MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Application for Claims-Made Medical Professional Liability Insurance for Physicians, Surgeons, Dentists and Podiatrists

APPLICATION INSTRUCTIONS AND CHECKLIST

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.

INSTRUCTIONS:
Please complete the entire application and indicate not applicable (n/a) where appropriate, then sign and date.

ATTACHMENTS TO PROVIDE WITH APPLICATION:

☐ Copy of current Curriculum Vitae

☐ Current letterhead

☐ 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.

☐ Include a copy of the Declarations page from your current or most recent insurance policy. If an extended reporting endorsement (tail) was purchased, please provide a copy as well.

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 8 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.

TEL: 800-227-4527
FAX: (510) 318-6700
E-MAIL: underwriting@miec.com

AGENT INFORMATION (if applicable)**:**

Agent Name: _____ Address 1: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

miec

MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Application for Claims-Made Medical Professional Liability Insurance for Physicians, Surgeons, Dentists and Podiatrists

GENERAL INFORMATION / COVERAGE REQUEST / LIMITS — ANSWERS 1-2

1. GENERAL INFORMATION

First Name _____ MI _____ Last Name _____ ☐ Male ☐ Female ☐ Other

Suffix: ☐MD ☐DO ☐DDS ☐DMD ☐DPM

Date of Birth (mm/dd/yyyy) _____

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Mobile Telephone Number _____

Principal Practice Address _____ City _____ State _____ Zip Code _____

County _____ Office Telephone Number _____ Office Fax Number _____

E-mail Address _____ Website Address or ☐ N/A

Tax I.D. Name _____ Federal E.I.N. _____ NPI# _____

Secondary Practice Address _____ City _____ State _____ Zip Code _____

Billing Address _____ City _____ State _____ Zip Code _____

Preferred Contact Person _____ Contact Information _____

Preferred Mailing Address: ☐Home ☐Practice ☐Billing *Please use "Additional Comments" section to list any additional locations.*

Request premises coverage: ☐Yes ☐No

2. COVERAGE REQUEST / LIMITS

Requested Effective Date (mm/dd/yyyy) _____

☐ Claims-made **WITHOUT** prior acts coverage. Under this option, the retroactive date will be the same as the effective date of coverage. Coverage for claims arising from an act or omission that occurred prior to the effective date of this policy will not be provided.

☐ Claims-made **WITH** prior acts coverage. Under this option, the retroactive date will be the same as the retroactive date on your current policy. **Please provide a copy of your current Declarations page.**

Please indicate the primary limits of liability requested (Limit per claim / annual aggregate):

☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

Do you wish to request excess limits of liability? ☐Yes ☐No (additional screening may be required). If Yes, please select an option:

☐ $1,000,000/$1,000,000 ☐ $2,000,000/$2,000,000 ☐ $3,000,000/$3,000,000 ☐ $4,000,000/$4,000,000

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

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

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

LICENSES / BOARD CERTIFICATION/MEMBERSHIPS — ANSWERS 3-5

3. LICENSES

A. Please list all states in which you are currently licensed. Use the "Additional Comments" section on page 8 to list any additional locations

1. State _____ License Number _____ % of Practice _____ **2.** State _____ License Number _____ % of Practice _____

3. State _____ License Number _____ % of Practice _____ **4.** State _____ License Number _____ % of Practice _____

B. DEA License Number _____ Date of Issue _____ Expiration Date _____

4. 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: _____

5. CURRENT MEMBERSHIPS AND ACTIVITIES ☐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.*

☐ *Attachment contains this information*

SPECIALTY AND PRACTICE INFORMATION — ANSWERS 6-8

6. SPECIALTY

A. What is the specialty you primarily provide? _____ Percentage of practice: _____

B. Secondary specialty of services provided? _____ Percentage of practice: _____

C. Have there been any changes in your specialty, or practice activity within the last 5 years? ☐Yes ☐No

If yes to question C, please explain: _____

7. TYPE OF PRACTICE

Which best describes your practice situation?

☐Alone/solo ☐Group practice ☐Educational/Institutional ☐Other: _____

8. PRACTICE ACTIVITY

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.: _____

B. Estimate the number of patients seen on an average weekly basis: _____

C. Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ☐Yes ☐No

If yes, provide details and name of insurance carrier: _____

SCOPE OF PRACTICE ANSWER 9

9. SCOPE OF PRACTICE

Does your practice involve any of the following?

A. Treatment of patients via virtual or telemedicine? ☐Yes ☐No If Yes,

1. What percentage of your practice does this comprise? _____
2. What percentage of patients are physically located in the state of your principal licensure/practice location/primary residence? _____

If not 100%, then

3. What states are your patients treated via telemedicine located in? _____

Are you licensed in all the states where your patients are physically located? ☐Yes ☐No

4. For patients treated via telemedicine, are they ☐New Patients? ☐Established Patients? Check all that apply.
5. For patients treated via telemedicine, do you prescribe any controlled substance? ☐Yes ☐No

If Yes, then

6. Do you follow DEA protocols which involves a prior in-person examination? ☐Yes ☐No

B. Employment or contract work to serve as a medical director? ☐Yes ☐No

If yes, please provide name(s) and locations and provide evidence of separate coverage: _____

_____

C. Work in an Emergency Department for purposes other than maintaining staff privileges or as required by the hospital? ☐Yes ☐No

If yes, how many hours each week? _____

D. Work as a Hospitalist? ☐Yes ☐No If yes, how many hours each week? _____

E. Performing or assisting in surgical procedures in a non-hospital setting during which anesthesia of any kind is administered? ☐Yes ☐No

If yes, explain: _____

F. Home health care or visits to a patient's home? ☐Yes ☐No

If yes, provide details: _____

G. Involvement or participation in non-IRB-approved clinical research trials? ☐Yes ☐No

If yes, please provide details and include supporting documents: _____

H. Professional services at any nursing home or correctional facility? ☐Yes ☐No If yes, how many hours per week: _____

Please include supporting documents (i.e. your contract with the facility, evidence of coverage for administrative duties).

I. Sharing of office space, employees, common letterhead with other physicians who are NOT employed by you? ☐Yes ☐No

J. Usage of experimental procedures, drugs or therapy in treatment or surgery? ☐Yes ☐No

If Yes, explain: _____

10. MEDICAL PROCEDURES

Do you perform any procedures that are outside the customary scope of practice for your specialty? ☐Yes ☐No

If yes, please list the procedures: _____

Check the boxes that, in your opinion, best describes the highest level of procedures performed by you in your practice:

☐ **No Surgery**—except incisions of boils, cysts, circumcisions (newborns) or other superficial abscesses or suturing minor lacerations

☐ **Minor Surgery**—includes most procedures performed under local anesthesia; or assisting in major surgery on your own patients, provide details:

_____

☐ **Major Surgery**—includes major surgical procedures done under general, spinal or caudal anesthesia; or assisting in major on other than your own patients

If you assist in surgery, please complete the following:

Major surgery on own patients # _____ per year

Major surgery on patients other than your own # _____ per year

Based on previous responses, check **all** procedures you perform with estimates of how many you perform **per year**. ☐ **Check here if none.**

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

MEDICAL AND SURGICAL PROCEDURES — ANSWERS 10-11

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

PROFESSIONAL EMPLOYMENT AND LIABILITY HISTORY — ANSWERS 12-15

12. EMPLOYMENT HISTORY ☐ None

List all locations where you have practiced within the last 5 years. Begin with current location.

Name/Type of practice	City	State	From	To

Any gaps? Please explain: _____

☐ *Attachment contains this information*

13. PAST PRACTICE LOCATIONS ☐ None

List all locations where you have practiced within the last 5 years. Begin with current location.

Name/Type of practice	City	State	From	To

☐ *Attachment contains this information*

14. INSURANCE HISTORY ☐ None

List all professional liability carriers (including current) who have insured you during the last 5 years. Use additional comments or separate sheet of paper, if necessary.

Name of Carrier	Limits	☐ Claims-Made ☐ Occurence	Coverage Dates: From	To	Retro Date

☐ *Attachment contains this information*

15. PROFESSIONAL DISCLOSURE

Use additional comment section to explain any "Yes" response.

A. Have you ever failed any licensing or Board Certification examinations? ☐ Yes ☐ No

If yes, how many times? _____

B. Have you ever practiced medicine while you were uninsured? ☐ Yes ☐ No

C. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

D. 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

E. 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

F. 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

G. 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? ☐ Yes ☐ No

H. Have you ever been investigated, arrested, indicted, pled guilty to, or been convicted of any misdemeanor or felony other than minor traffic violations not involving any allegation of alcohol or substance use? ☐ Yes ☐ No

I. Have you ever been investigated by any state or federal regulatory body or specialty society? ☐ Yes ☐ No

J. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ☐ Yes ☐ No

K. 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

L. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or other medical review committee? ☐ Yes ☐ No

M. Have you ever had a patient, or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? ☐ Yes ☐ No

N. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? If yes, please include 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. ☐ Yes ☐ No

15. PROFESSIONAL DISCLOSURE, continued

O. Are you aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? ☐Yes ☐No

If yes, please include 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.

P. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? ☐Yes ☐No

Q. 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

R. Have you ever in any way altered, embellished, deleted, changed, and/or destroyed any records, medical or otherwise, or were allegations made that you did so. ☐Yes ☐No

ADDITIONAL COMMENTS ☐ *Attachment contains this information*

EMPLOYEE INFORMATION ANSWER 16

16. EMPLOYEE INFORMATION ☐ *Attachment contains this information*

Do you employ or contract with any individual, that is licensed, certified, or otherwise authorized to deliver advanced level health care **in the absence of direct supervision by a licensed physician** including but not limited to the following: *Certified Registered Nurse Anesthetists, Nurse Practitioners, Nurse Midwives, Physician Assistants, Surgical Assistant, Psychologist, Chiropractors, Optometrist***.** A separate application will be required for each individual listed below.

Name	Type		Hours per week
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	
		☐ Employee ☐ Contractor	

If you employ any Nurse Midwives, how many deliveries are perform annually by these individuals? _____

Indicate the number and type of all other healthcare providers that provide healthcare services on behalf of or at the direction of yourself, or someone else in your practice.

Type	Number of Providers	Type	Number of Providers

Do any of your employed providers (licensed, certified, or otherwise) practice at a location geographically separate from yours? ☐Yes ☐No

If "Yes," please explain: _____

17. HOSPITAL PRIVILEGES

☐ *Attachment contains this information*

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	Send Certificate of Insurance
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ 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.*

ADDITIONAL COMMENTS

18. ENTITY INFORMATION

Do you wish to add an entity to your coverage? ☐ Yes ☐ No Limit Type: ☐ Shared ☐ Separate *(Separate limit require an Entity application)*

What type of practice organization applies to your practice?

☐ Solo Unincorporated ☐ Partner or Partnership ☐ Corporate Shareholder ☐ Government Employee

☐ Solo Corporation ☐ Independent Contractor ☐ Employee ☐ Other:

Name of Entity: _____

Is there any other name under which you practice (i.e. DBA, unincorporated name or trade name)? ☐ Yes ☐ No

If yes, please provide all names:

Name	Description

CLAIM INFORMATION FORM

CLAIM INFORMATION FORM ☐ *Attachment contains this information* ☐ None [Please be sure to check here if no 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 OR submit a current loss run representing the last 10 years of practice

Are you aware of 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? ☐ Yes ☐ No

All claims information should be provided. 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.

Last name of Patient/Claimant _____ ☐ Male ☐ Female ☐ Other Age _____

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

Allegation: _____

Date of Incident: _____ Location: _____

Insurance carrier(s): _____

Other defendants: _____

Present status: ☐ Open ☐ Closed

Indemnity and expenses reserved: _____

Loss of: $ _____ Expenses paid: $ _____

Date Closed: _____ ☐ Settlement ☐ Judgement

Conditions and diagnosis at time of incident:

_____

_____

Dates and description of professional services rendered:

_____

_____

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

_____

_____

Explain what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR <u>EACH</u> 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.

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, MIEC UNDERWRITERS, LLC., 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 MIEC UNDERWRITERS, LLC. 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 MIEC UNDERWRITERS, LLC. as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MIEC UNDERWRITERS, LLC.

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 MIEC UNDERWRITERS, LLC. and the Board of Governors or its Executive Committee shall be borne by MIEC UNDERWRITERS, LLC.

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 _____

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