, or staff one or more of the following? If yes, please describe in the Remarks section.

A. Facilities for Overnight Patient Monitoring/Care	☐ Own	☐ Control	☐ Staff	
B. Hospital	☐ Own	☐ Control	☐ Staff	
C. Nursing Home or Long-term Care Facilities	☐ Own	☐ Control	☐ Staff	
D. Surgicenter/Clinic Surgical Outpatient Unit	☐ Own	☐ Control	☐ Staff	
E. Emergency Room	☐ Own	☐ Control	☐ Staff	
F. Birthing Center	☐ Own	☐ Control	☐ Staff	
G. Substance Abuse Program	☐ Own	☐ Control	☐ Staff	
H. Radiation and/or Shock Therapy	☐ Own	☐ Control	☐ Staff	
I. Laboratory	☐ Own	☐ Control	☐ Staff	Annual gross sales: _____ Anatomical
				Annual gross sales: _____ Clinical
J. Imaging Center	☐ Own	☐ Control	☐ Staff	
K. Emergency Vehicles	☐ Own	☐ Control	☐ Staff	
L. Pharmacy	☐ Own	☐ Control	☐ Staff	Annual gross sales: _____
M. Optical Goods Store	☐ Own	☐ Control	☐ Staff	Annual gross sales: _____
N. Hearing Aid Store	☐ Own	☐ Control	☐ Staff	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 to list additional facilities. Please list the name of the facilities and/or provide copies of your contract.

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

Facility: _____ Department: _____

City: _____ State: _____ % of Practice: _____

16. Is the group engaged in any medical research other than IRB-approved clinical trials?

☐ 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. Risk Management

A. Does the group have a risk management program? ☐ Yes ☐ No

If yes, show date of last site inspection: _____
Also, please describe nature of program in the Remarks section.

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

If yes, please provide details in the Remarks section.

C. Please describe how fee-related complaints are handled (Use Remarks section if needed.):

_____

_____

_____

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

If yes, please provide details in the Remarks section, indicating if the physician is reimbursed for the program.

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

If yes, please provide details in the Remarks section, indicating if the physician is reimbursed for the program.

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

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

If yes, when? _____

19. Material Disposal

A. Describe how the group disposes of contaminated materials, human tissue, nuclear materials, or any other hazardous waste:

_____

_____

B. Does the group have have an EPA registration number? ☐ Yes ☐ No

If yes, attach the RCRA or Superfund application forms.

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

If yes, indicate where stored: _____

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

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

E. If applicable, 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. Please describe how the qualifications of new physicians are checked.

_____

_____

B. Are all prospective physicians required to be certified or board eligible?

☐ Yes ☐ No If no, explain reasons in the Remarks section.

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 the Remarks section 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 ☐ Joint Commission ☐ Other _____

MISCELLANEOUS

23. During the preceding six-year period, has any claim or suit been brought against the group, its physicians, or other employees, or after reasonable inquiry are you aware of any incident that has taken place in the last six years that may lead to a claim or suit? ☐ Yes ☐ No

    A. Please attach a copy of loss runs from current and prior carrier(s).

    B. For all losses of $50,000 or more, please complete the Claim Information Form.

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 If yes, explain:

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?

    ☐ Yes ☐ No

27. Has the group, a member physician, or other employee 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, surrendered 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 include 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 any physician's or other employee's ability to practice in their specialty?

    ☐ Yes ☐ No (If yes, please include 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. Have the group, any member physician, or other employee ever been indicted and/or convicted of a crime other than minor traffic violations?

    ☐ Yes ☐ No

NOTICE REGARDING RETROACTIVE COVERAGE

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.

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, attach a typed list or use the Remarks section to provide the name, date of birth, retroactive date, specialty, FTE, and the last day worked for each former employed physician.

(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.)

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

LIMITS OF LIABILITY

32. Clinic/Group Professional Liability

A. Desired limits of liability: ☐ Shared Limits ☐ Separate Limits

Each claim: _____ Aggregate: _____

Note: Shared entity limits means that if the entity is named in a claim it will share in a limit held by another scheduled insured. If separate entity limits are selected, the entity will maintain its own limit of liability and not share in another insured's limit.

B. Desired effective date: _____

C. Current policy expires: _____

D. Is retroactive coverage being requested for the entity?

☐ Yes ☐ No If yes, please indicate retroactive date: _____

33. Retention

A. ☐ Deductible ☐ Self-insured Retention Amount: _____

B. ☐ Quota Share Deductible

34. Does the medical group require umbrella or excess limits?

☐ Yes ☐ No If yes, please describe in the Remarks section.

PREVIOUS INSURANCE

35. 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 six years. If additional space is required, please use the Remarks section. 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: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

B. First prior carrier: _____ Policy number: _____

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

Deductible or self-insured retention: _____ Amount: _____

Retroactive date: _____ Policy period from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

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 from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

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 from: _____ to: _____
MM/DD/YYYY *MM/DD/YYYY*

E. Has the group or group members ever been insured with The Doctors Company in the past?

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

CLAIM INFORMATION

This section should be completed only if you answered yes to question #24 on page 10. Please photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

1. Name of patient: _____

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

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

_____

5. Allegation: _____

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

8. Insurance carrier(s): _____

9. Other defendants: _____

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

11. Conditions and diagnosis at time of incident:

_____

_____

_____

_____

_____

12. Dates and description of professional services rendered:

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

REMARKS SECTION

AGREEMENTS

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

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

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

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

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature | Date

NOTICES

INSURANCE FRAUD WARNING

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

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

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It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

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

KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

NOTICES (CONTINUED)

MAINE
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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

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

MISSOURI
An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

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

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. The absence of such a statement shall not constitute a defense in any prosecution.

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

PENNSYLVANIA
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

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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.

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It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company and agrees with The Doctors Company and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company ("the Attorney"), to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by The Doctors Company Board of Governors.

2. Subscriber designates and appoints the Attorney to be his or her true and lawful agent and Attorney-in-Fact to act in his or her name, place, and stead and in the name of The Doctors Company, to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of The Doctors Company and the business of interinsurance. Subscriber adopts and approves the Management Agreement between The Doctors Company and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of The Doctors Company authority to negotiate all the terms and conditions of the Management Agreement between The Doctors Company and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or The Doctors Company.

4. Subscriber further delegates to the Board of Governors of The Doctors Company all necessary and proper powers to conduct, manage, and control the affairs and business of The Doctors Company, subject to those retained by law or through the Rules and Regulations of The Doctors Company, or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of the liability insurance policy issued by The Doctors Company and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of The Doctors Company.

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of The Doctors Company and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument, and signature of the Application to which this Agreement is attached shall constitute signature of this Agreement. This Agreement shall continue in full force and effect until revoked by the written request of Subscriber who has signed this document. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of The Doctors Company, including the Subscriber who has signed this document.

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company.

This proxy is solicited on behalf of the management of The Doctors Company and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force for five years from the date stated below.

You may revoke this proxy by giving The Doctors Company written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

SIGNATURE (OPTIONAL):

X _____ _____

Signature Date

Type or print name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

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

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

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

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

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

B. Our Obligations and Activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AGREEMENTS

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

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

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

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

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature | Date

NOTICES

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PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company.

This proxy is solicited on behalf of the management of The Doctors Company and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

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SIGNATURE (OPTIONAL):

X _____ _____

Signature Date

Type or print name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

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B. Our Obligations and Activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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