MIEC

Medical Insurance Exchange of California
Medical Underwriters of California
management company

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

MIEC Solo Physician
Application for Claims-Made Professional Liability Insurance

IMPORTANT INSTRUCTIONS – PLEASE READ CAREFULLY

This application is specifically for individual physicians whose practice is:

- a 'solo' practice with no affiliation with a medical corporation or partnership

If not, please go to the Applications page under the resources tab on www.miec.com and complete the application titled: *MIEC Joining Group/Entity Affiliation Physicians and Surgeons*

- 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 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 represent 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 11 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) 318-6700
E-MAIL: UNDERWRITING@MIEC.COM

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Application for Claims-Made Professional Liability Insurance

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 (mm/dd/yyyy) _____ Place of Birth _____ State _____ Country _____

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

Principal Office Address _____ Suite # _____ City _____ State _____ Zip Code _____

County _____ Telephone Number _____ Fax Number _____ E-mail _____ Website Address or ☐ N/A

Tax I.D. Name:_____ Federal E.I.N._____ Mail to: ☐ Home ☐ Office

If you wish to be covered for professional premises liability at your principal office address under Part III of MIEC's policy, please indicate below. There is no additional premium charged for this coverage, but it will be provided only if you request it. ☐ Yes ☐ No

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

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

LICENSES / BOARD CERTIFICATION — ANSWERS 4-5

4. LICENSES

A. List All Medical Licenses Any additional licenses may be listed on separate attachment or in the Additional Comments section on page 11.

1. State _____ License Number _____ Date Licensed _____ Expiration Date _____ 2. State _____ License Number _____ Date Licensed _____ Expiration Date _____

4. LICENSES, cont'd.

3. 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 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

MEDICAL EDUCATION AND TRAINING / CME, cont'd. ANSWERS 6-11

☐ Attachment contains this information

11. FELLOWSHIPS AND ADDITIONAL MEDICAL TRAINING

Hospital/Facility	City	State	Type of Training	From	To

SPECIALTY / HOSPITAL PRIVILEGES ANSWERS 12-13

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
				☐ 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 11.*

PRACTICE, SCOPE AND PROCEDURES ANSWERS 14-24

14. TYPE OF PRACTICE Check the boxes that best describe the type of practice you have:

☐ Solo practice not incorporated ☐ "Solo" professional corporation – name: _____

☐ Fictitious entity or "dba" – name: _____ ☐ Other _____

15. OTHER ASSOCIATED PHYSICIANS

Do you practice with other physicians? ☐ 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

NOTE: If interested in entity coverage, all physicians must be individually insured by MIEC. Please contact MIEC for an application.

16. ON-CALL PHYSICIANS

Do all members of your night, weekend, vacation or illness "on-call" referral group carry professional liability insurance? ☐ Yes ☐ No

If no, list names of those who do not: _____

17. NON-PHYSICIAN HEALTH CARE PROVIDERS

A. Technicians

Please indicate below and list the hours worked per week if you employ individuals in the following categories to render health care services. (No charge for nurses and medical assistants.)

☐ *Check here if none.*

	Total Hours Per Week	Number of Employees		Total Hours Per Week	Number of Employees
☐ Laboratory technician			☐ X-ray technician		
☐ Physiotherapist			☐ Other (describe)		

B. Mid-Level Practitioners

Indicate if you employ any health care professionals in the following categories. List the hours worked per week. Attach a protocol of the services performed and a *curriculum vitae* of each practitioner.

☐ *Check here if none.*

	Total Hours Per Week	Number of Employees		Total Hours Per Week	Number of Employees
☐ Nurse anesthetist (CRNA)*			☐ Physician assistant*		
☐ Nurse midwife*			☐ Psychologist*		
☐ Nurse perfusionist*			☐ Scrub nurse*		
☐ Nurse practitioner*			☐ Surgical technician*		
☐ Optometrist/optician*			☐ Other (describe)		

**Special application or additional information required. Contact MIEC, or go to our website www.miec.com*

18. FACILITY ASSOCIATION

Indicate if you provide professional services at any of the following facilities.

☐ *Check here if none.*

☐ Blood bank
☐ Birthing center
☐ City, county, state or federal agency
☐ Clinic with bed and board facilities
☐ Emergency treatment facility (freestanding)
☐ Emergency treatment facility (hospital)
☐ Freestanding surgical facility
☐ Hospital (other than member of medical staff)
☐ Hospital, convalescent*
☐ Board and care or assisted living facility*
☐ Hospital, psychiatric
☐ Industrial firm medical care facility
☐ Laboratory
☐ Nursing home (SNF)*
☐ Sanitorium
☐ Urgent care clinic
☐ X-ray or imaging facility
☐ Other health care facility

**Submit copy of professional liability insurance from each facility.*

If you have a written contract with any of the facilities listed above, please attach a copy of the contract to this application.

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 additional facilities, please provide details in the Additional Comments section on page 11

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

A. Are you applying for full-time coverage? ☐ Yes ☐ No If yes, skip to 19c.

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:

_____

C. If you are employed elsewhere for which coverage is provided, complete question 18.

D. Indicate your weekly average practice activity: (If new practice, provide an estimate.) Number/Week

Patients seen in the office (nonsurgical)	_____
Patients seen in the hospital (nonsurgical)	_____
Patients seen only by paramedical personnel that you employ	_____
Number of surgical assists you perform	_____
Pathologists/radiologists: Procedures you perform without patient contact	_____

20. 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 provide health care services to patients or medical consults or participate in telemedicine in states other than where your principal practice is located? ☐ 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 11.

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 11.

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 11.

20. SCOPE OF PRACTICE, cont'd.

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 11.

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21. PROCEDURES

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

☐ Acupuncture	#_____	☐ Laser hair removal[1]	#_____
☐ Angiography	#_____	☐ Laser skin resurfacing[1]	#_____
☐ Angioplasty	#_____	☐ Mesotherapy[3]	#_____
☐ Aortography	#_____	☐ Pacemaker insertions, temporary	#_____
☐ Cardiac catheterization	#_____	☐ Pacemaker insertions, permanent	#_____
☐ Contrast media in CNS	#_____	☐ Periocular tattooing	#_____
☐ Coronary angiography	#_____	☐ Prolotherapy[3]	#_____
☐ Cosmetic Procedures[1]	#_____	☐ Therapeutic use of radioactive material	#_____
Types:_____		☐ Use of chelation therapy[3]	#_____
☐ Drug shock therapy[2]	#_____	☐ Use of injectable liquid silicone[3]	#_____
☐ Hair transplants[1]	#_____	☐ Use of laetrile[2]	#_____
☐ 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.*

22. 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
☐ Abortions _____ Type/Trimester	____/____%
☐ Anesthesiology[1]	____/____%
☐ Cardiovascular surgery	____/____%
☐ Chymopapain injections[1]	____/____%
☐ ENT procedures	____/____%
Describe: _____	
☐ General surgery	____/____%
☐ Gynecologic surgery (other than abortions)	____/____%
☐ Hand surgery	____/____%
☐ Head and neck surgery	____/____%
Describe: _____	
☐ Other laparoscopic surgery	____/____%
Describe: _____	
☐ Liposuction[1]	____/____%
☐ Neurosurgery	____/____%
☐ Obstetrics[1] – vaginal deliveries	____/____%
☐ Obstetrics[1] – cesarean section	____/____%
☐ Orthopedic surgery (include closed reduction)	____/____%
☐ Orthopedic surgery – total joint replacement[1]	____/____%
☐ Plastic surgery – cosmetic[2]	____/____%
☐ Plastic surgery – Other	____/____%
☐ Refractive surgery[1]	____/____%
☐ Robotic assisted surgery	____/____%
☐ Spinal surgery – posterior lumbar fusion	____/____%
☐ Spinal surgery – other spinal surgery[1]	____/____%
☐ Surgery intended for weight reduction[1]	____/____%
☐ Thoracic surgery (other than cardiovascular)	____/____%
☐ Trauma surgery	____/____%
☐ Urologic surgery	____/____%
☐ 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 11.

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23. MEDICAL PRACTICE ADVERTISEMENTS

Do you advertise your medical practice? ☐ Yes ☐ No

If yes, provide copies of current advertisements, including those placed in yellow pages (other than general listing), as well as periodicals, flyers and handouts. Provide a copy of the script if you use voice or film media.

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24. OTHER PRACTICES

Do you or an immediate family member have an ownership interest in any separate company or enterprise related to your medical practice such as a medical device or equipment manufacture, pharmacy, ancillary service provider, or other similar type of entity? ☐ Yes ☐ No

If yes, please explain. _____

PROFESSIONAL AND INSURANCE HISTORY ANSWERS 25-35

25. 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.*

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26. PAST PRACTICE LOCATIONS ☐ 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 _____

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27. 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 _____

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28. 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 15). 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.

Please answer the following questions "Yes" or "No". If you answer "Yes" to any of the questions, please provide full details on a separate sheet or in the Additional Comments area.

29. 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

30. 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

31. 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, teminated 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 heatlh 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 peding? ☐ Yes ☐ No.

32. 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

33. 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

34. 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 11).

35. HOW DID YOU LEARN ABOUT MIEC?

Please check all that apply:

☐ Previous MIEC insured
☐ MIEC Loss Prevention seminar
☐ Medical Society referral
☐ Medical Society bulletin advertisement
☐ Convention
☐ MIEC website
☐ MIEC mailing
☐ Colleague referral
☐ Other_____

ADDITIONAL COMMENTS

CLAIM INFORMATION FORM

☐ Attachment contains this information ☐ None [Please be sure to check here if no claims]

Last 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.

IMPORTANT

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 represents that the statements made in this application and any materials submitted herewith are true and correct, that neither the undersigned nor any of the undersigned's employees, agents, or representatives have withheld or failed to disclose pertinent information, and that all have given careful consideration to the statements and information provided. The undersigned further acknowledges that such statements are material representations and that any policy issued by MIEC is issued in reliance upon the truth and accuracy of such statements.

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 From / To		Retroactive Date	Per Claim Limit	Aggregate Limit

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

   B. Have you ever entered into a settlement or made a payment from an incident, claim or suit on your own behalf? ☐ Yes ☐ No

   If yes, complete a claim information form for each (page 12). 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 all statements and answers in this application 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

AUTHORIZATION TO RELEASE INFORMATION FOR HOSPITALS/MEDICAL STAFFS/AMBULATORY FACILITIES

As an applicant for initial or continued professional liability insurance coverage from MIEC, I hereby give my consent to MIEC, its agents and representatives, to make inquiries to hospitals, medical staffs, ambulatory facilities, health care service plans or other managed care organizations where I have exercised or applied for clinical privileges or membership.

I grant permission to such hospitals, medical staffs and managed care organizations and their representatives and agents to provide information to *MIEC* which pertains to those privileges I have exercised and to my fitness and qualifications to exercise such privileges. This includes but is not limited to information relating to the scope of privileges granted, any special limitations imposed on such privileges and any information regarding any disciplinary action taken with respect to such privileges.

I further agree that the organization releasing the information, its representatives, agents and employees shall not incur any liability as a result of furnishing or releasing information pursuant to this authorization, even if such information is incomplete or incorrect.

Signature _____ Print Name _____ Date _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature _____ Print Name _____ Date _____

Address _____ City _____ State _____ Zip _____

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 12)
- ☐ Sign your application (page 13)
- ☐ Sign the Subscriber's Agreement (page 14)
- ☐ Sign one of the limited practice warranties, if applicable (page 14)
- ☐ Complete and sign the "Supplementary Application: Prior Acts "Nose" Coverage," if applicable (page 15)
- ☐ Complete and sign the "Authorization to Release Information" forms (page 16)

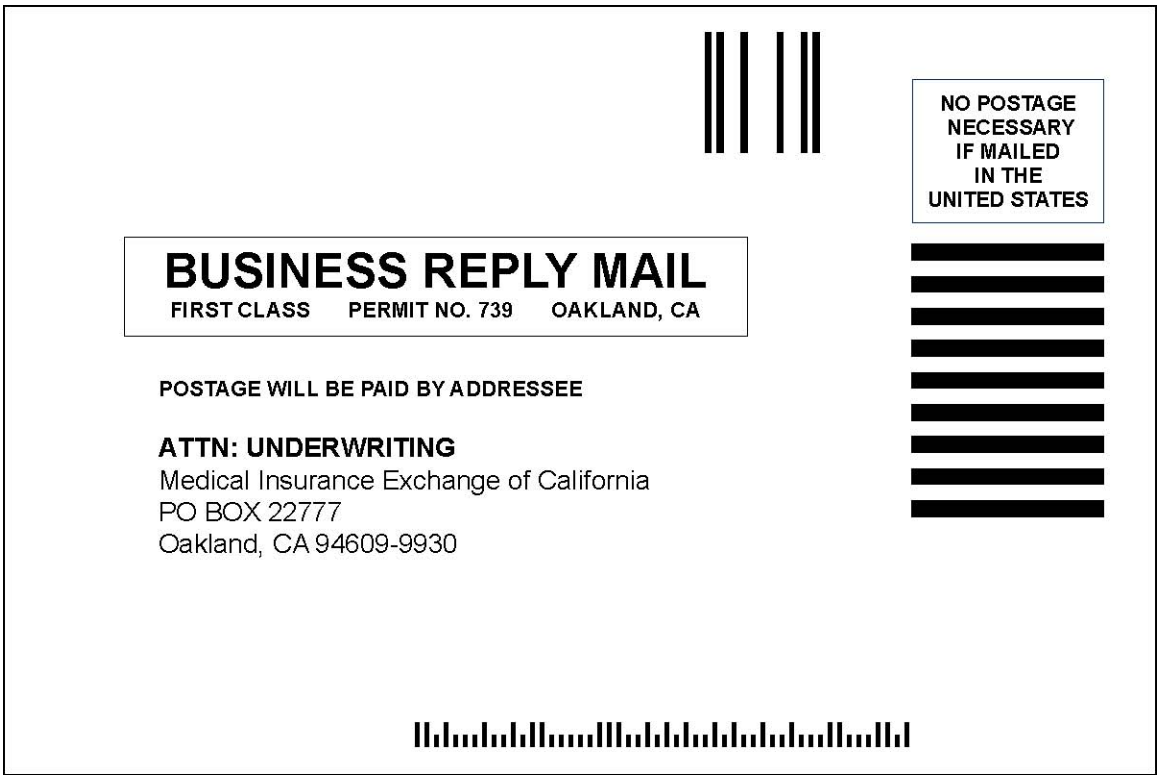
Please check all items that are to be included so we are sure we have received all attachments:

- ☐ 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

☐ Other _____

You can send in your application by:

1. Mail – [Print PRE-PAID Mailing Label below]
2. Fax – (510) 318-6700
3. E-mail – Underwriting@MIEC.com



PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE