

MIEC Joining Group / Entity Affiliation Physicians and Surgeons Application for Claims-Made Professional Liability Insurance

IMPORTANT INSTRUCTIONS – PLEASE READ CAREFULLY

This application is specifically for individual physicians who are joining a group as a member or employee. If not, please go to the **Applications** page under the resources tab on www.miec.com and complete the application titled: *MIEC Solo Physician Application for Claims-Made Professional Liability Insurance*

- **COMPLETE ALL QUESTIONS:** A complete application will allow us to process your application as quickly as possible.

- **ATTACHMENTS:** Certain portions of the application may require information that is already reflected on personal documents such as the curriculum vitae, etc. For your convenience we include the option to indicate “Attachment contains this information” rather than require that you type in all information. When you indicate “Attachment contains this information” you **warrant** to MIEC that the information contained in the attachments is true and correct. MIEC is relying upon the information in the attachments to make a determination of whether to issue coverage.

- **ADDITIONAL COMMENTS:** If you wish to provide detailed responses to any of the questions in the application, please use the “Additional Comments” section on page 9 of the application.

For assistance, you may call our main office at the number below from 8:00 a.m. to 5:00 p.m. PST or E-mail us at the address below. Please include in your E-mail the location of your practice or where you plan to practice including the city, state and zip code.

800-227-4527
(510) 428-9411
FAX: (510) 654-4634
E-MAIL: UNDERWRITING@MIEC.COM



6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

MIEC Joining Group / Entity Affiliation Physicians and Surgeons Application for Claims-Made Professional Liability Insurance

Name of group you will be joining: _____

Status: Employee Member

IMPORTANT NOTICE

You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

PERSONAL INFORMATION / REQUESTED COVERAGE / LIMITS

ANSWERS 1-3

1. PERSONAL INFORMATION Male Female

First Name _____ M.I. _____ Last Name _____ Date of Birth _____ Place of Birth _____ State _____ Country _____
(mm/dd/yyyy)

Home Address _____ City _____ State _____ Zip Code _____ Telephone Number _____

E-mail _____ Social Security Number or Tax I.D. Name _____ Federal E.I.N. _____

NOTE: Your mailing address will be the same as the group you are joining, unless you advise otherwise.

2. REQUESTED COVERAGE EFFECTIVE DATE

_____ Date (mm/dd/yyyy)

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

3. REQUESTED LIABILITY LIMITS

Check one: Limit Per Claim / Annual Aggregate

- \$500,000/\$1,500,000
 \$2,000,000/\$4,000,000
 \$4,000,000/\$6,000,000
 \$1,000,000/\$3,000,000
 \$3,000,000/\$5,000,000
 \$5,000,000/\$7,000,000

NOTE: Due to the potential for shared liability, we recommend that all physicians practicing in an employer-employee relationship, ostensible or formal partnership, medical association or medical corporation be insured with MIEC at the same limits of liability.

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department

4. LICENSES

A. List All Medical Licenses. Any additional licenses may be listed on separate attachment or in the Additional Comments section on page 9.

1. State License Number Date Licensed Expiration Date 3. State License Number Date Licensed Expiration Date

2. State License Number Date Licensed Expiration Date 4. State License Number Date Licensed Expiration Date

B. DEA License Number Date of Issue Expiration Date

5. BOARD CERTIFICATION

Are you certified by one or more boards of the American Board of Medical Specialties? Yes No

Name of Board Year Originally Certified Certification Expires Recertified (year)

Name of Board Year Originally Certified Certification Expires Recertified (year)

If not currently certified, are you scheduled to take the Board examination? Yes No If yes, when? _____

If eligible, have you taken the written exam? Yes No When? _____ Results _____

If eligible, have you taken the oral exam? Yes No When? _____ Results _____

If you are no longer eligible to take the board exams, state reason.

6. CONTINUING MEDICAL EDUCATION

How many hours of category 1 CME have you taken in each of the last two years? _____
(last year) (2 years prior)

Attachment contains this information

7. MEDICAL SCHOOL

School _____

City State Country From To Degree

Attachment contains this information

8. INTERNSHIP

Hospital City State From To

Attachment contains this information

9. RESIDENCY

Hospital City State From To

Medical Specialty Residency completed? Yes No

Attachment contains this information

10. ADDITIONAL RESIDENCY

_____ Hospital _____ City _____ State _____ From _____ To _____
 Medical Specialty _____ Residency completed? Yes No

11. FELLOWSHIPS AND ADDITIONAL MEDICAL TRAINING

Attachment contains this information

_____ Hospital/Facility _____ City _____ State _____ Type of Training _____ From _____ To _____

SPECIALTY / HOSPITAL PRIVILEGES

12. SPECIALTY

- A. What is your medical specialty? _____
 Do you limit your practice to this specialty? Yes No
- B. Do you have a subspecialty? If yes, please describe. _____
 Do you limit your practice to this subspecialty? Yes No
- C. Are you entering the private practice of medicine for the first time? Yes No

If yes to question C., but not just completing your residency, please describe previous type of practice (e.g., teaching hospital, governmental agency, military).

13. HOSPITAL AND AMBULATORY SURGERY CENTER PRIVILEGES

Attachment contains this information

None

List all hospitals and ambulatory surgery centers where you currently have privileges or have applications for privileges pending. Indicate type of privileges and restrictions, if any. If you want MIEC to send evidence of coverage (certificate of insurance) to any of these hospitals, please indicate.

_____ Hospital/Facility _____ City _____ Type of Privileges _____ Restrictions _____ *Certificate?
 Yes No

_____ Hospital/Facility _____ City _____ Type of Privileges _____ Restrictions _____ *Certificate?
 Yes No

**A certificate of your insurance will be sent only if you request it and if MIEC approves your application for insurance. Any additional privileges may be listed on separate attachment or in the Additional Comments section on page 9.*

PRACTICE, SCOPE AND PROCEDURES

14. Do you have a "solo" medical corporation? Yes No

If yes, name: _____

15. OTHER ASSOCIATED PHYSICIANS

Do you practice with other physicians outside of this group? Yes No

If yes, list the physician(s) and indicate the nature of your association (e.g. common billing, share offices, share employees, common letterhead).

_____ Name of Physician(s) _____ Nature of association _____

16. OTHER PRACTICE LOCATION(S)

Name	Address	Type of Association
------	---------	---------------------

Duties	Number of Weekly Hours	Percentage of Weekly Practice
--------	------------------------	-------------------------------

Is the facility insured for professional liability? (If yes, submit a copy) Yes No

Does the facility's coverage extend to you? Yes No

Must evidence of your coverage be submitted to the facility? Yes No

If you have a written contract, please attach a copy of the contract to this application. Any additional facilities may be listed on separate attachment or in the Additional Comments section on page 9.

17. PRACTICE ACTIVITY (FULL-TIME/PART-TIME)

A. Are you applying for full-time coverage? Yes No If yes, skip to #18.

B. Are you applying for part-time coverage not more than 20 hours per week, non-surgical practice? Yes No

If yes, you must complete the following:

1. Days Per Week: _____ Hours Per Day (office): _____

Patients Per Week: _____ Hours Per Day (hospital): _____

2. Name of on-call physician: _____

3. Provide a description of this part-time practice: _____

4. Provide an outline of your activities when you are not practicing or for which other professional liability coverage is provided and will not be covered by MIEC:

18. SCOPE OF PRACTICE

A. Do you take and interpret X-rays in your office? Yes No

If yes, describe type of X-rays taken and interpreted: _____

B. If you are a psychiatrist and currently participate in managed care programs, please respond to the following questions.

1. Is therapy limited by the managed care organization (length of time, number of sessions)? Yes No

If yes, please describe: _____

2. Are type and amount of medications prescribed to enrollees dictated by the health plan? Yes No

If yes, please describe: _____

3. Does the plan encourage non-physician psychotherapy versus physician treatment and evaluation? Yes No

If yes, please describe the relationship between non-physician therapists and you regarding care and treatment of enrollees.

C. Do you participate in teletechnology? Yes No

If yes, please call for questionnaire.

D. Do you have a concierge medicine practice? Yes No

If yes, describe fully on separate attachment or in the Additional Comments section on page 9.

E. Do you specialize in weight control practice? Yes No

If yes, describe fully on separate attachment or in the Additional Comments section on page 9.

18. SCOPE OF PRACTICE, cont'd.

- F. Do you prescribe or dispense medications for weight control purposes? Yes No
 If yes, describe fully on separate attachment or in the Additional Comments section on page 9.
- G. Do you specialize in, or does a significant portion of your practice include therapy or counseling for sexual dysfunction? Yes No
 If yes, explain methodology: _____
- H. Do you specialize in, or does a significant portion of your practice include drugs, treatment or therapy for pain management? Yes No
 If yes, please call for a questionnaire.
- I. Do you use experimental procedures, drugs or therapy in treatment or surgery? Yes No
 1. If yes, do you follow an FDA-approved protocol? Yes No
 If no, describe fully on separate attachment or in the Additional Comments section on page 9.

19. PROCEDURES

Check here if none. Check all procedures you perform, and provide estimates of how many you perform per year.

- | | | | |
|---|---------|---|---------|
| <input type="checkbox"/> Acupuncture | # _____ | <input type="checkbox"/> Laser hair removal ¹ | # _____ |
| <input type="checkbox"/> Angiography | # _____ | <input type="checkbox"/> Laser skin resurfacing ¹ | # _____ |
| <input type="checkbox"/> Angioplasty | # _____ | <input type="checkbox"/> Mesotherapy ³ | # _____ |
| <input type="checkbox"/> Aortography | # _____ | <input type="checkbox"/> Pacemaker insertions, temporary | # _____ |
| <input type="checkbox"/> Cardiac catheterization | # _____ | <input type="checkbox"/> Pacemaker insertions, permanent | # _____ |
| <input type="checkbox"/> Contrast media in CNS | # _____ | <input type="checkbox"/> Periocular tattooing | # _____ |
| <input type="checkbox"/> Coronary angiography | # _____ | <input type="checkbox"/> Prolotherapy ³ | # _____ |
| <input type="checkbox"/> Cosmetic Procedures ¹ | # _____ | <input type="checkbox"/> Therapeutic user of radioactive material | # _____ |
| Types: _____ | | <input type="checkbox"/> Use of chelation therapy ³ | # _____ |
| <input type="checkbox"/> Drug shock therapy ² | # _____ | <input type="checkbox"/> Use of injectable liquid silicone ³ | # _____ |
| <input type="checkbox"/> Hair transplants ¹ | # _____ | <input type="checkbox"/> Use of laetrile ² | # _____ |
| <input type="checkbox"/> IVPs | # _____ | | |

¹ Additional information required, or not necessary if you are Board certified dermatologist, plastic surgeon or otolaryngologist. Please attach description of cosmetic procedures that you perform and evidence of training and certification.

² MIEC does not provide coverage for these procedures.

³ Underwriting Committee approval required.

20. SURGICAL PROCEDURES

Check here if none. Check all surgical procedures you perform and provide an estimate of the percentage of your total medical practice each represents. Do not include assisting at surgery.

	# Performed Per Year / Percent		# Performed Per Year / Percent
<input type="checkbox"/> Abortions _____ Type/Trimester	_____/_____%	<input type="checkbox"/> Neurosurgery	_____/_____%
<input type="checkbox"/> Anesthesiology ¹	_____/_____%	<input type="checkbox"/> Obstetrics ¹	_____/_____%
<input type="checkbox"/> Cardiovascular surgery	_____/_____%	<input type="checkbox"/> Orthopedic surgery (include closed reduction)	_____/_____%
<input type="checkbox"/> Chymopapain injections ¹	_____/_____%	<input type="checkbox"/> Orthopedic surgery – total joint replacement ¹	_____/_____%
<input type="checkbox"/> ENT procedures	_____/_____%	<input type="checkbox"/> Plastic surgery – cosmetic ²	_____/_____%
Describe: _____		<input type="checkbox"/> Plastic surgery – Other	_____/_____%
<input type="checkbox"/> General surgery	_____/_____%	<input type="checkbox"/> Refractive surgery ¹	_____/_____%
<input type="checkbox"/> Gynecologic surgery (other than abortions)	_____/_____%	<input type="checkbox"/> Spinal surgery – posterior lumbar fusion	_____/_____%
<input type="checkbox"/> Hand surgery	_____/_____%	<input type="checkbox"/> Spinal surgery – other spinal surgery ¹	_____/_____%
<input type="checkbox"/> Head and neck surgery	_____/_____%	<input type="checkbox"/> Surgery intended for weight reduction ¹	_____/_____%
Describe: _____		<input type="checkbox"/> Thoracic surgery (other than cardiovascular)	_____/_____%
<input type="checkbox"/> Other laparoscopic surgery	_____/_____%	<input type="checkbox"/> Trauma surgery	_____/_____%
Describe: _____		<input type="checkbox"/> Urologic surgery	_____/_____%
<input type="checkbox"/> Liposuction	_____/_____%	<input type="checkbox"/> Vascular surgery	_____/_____%

¹ Questionnaire or additional information required. Please call MIEC for information.

² If you previously have performed or your current practice includes breast augmentations, please provide details, including number, type, etc. If you are not a Board-certified or Board-eligible plastic surgeon, please attach a description of cosmetic procedures that you perform.

NOTE: If your surgical practice will change significantly in the coming year, give complete details on separate attachment or in the Additional Comments section on page 9.

21. OTHER PRACTICES

Do you own or control any separate company or enterprise related to your medical practice? Yes No

If yes, please explain. _____

PROFESSIONAL AND INSURANCE HISTORY

22. CURRENT MEMBERSHIPS AND ACTIVITIES

Attachment contains this information None

Medical specialty societies, professional associations and hospital committees

Organization, Society, Committee Name _____ Title or Position Held _____

Are you a member of the state/county medical association in the locale of your future practice?* Yes No

Name of association _____

If no, are you planning to apply for membership? Yes No

*Your medical association provides peer review services for MIEC policyholders, as required by MIEC.

23. PAST PRACTICE LOCATIONS PRIOR TO JOINING THIS GROUP Attachment contains this information None

List all locations you have practiced since completing your formal training (include military, private, teaching, and group organizations).

_____ Name/Type of Practice	_____ City	_____ State	_____ From	_____ To
_____ Name/Type of Practice	_____ City	_____ State	_____ From	_____ To
_____ Name/Type of Practice	_____ City	_____ State	_____ From	_____ To

24. PAST HOSPITAL STAFF PRIVILEGE LOCATIONS Attachment contains this information None

If you have relocated your practice within the past five years, list names and addresses of hospitals where you had staff privileges prior to relocating.

_____ Name of Hospital	_____ Address	_____ City	_____ State	_____ Zip	_____ From	_____ To
_____ Name of Hospital	_____ Address	_____ City	_____ State	_____ Zip	_____ From	_____ To

25. INSURANCE HISTORY Attachment contains this information None

List all professional liability carriers (including current) who have insured you. Use separate sheet, if necessary.

_____ Name of Carrier	_____ Address	_____ Policy Number	Coverage Dates: _____	_____ From	_____ To
_____ Name of Carrier	_____ Address	_____ Policy Number	Coverage Dates: _____	_____ From	_____ To
_____ Name of Carrier	_____ Address	_____ Policy Number	Coverage Dates: _____	_____ From	_____ To

If current policy is claims-made, have you or do you intend to purchase "tail" coverage? Yes No

NOTE: If your most recent coverage was a claims-made policy, you must either purchase "tail" coverage from your former carrier, or apply for "Prior Acts" (also called "nose") coverage with MIEC. Prior Acts coverage may be available if you are currently insured under a claims-made policy in a state where MIEC provides professional liability insurance. If MIEC approves you for Prior Acts coverage, MIEC premiums will be at the claims-made step rate based on the number of years you have been insured by your previous claims-made carrier. If you wish to apply, please complete the Supplementary Application: Prior Acts "Nose" Coverage (page 13). Coverage is provided only after review and underwriting approval by MIEC.

If you have purchased tail coverage from your former carrier, and do not need Prior Acts coverage from MIEC, please attach a copy of the tail coverage endorsement to this application.

26. CLINICAL EDUCATION

Have your ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes No

If yes, give complete details including dates on separate attachment or in the Additional Comments section on page 9.

27. INSURANCE

Has any insurance carrier ever denied, declined, canceled, refused to renew, restricted, or placed a surcharge on the premium of your professional liability insurance? Yes No

If yes, give complete details including dates on separate attachment or in the Additional Comments section on page 9.

28. STAFF PRIVILEGES/MANAGED CARE ORGANIZATION ACTIONS OR INVESTIGATIONS

- A. Have you ever had any hospital, surgical outpatient or healthcare services plan privileges denied, suspended, revoked, restricted, reduced, not renewed, proctored or modified in any way? Yes No
- B. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization [e.g., hospital medical staff, medical group, independent practice association (IPA), health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system] while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No.

If yes, please furnish details, including facility or managed care organization name, dates, allegations, circumstances, and outcome on separate attachment or in the Additional Comments on page 9.

29. GOVERNMENTAL ACTION

- A. Have you ever been investigated as the subject of, charged with or convicted of a misdemeanor or felony? Yes No
- B. Have you ever entered a "no contest" plea to a crime, other than a traffic violation? Yes No
- C. Have you ever been investigated by any state or federal regulatory body or specialty society? Yes No
- D. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your medical license or your narcotics license? Yes No

If you answered "yes" to question 29.a., b., c., or d., please furnish full details on separate attachment or in the Additional Comments section below.

30. HEALTH

- A. Have you ever received treatment or consultation for drug or alcohol abuse? Yes No
- B. Are you being treated for any medical condition, disease or illness that affects your ability to practice medicine? Yes No

If you answered "yes" to question 30.a., or b., please furnish full details on separate attachment or in the Additional Comments section below.

31. CLAIMS

Have you ever been involved in a malpractice claim, suit or arbitration proceeding, or have you reported any incidents which resulted in a claim to a former carrier? Yes No

If yes, you must complete a claim information form for each claim (on page 10).

ADDITIONAL COMMENTS

CLAIM INFORMATION FORM

Attachment contains this information

None [Please be sure to check here if no claims]

Name of Patient/Claimant

Gender

Age

1. Condition and diagnosis of patient prior to treatment and/or surgery:

2. Date(s) and type of treatment and/or surgery rendered by you:

3. Condition of patient subsequent to treatment and/or surgery by you:

4. Nature of allegation:

5. Was a suit ever filed against you? Yes No

If yes, was it served? Yes No

When? _____

6. Names of other doctors and hospital, if any, involved:

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

Name of insurance carrier defending you

Name of attorney defending you

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.



THE FOLLOWING SECTIONS PROVIDE IMPORTANT INFORMATION RELATING TO VARIOUS ASPECTS OF THE INSURANCE YOU ARE APPLYING FOR.

"CLAIMS-MADE" COVERAGE EXPLANATION

MIEC issues a "claims-made" policy, which insures against claims and suits arising from covered health care services rendered to patients during the time the MIEC policy is in effect, so long as an MIEC policy or a renewal of it is also in effect at the time a claim or suit is first reported to MIEC. If the policy is canceled, not renewed, or terminated for any reason, the insured named in the policy Declaration has a contractual right to purchase Reporting Endorsements ("tail" coverage). If purchased, these Reporting Endorsements will cover claims first made after the date of cancellation, termination or non-renewal provided they arise from covered incidents which occurred while the MIEC policy was in effect.

Under a policy issued by MIEC to an individual doctor, a Reporting Endorsement ("tail" coverage) is provided at no cost in the event of the insured doctor's death or permanent disability. A doctor who has been insured five years or more by MIEC and then retires from private practice at age 55 or more, will also receive "tail" coverage at no additional premium.

First-year claims-made premiums are discounted because only about one-third of claims ultimately attributable to first year incidents will actually be reported to MIEC during the first year. The rest of first year's incidents will be reported as claims during subsequent years. Second, third, fourth and fifth year claims-made premiums increase to reflect this delayed pattern of claims reporting.

Actual premiums charged in future years will vary with inflation, MIEC's claims experience, changes in the legal climate and many other factors that affect professional liability insurance rates. Premiums are based on conservative actuarial recommendations.

Policy provisions which describe the coverage are stated in the policy itself. This explanation does not replace, alter or supersede any of these policy provisions.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that the above statements and answers are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose limits in this application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature

Date

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MEDICAL UNDERWRITERS OF CALIFORNIA, herein called "MUC," to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MUC to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MUC as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MUC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MUC and the Board of Governors or its Executive Committee shall be borne by MUC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with *Section 1399 and 1400 or 1401 or 1401.5 of the Insurance Code of the State of California* subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature

Date

LIMITED PRACTICE WARRANTIES

PLEASE READ AND SIGN THE APPROPRIATE WARRANTY

Non-surgical specialists and family/general practitioners who do not perform surgery

I limit my practice to non-surgical and non-obstetrical cases, and do not assist in any element of surgery.

Signature

Date

Non-surgical specialists and family/general practitioners who do not perform surgery but occasionally assist

I limit my practice to non-surgical and non-obstetrical cases, and assist in surgery only on my own patients.

Signature

Date

Limited performance of surgery, unlimited surgery assists, excluding obstetrics

I estimate that during the next 12 months less than 5% of my medical practice will be surgery. I do not include obstetrics, orthopedics (other than closed reductions).

Signature

Date

NOTE: Procedures such as suturing and the removal of skin lesions are not considered surgical procedures by MIEC.

SUPPLEMENTARY APPLICATION: PRIOR ACTS "NOSE" COVERAGE

****Complete ONLY if applying for Prior Acts coverage****

1. Prior professional liability coverage was provided by the following claims-made policies and each remained in full force and effect for its entire term:

Company	Policy #	Policy Period		Retroactive Date	Per Claim Limit	Aggregate Limit
		From	To			

2. **Attach a complete copy of your previous policy or policies, including declarations and all endorsements.**

3. Did you practice as part of a partnership or corporation during the above policy periods? Yes No

If yes, please describe your status (partner/shareholder/employee, etc.): _____

4. Have you reported any claims, suits or incidents to the companies listed in Question 1? Yes No

If yes, complete a claim information form for each (page 10). Please include acknowledgment that your prior carrier is defending you for all such known claims. *MIEC will not provide any coverage for previously known claims or suits.*

5. Has there been any incident, notification from a patient or patient's attorney, oral or written threat of legal action, subpoena, summons & complaint or any other indication that leads you to believe a malpractice claim or suit will be lodged against you arising from professional services rendered while you were insured with your prior carrier during the period shown under Question 1? Yes No

If yes, provide full details on your letterhead and report all such incidents to your prior carrier immediately.

6. Have you been classified and rated in the same classification for the entire duration of your coverage with your prior carrier? If no, please explain and describe any practice changes during the above policy periods on your letterhead. Yes No

The undersigned represents that the above statements and answers are true and complete, and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

Signature

Date

Print Name

APPLICATION CHECK LIST

To avoid delays in your application, please remember to:

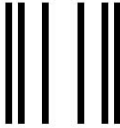
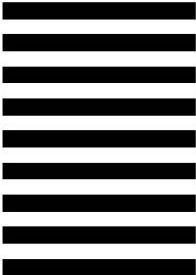

- Complete all questions or indicate "not applicable" (n/a)
- Complete the "Claim Information Form," if applicable (page 10)
- Sign your application (page 11)
- Sign the Subscriber's Agreement (page 12)
- Sign one of the limited practice warranties, if applicable (page 12)
- Complete and sign the "Supplementary Application: Prior Acts "Nose" Coverage," if applicable (page 13)
- Complete and sign the "Authorization to Release Information" forms (page 14)

Please check all items that are to be included so we are sure we have received all attachments:

- Curriculum vitae (CV)
- Your letterhead
- Advertisements
- The Declarations Page from your current carrier
- Current written contracts/service agreements
- Any Special Applications, policy exclusion statements, or application supplements (questions 19 & 20)
- Other _____

You can send in your application by:

1. Mail – [[Print PRE-PAID Mailing Label below](#)]
2. Fax – (510) 654-4634
3. E-mail – Underwriting@MIEC.com

	NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES
BUSINESS REPLY MAIL FIRST CLASS PERMIT NO. 739 OAKLAND, CA	
POSTAGE WILL BE PAID BY ADDRESSEE	
Medical Insurance Exchange of California Attn: UNDERWRITING 6250 Claremont Avenue Oakland, CA 94618-9983	
	

PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE