THE DOCTORS COMPANY

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE EXPRESS APPLICATION

For Healthcare Facilities

J11151A 7/17

185 Greenwood Road Napa, CA 94558 (800) 421-2368 Fax: (707) 226-0107 E-mail: sales@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.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current carrier loss runs.

Required Attachments

Please include a current copy of each of the following documents with the application:

☐ Your Declarations Page from your current policy, showing your policy period, limits of liability, retroactive date, and any exclusions that were applied to your policy.

☐ Your audited financial statement.

☐ Your schedule of named insureds.

☐ Your loss runs from all insurance carriers that insured you for the past six years (if applicable).

☐ Your letterhead and advertisements (if applicable).

Except to the extent as may otherwise be provided in the policy and its endorsements, the coverage of a claims-made policy is limited generally to liability for only those claims that are first reported in writing to the Company while the policy is inforce.

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

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

IDENTIFYING INFORMATION

Please complete a separate application for each location.

1. Name of Applicant/Facility: _____

2. Primary address: _____

   City: _____ State: _____ Zip: _____

3. Phone Number: _____ Fax Number: _____

4. Do you: ☐ Lease ☐ Rent Or ☐ Own this location? Sq. Ft. _____

5. E-mail address: _____

   a. Does the applicant operate a Website(s)? ☐ Yes ☐ No

      If yes, site address(es): _____

   b. Is advertising by others accepted on the applicant's Website(s)? ☐ Yes ☐ No

   c. Does an outside vendor maintain or support the applicant's Website(s)? ☐ Yes ☐ No

      If yes, please provide the name: _____

6. Mailing/Billing Address: _____

   City: _____ State: _____ Zip: _____

7. Contact Person: _____

8. Phone Number: _____ Fax Number: _____

9. Federal Tax ID Number: _____

10. Number of Locations: _____
    Please complete a separate application for each location. List additional names and/or locations in the Remarks section and attach a copy of any fictitious name permits or licenses, if applicable.

11. Name of Director: _____

12. Name of Assistant Director: _____

13. Name of Owner: _____

14. Ownership
    a. The applicant is a (check the appropriate box):

    ☐ Corporation ☐ Limited Liability Partnership ☐ Sole Proprietorship

    ☐ General Partnership ☐ Professional Association ☐ Other _____

    b. Applicant operates: ☐ For Profit ☐ Not For Profit

    Please list names of all partners and/or shareholders in the Remarks section.

15. Type of organization (please check all appropriate boxes):

☐ Birthing Center	☐ Group Home	☐ Developmental Disability Center
☐ Cardiac Rehabilitation Center	☐ Halfway House	☐ Physical/Occupational Rehabilitation Center
☐ College/University Health Center	☐ Health Department	
☐ Community Health Center	☐ Home Health Agency	☐ Surgicenter
☐ Crisis Stabilization Center	☐ Hospice	☐ Trauma Rehabilitation Center
☐ Detoxification Facility	☐ Laboratory; Type _____	☐ Urgicenter
☐ Dialysis Center	☐ Medical Registry Service	☐ Visiting Nurses Association
☐ Drug/Alcohol & Substance Abuse Center	☐ Mental Health Clinic	☐ X-Ray Imaging Center
☐ Emergicenter	☐ Optical Establishment	☐ Other _____

16. Does the facility use an Electronic Health Record? ☐ Yes ☐ No

    If yes, please provide the name of the facility's EHR provider: _____

IDENTIFYING INFORMATION

17. Does your facility have board and care exposure, including, but not limited to: detoxification facilities, group homes, halfway homes, or nursing facilities? ☐ Yes ☐ No

18. Is your organization currently accredited by:

    a. The Joint Commission? ☐ Yes ☐ No

    b. Any other accrediting organization(s)? ☐ Yes ☐ No

    If yes, please specify: _____

19. Are you a member of any state association(s) or any other industry association(s)? ☐ Yes ☐ No
    If yes to either, please give name(s) and specifics in the Remarks section.

20. LIMITS DESIRED (professional and general liability limits MUST be the same):

Healthcare Facility Professional Liability

Claims Made Coverage

☐ $1,000,000 Each Claim/$3,000,000 Aggregate Limit

☐ $_____ Each Occurrence/$_____ Aggregate Limit

General Liability
List all general liability products you currently carry on your facility:

_____

_____

_____

Occurrence Coverage

☐ $1,000,000 Each Occurrence/$3,000,000 Aggregate Limit

☐ $_____ Each Claim/$_____ Aggregate Limit

21. Requested effective date (coverage start date): _____ Requested retroactive date (prior acts date): _____
    Please attach a copy of your most recent Declarations Page from your present carrier.

DESCRIPTION OF SERVICES

22. Services Provided (Please check each box that applies, provide the requested information for each classification, and provide projected information for the next 12 months. If not applicable, please note as "N/A".)

[1]Use a threshold count. Count each patient each time he or she enters the healthcare facility for health-related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health-related services.

[2]Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

[3]This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible accounts, or amount billed but not paid by third-party payers.

[4]Surgical procedures are defined as all procedures cutting beyond the subcutaneous layer, hemorrhoidectomies and all other procedures limited to the anal ring, herniorraphies (including inguinal, femoral, epigastric, ventral, and umbilical), myringotomies, tonsillectomies, and adenoidectomies.

Counseling/Rehabilitation	Previous 12 Months' Visits[1]	Projected 12 Months' Visits[1]
☐ Cardiac Rehabilitation		
☐ Crisis Stabilization		
☐ Developmental Disability		
☐ Mental Health/Counseling		
☐ Physical or Occupational Rehab		
☐ Substance Abuse		
Counseling		
Skilled Medical Services		
☐ Trauma Rehabilitation Therapy		
Transitional Living		
Skilled Nursing		
☐ Weight Loss Center		

Laboratory	Previous 12 Months' Receipts[3]	Projected 12 Months' Receipts[3]
☐ Dental		
☐ Medical		
☐ Ocular		
☐ Optical Establishment		
☐ Pathology		
☐ Pharmaceutical		
☐ Quality Control/Reference		
☐ Research/Development		
☐ X-ray/Imaging Center		

DESCRIPTION OF SERVICES

Surgical Center	Previous 12 Months' Visits[1]	Projected 12 Months' Visits[1]
☐ Abortion Clinic	_____	_____
☐ Birthing Center	_____	_____
☐ Surgicenter	_____	_____

Laboratory	Previous 12 Months' Receipts[3]	Projected 12 Months' Receipts[3]
☐ Organ or Tissue Procurement (No Direct Processing or Contact)	_____	_____
☐ Organ or Tissue Procurement (Direct Processing or Contact)	_____	_____

FOR THE FOLLOWING SERVICES, DESCRIBE YOUR OPERATIONS IN THE REMARKS SECTION

Home Care/Hospice	Previous 12 Months' Visits[1]	Projected 12 Months' Visits[1]	Previous 12 Months' Beds[2]	Projected 12 Months' Beds[2]
☐ Hospice Care	_____	_____	_____	_____
☐ Intravenous Therapy	_____	_____	_____	_____
☐ Personal/Companion Care	_____	_____	_____	_____
☐ Rehabilitation Therapy	_____	_____	_____	_____
☐ Respiratory Therapy	_____	_____	_____	_____
☐ Skilled Care	_____	_____	_____	_____

Schools For Home Healthcare Professionals	Previous 12 Months' No. of Students	Projected 12 Months' No. of Students
☐ Dental	_____	_____
☐ Medical	_____	_____
☐ Nursing	_____	_____
☐ Optometry	_____	_____
☐ Other	_____	_____
☐ Skilled Care	_____	_____

Treatment	Previous 12 Months' Visits[1]	Projected 12 Months' Visits[1]
☐ College or University Health Center	_____	_____
☐ Dialysis	_____	_____
☐ Emergicenter	_____	_____
☐ Health Department	_____	_____
☐ Urgicenter	_____	_____

Ambulance Companies	No. of Staff
☐ Air Ambulance	_____
☐ Ambulance Service Company	_____
☐ Medical Registry Services/ Medical Personnel Pools	_____

DESCRIPTION OF SERVICES

Examinations		Previous 12 Months	Projected 12 Months
☐ Health Examinations (Diagnosis and Inoculations/No Follow-up)	Annual Exams	_____	_____
☐ Insurance Physicals	Annual Physicals	_____	_____
☐ Pharmacy	Annual Receipts	_____	_____
☐ Blood or Plasma Bank	Annual Donations	_____	_____

Community Health Center (Nonprofit)	Previous 12 Months	Projected 12 Months
☐ Visits	_____	_____
☐ Physician Hours	_____	_____
☐ Surgical Procedures[4]	_____	_____
☐ Deliveries	_____	_____
☐ Abortions	_____	_____

23. Locations Where Services Are Provided—In Percentages (%) (TOTAL MUST EQUAL 100%)

☐ Private Homes	_____%	☐ Clinics	_____%
☐ Nursing Homes	_____%	☐ Doctor's Office	_____%
☐ Hospitals	_____%	☐ Other Locations	_____%

Please Specify _____

24. Types Of Services Provided—In Percentages (%) (TOTAL MUST EQUAL 100%)

☐ Personal Care Chore or Companion	_____%	☐ Radiation	_____%
☐ Rehabilitation	_____%	☐ Radiation Therapy	_____%
☐ Infusion Therapy	_____%	☐ Skilled Nursing Care	_____%
☐ Hospice	_____%	☐ Training Consultants	_____%
☐ Obstetrical Services	_____%	☐ Infant Care	_____%
☐ Adult Daycare	_____%	☐ Pediatric Care	_____%
☐ Child Daycare	_____%	☐ Retail Pharmacy	_____%
☐ Medical Equipment Supplier	_____%	☐ Closed Pharmacy	_____%
☐ Meals on Wheels	_____%	☐ Clinics Owned/Operated	_____%
☐ Respiratory Therapy Check One: ☐ Trachea Care ☐ Ventilator Care	_____%	☐ Other Services	_____%

Please Specify _____

_____

_____

_____

_____

DESCRIPTION OF SERVICES

25. Services Of Healthcare Professionals—Indicate Number In Each Category

HEALTHCARE PROFESSIONALS	EMPLOYEES		CONTRACTORS		VOLUNTEERS	
	FULL TIME	PART TIME	FULL TIME	PART TIME	FULL TIME	PART TIME
Acupuncturists						
Chiropractors						
Dentists						
Dietitians						
Emergency Medical Technicians						
Hearing Aid Dispensers						
Home Health Aides						
LPNs/LVNs						
Marriage and Family Therapists						
Mental Health Counselors						
Nurses (RNs)						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinicians						
Nutritionists						
Occupational Therapists						
Opticians						
Orthopedic Technicians						
Oral and Maxillofacial Surgeons						
Perfusionists						
Pharmacists						
Physical Therapists						
Physicians						
Physician Assistants						
Podiatrists						
Psychologists						
Respiratory Therapists						
Social Workers						
Speech Therapists						
Technicians						
Other (Describe in the Remarks section)						
TOTALS	0	0	0	0	0	0

SALARIED EMPLOYEES/INDEPENDENT CONTRACTORS

26. Physicians Who Are Salaried Employees of or Independent Contractors for the Facility
Each physician must complete a separate physician application

PHYSICIAN'S NAME	SPECIALTY	EMPLOYMENT DATE	NUMBER OF HOURS WORKED PER MONTH

IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE REMARKS SECTION.

CLAIMS/LOSS HISTORY

27. Prior PROFESSIONAL LIABILITY coverage for the past six (6) years

INSURANCE CARRIER	LIMITS OF LIABILITY	EFFECTIVE DATES	ANNUAL PREMIUM	CLAIMS MADE FORM	RETRO DATE

28. Has a claim or suit for alleged malpractice been asserted against the applicant within the last six (6) years? ☐ Yes ☐ No
If yes, please complete the attached Claim Information form for each claim/suit.

29. Is there knowledge of any incident(s) that might provide a basis for any claim or suit to be brought against the applicant? (Include any non-billing or non-record transfer related requests for medical records.) ☐ Yes ☐ No
If yes, please provide details in the in the Remarks section.

30. Has any insurance company ever canceled coverage, declined coverage, modified coverage (e.g., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any professional liability insurance? ☐ Yes ☐ No
If yes, please provide details in the in the Remarks section and include company name and policy number.

31. Do any of the physicians working at your facility have medical malpractice insurance coverage through The Doctors Company? ☐ Yes ☐ No
If yes, how many and what percentage of procedures at your facility are performed by these physicians?

Number _____ Percent _____

32. Attach a list of names of the physicians insured by The Doctors Company.

CLAIM INFORMATION

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

NOTE: Please provide sufficient information for underwriters to evaluate the medical aspects of the case, especially those relating to your involvement.

1. Name of patient: _____

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

4. Allegation(s): _____

5. Date of incident: _____ 6. Date claim was made or filed: _____

7. Insurance carrier(s): _____

8. Additional defendants: _____

9. Location of occurrence: _____

10. Present status: ☐ Open claim a. Exact date closed: _____
☐ Closed claim b. Total settlement or judgment $ _____
c. Amount paid on your behalf $ _____

11. Condition and diagnosis at time of incident (Include dates of visits):

12. Date and description of treatment rendered (Include dates of visits):

13. Condition of patient/resident subsequent to treatment (Include dates of follow-up treatment):

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.

COLORADO
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.

TENNESSEE
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.

VIRGINIA
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 and civil damages.

WASHINGTON
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