THE DOCTORS COMPANY

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE EXPRESS APPLICATION

For the John A. Burns School of Medicine
and University Clinical Education Research Associates

J7157 10/08

185 Greenwood Road Napa, CA 94558-0900 (800) 421-2368 fax (707) 257-8970 e-mail TDCSales@thedoctors.com www.thedoctors.com

APPLICATION INSTRUCTIONS AND CHECKLIST

Prior to completing the attached application, please read and observe the following instructions. Please verify that all required attachments are included in order to assist us in processing 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."
- The Medical Procedures questionnaire must be completed. If the procedures you perform are not mentioned in the questionnaire, please list them in the Remarks Section.
- If you wish to explain any of your answers, please use the Remarks Section. If you need additional space, please continue your answers on your letterhead and attach it to the application.
- Claims information should be provided for a five-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 company loss runs.

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

☐ Please attach a copy of your curriculum vitae (CV).

☐ Please enclose a copy of 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.

☐ Please include a copy of your loss runs from all insurance carriers that insured you for the past five years (if applicable).

☐ Please include a copy of 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 in force.

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 call your broker/agent or The Doctors Company Member Services at (800) 421-2368.

I authorize the following person to be added to our group policy with The Doctors Company.

SIGNATURE REQUIRED: **X** _____ _____

Authorized Departmental Signature — Date

IDENTIFYING INFORMATION

1. First name:_____ Middle name:_____ Last name:_____ Suffix:____ Title:_____
2. Date of birth *(MM/DD/YYYY)*:_____ 3. Social Security no.: _____ 4. Gender: ☐ Male ☐ Female
5. E-mail address(es): _____
6. Web site address(es): _____ 7. National Provider ID no. *(if available)*: _____
8. This application is a ☐ Request to join a physician or group already insured with The Doctors Company under policy number: _____ *or* ☐ New application
9. Practice address: Please list all office locations and entities for which you are requesting coverage. Please indicate if they are: hospital, medical office, surgery center, nursing home, urgent care center, correctional facility, etc.

_____

_____

10. Office phone number:_____ Fax number: _____
11. Home address and telephone number: _____
12. Billing address: _____
13. Requested effective date *(coverage start date)*:_____

PRACTICE INFORMATION

14. Primary specialty: _____ Secondary specialty: _____
15. Are you ABMS or AOA Board certified? ☐ Yes ☐ No If yes, date of certification or recertification: _____
16. Are you currently participating in a Maintenance of Certification Program? ☐ Yes ☐ No
17. Please indicate your medical license(s): License state: _____ Number: _____
18. a) Please indicate your average number of practice hours per week that will be covered by this policy including office hours, administrative activities, direct patient care, surgery, consultation, etc. (excluding on-call): _____
    b) Estimate the number of patients seen on an average weekly basis: _____
19. Current carrier:_____ Number of years with carrier:_____ Current premium:_____
20. Have you had any time period where you were uninsured? ☐ Yes ☐ No *If yes, please explain in Remarks Section.*
21. Are you affiliated with any other doctor or group? ☐ Yes ☐ No *If yes, please provide information below.*

_____

22. Do you have other locations where you provide or serve as the following:
    Medical director: ☐ Yes ☐ No Medical services: ☐ Yes ☐ No
    Independent contractor: ☐ Yes ☐ No Supervision only: ☐ Yes ☐ No
    If yes to any of the above, please provide name and location: _____

_____

23. Do you maintain an ownership interest (in whole or in part) in any entity(ies) related to the practice of medicine (e.g., spa, laboratory, etc.)?
    ☐ Yes ☐ No *If yes, please list name(s) and explain:* _____

_____

24. a) Do you share office space, employees, billing, or letterhead with any physician?
    ☐ Yes ☐ No *If yes, provide details in the Remarks Section or supporting documents.*
    b) Is this physician an employee of JABSOM/UCERA?
    ☐ Yes ☐ No
25. Please indicate if you are an active member of any medical society or specialty association:

_____

INSURANCE INFORMATION

26. Please indicate the limits of liability requested (example: $1,000,000 per claim, $3,000,000 annual aggregate):

    Per claim: $1,000,000 Annual aggregate: $3,000,000

27. Have your limits of liability changed (increased or decreased) in the past three years? ☐ Yes ☐ No

    If yes, please indicate your prior limits of liability: _____

28. Are you involved or do you participate in non-IRB-approved clinical research trials? ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

29. Do you have a contract with nursing homes or correctional facilities? ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

30. Are you now being or have you ever been evaluated for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, or any mental illness? ☐ Yes ☐ No
    If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any agreement you have made with any recovery organization.

31. Have you become aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? *If yes, please accompany this application with a letter from your treating physician or institution outlining dates of treatment, results of treatment, and current status, and any limitations on your ability to practice the specialty(ies) listed.* ☐ Yes ☐ No

32. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted or had an involuntary deductible or surcharge assessed against you? NOTE: MISSOURI APPLICANTS DO NOT RESPOND. ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

33. Have you ever appeared before, been investigated by, entered into any consent agreement with, or do you have an investigation currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental agency? *If yes, please provide copies of complaint and disposition documents.* ☐ Yes ☐ No

34. Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way? *If yes, please provide details in the Remarks Section or supporting documents.* ☐ Yes ☐ No

35. Has any physician, patient, or insurance plan ever filed a complaint against you with any medical association/society or foundation, consumer protection agency, Chamber of Commerce, or Better Business Bureau? ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

36. Have you ever been indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

37. Has your participation in any governmental or nongovernmental health program (e.g., Medicare, Medicaid, HMO, PPO, or any managed care program) ever been suspended, placed on probation, terminated, or limited in any way? *If yes, please provide details in the Remarks Section or supporting documents.* ☐ Yes ☐ No

38. Have your staff privileges at any hospital or health care facility ever been suspended, refused, revoked, placed on probation, or in any way restricted, or do you have an investigation relative to your staff privileges pending or in progress at any hospital or health care facility? *If yes, please provide details in the Remarks Section or supporting documents.* ☐ Yes ☐ No

39. Have you ever been accused of sexual misconduct of any kind in your professional capacity? ☐ Yes ☐ No
    If yes, please provide details in the Remarks Section or supporting documents.

40. Are there any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have not been reported to your current or prior medical professional liability carrier? *If yes, please provide details in the Remarks Section or supporting documents.* ☐ Yes ☐ No

41. Have you been a party to a malpractice claim, suit, or incident in the past five years? ☐ Yes ☐ No
    If yes, please complete the attached Claim Information form for each claim/incident.

MEDICAL PROCEDURES

Please indicate if you or any of your staff perform the following procedures:	Physician	Non-Physician Licensed Staff	Non-Licensed Staff
Botox Injection	☐	☐	☐
Chemical Peel	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Microdermabrasion	☐	☐	☐
Permanent Make-up	☐	☐	☐
Sclerotherapy	☐	☐	☐
Other Cosmetic Procedures	☐	☐	☐

Do you perform any procedures for which you did not receive training in your residency or that are outside the customary scope of practice of your specialty?
☐ Yes ☐ No *If yes, please list the procedures:*

_____

_____

Please check all procedures that you perform:

CARDIOLOGY

- ☐ Cardiac Catheterization
- ☐ Coronary Angiography
- ☐ Coronary Angioplasty/Stents

COSMETIC PROCEDURES

- ☐ Abdominoplasty
- ☐ Autologous Fat Injection
- ☐ Blepharoplasty
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Coronal Lift
- ☐ Endoscopic-Assisted Forehead Lift
- ☐ Facial Laser Resurfacing
- ☐ Hair Implant
- ☐ Implants Other than Breast
- ☐ "Lifestyle" Lift
- ☐ Liposuction
- ☐ Penile-Related Cosmetic Procedure
- ☐ Rhinoplasty *(cosmetic)*
- ☐ Rhinoplasty *(functional only)*
- ☐ Rhytidectomy
- ☐ Sex Reassignment Surgery
- ☐ Thread Lift *(contour threads)*

PRIMARY CARE

- ☐ Adenoidectomy
- ☐ Anal Fistulectomy
- ☐ Analgesia, IV Conscious Sedation
- ☐ Anesthesia *(spinal)*
- ☐ Appendectomy
- ☐ Cesarean Section Delivery
- ☐ Cholecystectomy
- ☐ Circumcision *(adult)*
- ☐ Circumcision *(pediatric only)*
- ☐ Closed Reduction *(other than simple)*
- ☐ Colonoscopy
- ☐ Cryotherapy and LEEPs
- ☐ Culdocentesis
- ☐ Dilation and Curettage
- ☐ Ectopic Pregnancy
- ☐ Elective Cardioversion
- ☐ Endometrial Biopsy
- ☐ Endoscopic Procedures
- ☐ Hemorrhoidectomy
- ☐ Hydrocelectomy
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Myringotomy
- ☐ Nasal Polypectomy
- ☐ Normal Vaginal Delivery
- ☐ Oophorectomy
- ☐ Orchidectomy
- ☐ Prenatal and Postnatal Care
- ☐ Salpingectomy
- ☐ Tendon Repair
- ☐ Therapeutic Abortion
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Vein Stripping

OPHTHALMOLOGY *(If not applicable, please skip this section.)*

- ☐ Medical Procedures Only
- ☐ All Surgical Procedures
- ☐ Limited Surgical Procedures—limited to minor surgical procedures, including:
  - • Assisting in Surgery
  - • Laser Ablation
  - • Laser Capsulotomy
  - • Laser Iridoplasty
  - • Laser Iridotomy
  - • Laser Punctual Closure
  - • Laser Trabeculoplasty
  - • Thermage
  - • Wedge Resection

PHYSICAL MEDICINE AND REHABILITATION/PAIN MANAGEMENT *(If not applicable, please skip this section.)*

- ☐ Block *(spine and non-spine)*
- ☐ Cryoanalgesia
- ☐ Dorsal Column Stimulator Implants
- ☐ Epidural or Spinal Catheter
- ☐ Intra-Articular Block *(joint injection)*
- ☐ Intradiscal Electrothermal Therapy
- ☐ Myofascial Trigger Point Injections
- ☐ Nerve Root Injections
- ☐ Radio Frequency Nerve Ablation
- ☐ Rapid Detoxification
- ☐ Spinal Infusion Implant
- ☐ Spinal Infusion Pump
- ☐ Spinal Stimulation Implant
- ☐ Spinal Stimulation Programming
- ☐ Stellate Ganglion Block

General Surgeons only: Do you perform bariatric surgery? ☐ Yes ☐ No

Orthopedic Surgeons only: Do you operate on the spine? ☐ Yes ☐ No

Obstetricians, Gynecologists, and Endocrinologists only:

A. If you are an obstetrician, how many deliveries do you perform per year? _____

B. Do you perform in vitro fertilization (IVF) or other ART procedures? ☐ Yes ☐ No

SIGNATURE REQUIRED: **X** _____ _____

Applicant Signature Date

CLAIM INFORMATION

This section should be completed only if you answered yes to question #41 on page 2. 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, etc.):

_____

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 and follow-up visits if known):

_____

_____

_____

_____

_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE REQUIRED: **X** _____ _____

Applicant Signature Date

REMARKS SECTION

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

This Agreement is entered into by and between The Doctors Company, an interinsurance Exchange (including its subsidiaries, Underwriter for the Professions Insurance Company and Professional Underwriters Liability Insurance Company), hereinafter referred to as "We" and _____ (Applicant Name), hereinafter referred to as "You."

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 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 are Your "business associate." We must use and/or disclose information that identifies an individual, relates to health, health treatment, or health care payment ("Protected Health Information") and is maintained in any form (e.g., electronic, paper, verbal) in Our performance of services with respect to Your application for insurance, and We agree to abide by the assurances, terms, and conditions contained herein in the performance of Our obligations.

This Agreement 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 involve the use and disclosure of Protected Health Information as defined by the Privacy Regulation. These Services may include, among others, quality assessment, quality improvement, outcomes evaluation, protocol, and clinical guidelines development, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs to improve the skills of health care 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 B(5) below; (ii) as directed by You; 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:

(1) Our **Business Activities**.

We may:

(a) Use the Protected Health Information in Our possession for Our proper management and administration and to fulfill any of Our present or future legal responsibilities provided that such uses are permitted under state and federal confidentiality laws; and

(b) Disclose the Protected Health Information in Our possession to third parties for the purpose of Our proper management and administration or to fulfill any of Our present or future legal responsibilities 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).

(2) Our **Additional Activities**.

In addition to using the Protected Health Information to perform the Services set forth above, We may:

(a) 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 health care 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 explicit authorization; and

(b) 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.

B. Our Responsibilities.

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;

BUSINESS ASSOCIATE AGREEMENT (CONTINUED)

(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 within ten (10) business days of Our discovery of such unauthorized use and/or disclosure;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and appropriate 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, or 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 U.S. 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 health care operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Whether or not an insurance policy is issued as a result of this application, 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; and

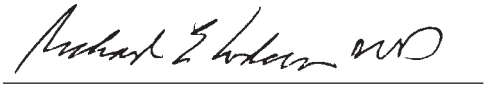
(9) In those rare instances when You would be required to honor an individual's request for access and/or amendment of Protected Health Information disclosed to Us, We will assist You to comply with Your duties under 45 C.F.R. Sections 154.524 and 164.526. However, usually You will not be required to 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 superceding 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 if We violate a material term of this Agreement.

SIGNATURE REQUIRED: **X** _____ _____

Applicant Signature | Date

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 & NOTICES

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information or material misrepresentation will 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—in ink—and returned the original to the company with the required payment.

(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability 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: I understand that in connection with this application for insurance, the company may review my credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. The company may use a third party in connection with the development of my insurance score.

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.

SIGNATURE REQUIRED: **X** _____ _____

Applicant Signature | Date

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant 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.

Notice to District of Columbia Applicants: 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.

Notice to Florida Applicants: 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.

Notice to Kentucky Applicants: 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.

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

Notice to Maine Applicants: 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.

Notice to Maryland Applicants: 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.

Notice to Missouri Applicants: 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.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 (five thousand dollars) and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he or she 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.

AGREEMENTS & NOTICES

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

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

Notice to Tennessee Applicants: 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.

Notice to Virginia Applicants: 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, denial of insurance benefits, and civil damages.

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

SIGNATURE REQUIRED: **X** _____ _____

Applicant Signature | Date

PART 1 – 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, an Interinsurance Exchange.

This proxy is solicited on behalf of the management of the Exchange 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 Exchange 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: _____

Street: _____

City: _____ State: _____ Zip code: _____

PART 2 – 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, an Interinsurance Exchange ("the Exchange"), and agrees with the Exchange 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 Exchange's Board of Governors.

2. Subscriber designates and appoints the Attorney to be its true and lawful agent and Attorney-in-Fact to act in its name, place, and stead and in the name of the Exchange, 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 Exchange and the business of interinsurance. Subscriber adopts and approves the Management Agreement between the Exchange 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 Exchange authority to negotiate all the terms and conditions of the Management Agreement between the Exchange 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 Exchange.

4. Subscriber further delegates to the Board of Governors of the Exchange all necessary and proper powers to conduct, manage, and control the affairs and business of the Exchange, subject to those retained by law or through the Rules and Regulations of the Exchange, 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 a claims-made insurance policy issued by the Exchange 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 Exchange.

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 Exchange 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. 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 Exchange, including the Subscriber who has signed this document.

SIGNATURE REQUIRED:

X _____ _____

Signature Executed this day of

Type or print name:_____