1800 Northern Blvd., P.O. Box 9009
Roslyn, NY 11576
(516) 365-6345
(833) 774-6625
www.MyEmPRO.com

Hospital Professional Liability Application

Requested Effective Date: ____________________

Section 1 - Applicant Information

Name of Applicant:	d/b/a (If Applicable):		
Contact Person Name:	Contact Person Email Address:		
Primary Business Phone:	Primary Business Fax:		
Primary Business Address:	City:	State:	Zip:
Website:			
Mailing Address (if different from Primary):	City:	State:	Zip:
Billing Address (if different from Primary):	City:	State:	Zip:

Hospital Tax I.D. Number:____________________

Tax Status:

☐ For Profit - Private ☐ For Profit - Publicly Traded ☐ Not for Profit ☐ Government

Applicant's Legal Structure:

☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Sole Propriertorship ☐ Other

Type of Risk (Select all that apply):

☐ Acute Care Hospital ☐ Behavioral Health Hospital ☐ Rehabilitation Hospital
☐ Critical Access Hospital ☐ Children's Hospital ☐ Teaching Hospital
☐ Other ☐ Specialty Hospital: ________________

List all states where the Applicant is operating and providing services: ____

____

Named Insureds: List all subsidiaries, date acquired, description of operation, ownership, and if coverage is requested for the subsidiary.

Subsidiaries	Date Acquired	Description Of Operation	% of Ownership	Coverage Requested?

Section 1 - Continued

Within the past 36 months or within the next 12 months has the Applicant or does the Applicant expect to:

Merge, acquire or consolidate with another entity? ☐ **Yes** ☐ **No**

Sell or divest another entity or facility? ☐ **Yes** ☐ **No**

Discontinue any operations or services? ☐ **Yes** ☐ **No**

Enter into any new business activities or services (including new procedures or products being offered)? ☐ **Yes** ☐ **No**

If "Yes" to any, please describe the essential terms of each such transaction: ____________________

____

Section 2 - Coverage Options

☐ Primary ☐ Excess ***(Only Available in New York)***

Coverage Type

☐ Claims-Made ☐ Occurrence ☐ Modified Claims-Made ***(Not Available in New York)***

Limits of Liability

Per Claim: ____________________ **Aggregate:** ____________________

Physicians (if coverage is being requested for employed physicians under the facility policy):

Shared Limit Option ***(Only Available in certain states)***: ☐ **Yes** ☐ **No**

Per Claim: ____________________ **Aggregate:** ____________________

Deductible/Annual Aggregate:

☐ $100K/$300K ☐ $250K/$750K ☐ No Annual Aggregate ☐ No Deductible ☐ Other: __________

Self-Insured Retention (SIR):

☐ $100K ☐ $250K ☐ $300K ☐ No SIR ☐ Other: __________

If Self-Insured Retention is Applicable:

How are loss adjustment expenses handled? ☐ Within SIR Limit ☐ Outside SIR

Is there a dedicated trust? ☐ **Yes** ☐ **No**

If "No," how is SIR secured? ____________________

Is there an independent actuarial review? ____________________

What organization handles the claims? ____________________

What legal firm is responsible for defending the claims? ____________________

Section 3 - Professional Liability Insurance History

Primary Professional Liability

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims-Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability?	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	

Excess Professional Liability

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims-Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability?	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	

Has the Applicant's policy or coverage ever been declined, canceled or non-renewed during the past three (3) years? ☐ **Yes** ☐ **No**

If "Yes," please explain: ____

____

For Claims-Made coverage, was an extended reporting period (tail coverage) purchased for any previous primary or excess policy? ☐ **Yes** ☐ **No**

Has the Applicant received any fines or sanctions or Statements of Deficiency imposed by regulatory agencies in the past 12 months? ☐ **Yes** ☐ **No**

If "Yes," please describe below. Attach, also, each Plan of Correction and Statement of Acceptance by the regulatory agency:

____

____

Section 4 - Hospital Information

Type(s) Services Offered:

- [ ] Acute Care
- [ ] Alcohol Dependency
- [ ] Dental
- [ ] Drug Addiction
- [ ] Geriatric
- [ ] Pharmacy
- [ ] Long Term Care (on or off site)
- [ ] Intensive Care
- [ ] Intensive Care
- [ ] Specialty
- [ ] Pediatric
- [ ] EMS/Ambulance
- [ ] Dialysis
- [ ] Psychiatric
- [ ] Outpatient
- [ ] Transplant
- [ ] Trauma Center
- [ ] Bariatric Surgery
- [ ] Rehabilitation
- [ ] Surgery, Specialty
- [ ] Obstetrical
- [ ] Other: ______________________

Hospital Beds	**Projected # Certified**	**Projected Year % Occupied**	**Current Year # Certified**	**Current Year % Occupied**	**Previous Year # Certified**	**Previous Year % Occupied**
Medical/Surgical						
ICU/NICU/CCU						
Obstetrical						
Pediatric						
Psychiatric						
Physical Rehab						
Alcohol/Drug						
Long Term Care*						
Subacute Care						
LTC Assisted Living						
Other:						
Total Licensed Beds:						

* If located in a separate facility, please complete a separate Nursing Home Application.

Surgical Procedures – Please provide the number of procedures performed:

	Projected Year	**Current Year**	**Previous Year**
Inpatient Surgery			
Ambulatory Surgery			
Deliveries:			
a. C-Section			
b. Normal Vaginal			
c. % VBACs			
Total:			

Section 4 - Continued

Outpatient Visits – Please provide the number of visits:

	Projected Year	**Current Year**	**Previous Year**
Emergency Department			
Ambulatory Care			
Rehabilitation			
Psychiatric			
Home Healthcare			
Clinic Visits			
Dialysis			
Other			
Total:			

Ancillary Procedures - Please provide the number of procedures:

	Projected Year	**Current Year**	**Previous Year**
Radiology			
Laboratory			
Other:			
Other:			
Total:			

Training Services

If the Applicant is an Academic or Teaching Hospital, list programs below:

____

____

Do any of the programs listed above include resident rotations? ☐ Yes ☐ No
Please include any contractual agreements.

Do the training program(s) include rotations outside teaching hospitals? ☐ Yes ☐ No

If "Yes," list participating Departments and indicate whether the receiving facility is responsible for professional liability coverage.

____

____

Additional Information

Please indicate the following special activities/exposures:

- Clinical Research ☐ Yes ☐ No
- Experimental Drugs Administration ☐ Yes ☐ No
- Bio-Medical Device Research ☐ Yes ☐ No
- Does the Applicant own or operate a helipad or heliport? ☐ Yes ☐ No
- Does the hospital operate an urgent care center? ☐ Yes ☐ No
  - If "Yes," is it in compliance with The Emergency Medical Treatment and Labor Act (EMTALA)? ☐ Yes ☐ No
- Has senior leadership been in place for the last 3 years? ☐ Yes ☐ No
- Has Applicant implemented a system-wide EHR system? ☐ Yes ☐ No

Section 5 - Professional Staff

Attach a schedule of all physicians to be covered under this policy. Please include name, specialty, date of hire, full or part time status. Attach additional pages if necessary.

	# Employed Full-Time	**# Employed Part-Time**	**Include in Coverage (Yes or No)**	**# Contracted Full-Time**	**# Contracted Part-Time**	**Include in Coverage (Yes or No)**
Physicians						
Surgeons						
Obstetricians						
Hospitalists						
Neonatologists/Pediatricians						
Podiatrists						
Dentists						
Fellows						
Residents						
Certified Nurse Midwives						
CRNAs						
Physician Assistants						
Advanced Practice Nurses						
Registered Nurses						
Pharmacists						
Other:						
Total Number:						

Name of Medical Director: ______________________________

Please note that above referenced physician (Medical Director) will only be covered for administrative duties. No clinical activities or direct patient care coverage will be afforded unless specifically requested.

Is medical professional liability coverage for the facility provided under the Federal Tort Claims Act (FTCA)? ☐ Yes ☐ No

If "Yes," please provide a list of physicians that are covered by the FTCA and submit letter with proof of current deemed status.

Section 6 - Medical Service Departments

Anesthesiology

Not Applicable ☐

Staffing is provided by:	# of Each	% Board Certified or Eligible
Employed Physicians	________	________
Contracted Physicians	________	________
Employed CRNAs	________	________
Contracted CRNAs	________	________
Contracted Group	________	________

If staffing is provided by a contracted group, please provide the following information:

Name of Group: ______________________________

Limits of Liability required: Per Claim: ____________ Aggregate: ____________

Is a certificate of insurance required? ☐ Yes ☐ No

Does the Applicant obtain certificates of insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

Section 6 - Continued

Radiology

Not Applicable ☐

Staffing is provided by:	# of Each	% Board Certified or Eligible
Employed Physicians	________	________
Contracted Physicians	________	________
Residents	________	________
Contracted Group	________	________

If staffing is provided by a contracted group, please provide the following information:

Name of Group: ______________________________

Limits of Liability required: Per Claim: ____________ Aggregate: ____________

Is a certificate of insurance required? ☐ **Yes** ☐ **No**

Does the Applicant obtain certificates of insurance from the companies providing professional liability insurance for contracting physicians? ☐ **Yes** ☐ **No**

Emergency Department

Not Applicable ☐

Level of Service: ☐ Level I ☐ Level II ☐ Level III ☐ Other

If Other, please describe: ______________________________

Staffing is provided by:	# of Each	% Board Certified or Eligible
Employed Physicians	________	________
Contracted Physicians	________	________
Residents	________	________
Contracted Group	________	________

If staffing is provided by a contracted group, please provide the following information:

Name of Group: ______________________________

Limits of Liability required: Per Claim: ____________ Aggregate: ____________

Is a certificate of insurance required? ☐ **Yes** ☐ **No**

Does the Applicant obtain certificates of insurance from the companies providing professional liability insurance for contracting physicians? ☐ **Yes** ☐ **No**

Obstetrics

Not Applicable ☐

Staffing is provided by:	# of Each	% Board Certified or Eligible
Employed Physicians	________	________
Voluntary Physicians	________	________
Contracted Physicians	________	________
Contracted Group	________	________

Section 6 - Continued

If staffing is provided by a contracted group, please provide the following information:

Name of Group: ______________________

Limits of Liability required: Per Claim: __________ Aggregate: __________

Is a certificate of insurance required? ☐ Yes ☐ No

Does the Applicant obtain certificates of insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

Besides obstetricians, please indicate providers with privleges to perform deliveries:

☐ Family Practitioner ☐ General Practitioner ☐ Certified Nurse Midwife
☐ Residents ☐ Physician Assistant ☐ Other (describe): __________

Level of Neonatal Services:

☐ Level I (Well Baby) # of Bassinets __________
☐ Level II (Intermediate Care) # of Bassinets __________
☐ Level III (Neonatal Intensive Care) # of Bassinets __________

Is there an obstetrician available in-house 24/7? ☐ Yes ☐ No

Is there an obstetrician on call 24/7? ☐ Yes ☐ No

Is there an anesthesiologist or CRNA available in-house 24/7 for the obstetrical suite? ☐ Yes ☐ No

Other Contracted Services

☐ Laboratory ☐ Pathology ☐ Home Health Care ☐ Physical/Occupational Therapy
☐ Bariatrics ☐ Social Work ☐ Other (specify): __________

Is a certificate of insurance required? ☐ Yes ☐ No

Does the Applicant obtain certificates of insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

Section 7 – Contractual Agreements

Are there contractual agreements in place, whereby the Applicant either receives or provides medical services? ☐ Yes ☐ No

If "Yes", please provide a copy of each agreement.

Does the Applicant rent or lease the premises? ☐ Yes ☐ No

If "Yes," does the Applicant rent or lease any medical or therapeutic supplies and/ or equipment to others? ☐ Yes ☐ No

Does the Applicant indemnify (hold harmless) any other party for liability? ☐ Yes ☐ No

If "Yes", please provide a copy of each agreement.

Section 8 – Licensing/Accreditation

Is the Applicant JCAHO/CARF/OASAS/CAP/AAAHC accredited? ☐ Yes ☐ No

Accreditation Period: ____________________ **to** ____________________

If "No", when does the Applicant expect to get accredited? ____________________

Has the Applicant's license ever been revoked/suspended/refused/canceled/voluntarily surrendered or subject to enforcement action? ☐ Yes ☐ No

If "Yes", please explain:

____

____

Are there any pending investigations being conducted by any city, state, or federal agency? ☐ Yes ☐ No

If "Yes", please explain:

____

____

Has the Applicant ever filed for protection under Chapters 11 or 7 of the Bankruptcy code? ☐ Yes ☐ No

Section 9 – Risk Management

Does the Applicant employ a Risk Manager? ☐ Yes ☐ No

If "No," please explain:

____

____

Is there a written, formalized Risk Management and/or Patient Safety Program? ☐ Yes ☐ No

If "Yes:"

a. Is this plan regularly reviewed for effectiveness and/or any necessary changes? ☐ Yes ☐ No

b. How often is the plan reviewed? ____________________

Is there an ongoing Quality Assessment or Improvement Plan? ☐ Yes ☐ No

If "No," please explain:

____

____

Are transfer agreements in place with the closest hospital(s) for patients who develop a need for care beyond the scope of the Applicant? ☐ Yes ☐ No

Is a formal process in place to evaluate and address concerns of unexpected patient outcomes? ☐ Yes ☐ No

Are written policies and procedures in place for reporting of any suspected abuse? ☐ Yes ☐ No

Has the Applicant had any incident at any facility that resulted in an allegation of sexual abuse or molestation? ☐ Yes ☐ No

If "Yes," please explain:

____

____

Section 9 - Continued

Question	Yes	No
Are complete records kept on all patients or clients?	☐ Yes	☐ No
Is an informed consent process in place?	☐ Yes	☐ No
Does the Applicant have a written policy in place to address staff when complaints are received?	☐ Yes	☐ No
If "Yes," does the Applicant investigate complaints made against its staff prior to placing them in other roles?	☐ Yes	☐ No
Does the Applicant have written job descriptions?	☐ Yes	☐ No
Before staff can provide care, is a competency based checklist used to assess and document their skills?	☐ Yes	☐ No
Is there a fall risk and reduction program in place?	☐ Yes	☐ No
Is there an infection program in place?	☐ Yes	☐ No
Does the Applicant provide simulation training at the facility or offsite?	☐ Yes	☐ No
Has the Applicant established a Pressure Ulcer Program employing a Certified Wound Care Nurse?	☐ Yes	☐ No
Does the Applicant have a Wandering Prevention Program in place?	☐ Yes	☐ No

Does the Risk Manager particiapte in or maintain the following:

Item	Yes	No
Claims Management	☐ Yes	☐ No
Contract Review and Evaluation	☐ Yes	☐ No
Disclosure	☐ Yes	☐ No
Staff Education	☐ Yes	☐ No
Formal link to quality management	☐ Yes	☐ No
Incident/Occurrence reporting	☐ Yes	☐ No
Infection Control Committee	☐ Yes	☐ No
IRB Committee	☐ Yes	☐ No
Patient Satisfaction Results	☐ Yes	☐ No
Policy and Procedure Development/Review	☐ Yes	☐ No
Risk Management Committee	☐ Yes	☐ No
Patient Safety Program and Committee	☐ Yes	☐ No
Sentinel Event Investigation	☐ Yes	☐ No
Emergency Preparedness	☐ Yes	☐ No

Section 10 – Claims History

During the past ten (10) years, has any claim that would fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance?
(Please provide a loss report for the last 10 years.)

☐ Yes ☐ No

Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance?

☐ Yes ☐ No

If "Yes," please provide details:

____

____

Note: Without prejudice to any other rights or remedies of the underwriter, it is agreed that any claim arising from any fact, circumstance, situation, transaction, event, act, error or omission required to be disclosed in reponse to the question above is excluded from the proposed insurance.

Section 11 – Additional Information Required

1. Copy of the most recent Department of Health survey, including the Plan of Correction.
2. Complete copy of the most recent JCAHO or AAAHC accreditation report.
3. Copy of current state license.
4. Copies of Certificates of Insurance for physicians covered under individual policies.
5. If applicable, completed EmPRO applications for all physicians to be covered under this facility policy.
6. Copies of any contracts with independent physician groups.
7. Current annual audited financials.
8. Public relations materials, brochures, etc.
9. Copies of any hold harmless agreements.
10. Copy of Certificate of Incorporation (Articles of Organization).
11. Copy of loss runs for the last ten (10) years.

READ CAREFULLY BEFORE SIGNING.

The statements in this application, together with any supplemental applications, attachments, and any other information submitted to the Company in connection with this application will be referred to as the “Policy Application.”

REPRESENTATIONS AS TO THE ACCURACY OF THIS APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT’S OBLIGATION TO SUPPLEMENT INFORMATION

By signing below, I represent and certify: (i) that the information contained in this Policy Application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in this Policy Application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; (iii) that I am duly authorized to sign this Policy Application on behalf of all persons and entities to be insured by the requested insurance; and (iv) that I have carefully read this Policy Application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this Policy Application, and any such insurance that may be issued will be based upon the Company’s reliance on the information provided in this Policy Application. I also agree and understand that this Policy Application shall be the basis of the contract should a policy be issued, and that this Policy Application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued.

Additionally, I agree that in the event there is any change in the information provided in this Policy Application before the effective date of the requested insurance or before any renewal of the requested insurance, I will immediately notify the Company in writing. I understand that if there is a change in the information provided in this Policy Application the Company, in its sole discretion, may modify or withdraw any quotation or agreement to bind insurance.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I understand that this Policy Application is not a binder of insurance. Accepting this Policy Application does not bind the Company to issue, or me to purchase, the requested insurance.

AUTHORIZATION TO OBTAIN INFORMATION

The Company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney, or other person or entity concerning: (i) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action, or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the Company, may have a bearing on whether to issue the requested insurance.

I agree to hold harmless any person or entity providing such information to the Company and the Company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

This application shall be deemed appended to and a part of any policy of insurance issued to you based on this Policy Application.

CONNECTICUT APPLICANTS: Any person who knowingly with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false, incomplete, or misleading information concerning any fact or thing material to such application or claim is guilty of insurance fraud, which is a crime and subjects such person to criminal penalties.

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

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

Signature of Applicant: ______________________________ Title: ______________________

Printed Name: ______________________________ Date: ______/______/______

SUBSCRIBERSHIP TO PRI EXCHANGE

Your signature on this application subscribes you to membership in the reciprocal exchange of Physicians' Reciprocal Insurers ("PRI"), the parent company of EmPRO Insurance Company, and all of the benefits of the exchange and shall be deemed to be a concurrent execution of the attached Subscriber's Agreement and Power of Attorney of PRI.

Subscribership begins with the commencement of the policy period of the professional liability insurance policy issued by EmPRO Insurance Company and ends upon cancellation or other termination of that policy.

Signature of Applicant: ______________________ Date: ________/________/________

ASSIGNMENT OF DISTRIBUTIONS

Paragraph 13(e) of the Subscriber's Agreement provides that the PRI Exchange may declare and make Distributions, as defined therein. Such Distributions shall be made to the Subscriber policyholder. However, in instances where the Subscriber's premium will be paid by a person or entity other than the Subscriber policyholder, the Subscriber may agree in advance to assign such Distribution and designate the person or entity which has paid the premium to receive such Distribution by signing below and naming such recipient:

______________________________________ Date: ________/________/________

Subscriber Policyholder Signature

____

Name of Designated Recipient (Print)

PHYSICIANS' RECIPROCAL INSURERS
SUBSCRIBER'S AGREEMENT AND POWER OF ATTORNEY

This Subscriber's Agreement and Power of Attorney (the "Agreement") is made by and between Physicians' Reciprocal Insurers (hereinafter "PRI") and the "Subscriber," holder of an insurance policy, to which this Agreement is appended, issued by PRI or by a wholly owned subsidiary of PRI, subject to the approval of those insurance regulator(s) having jurisdiction over holders of policies issued by any subsidiary of PRI under the laws of states other than New York. For purposes of this Agreement, PRI and its wholly owned subsidiary are hereinafter, collectively, the Exchange.

WHEREAS, the Subscriber desires to participate as a subscriber of the Exchange pursuant to which PRI or its wholly owned subsidiary will issue policies of insurance.

NOW THEREFORE, the Subscriber hereby agrees as follows:

POLICIES OF INSURANCE

1. The Exchange shall issue non-assessable policies of professional liability insurance and ancillary general liability insurance to policyholders insuring against liability for claims arising from alleged incidents of malpractice.

ATTORNEY-IN-FACT

2. The Subscriber hereby designates and appoints PRIMMA LLC, a wholly owned subsidiary of PRI, ("PRIMMA") as the Attorney-in-Fact to act for and bind the Subscriber in all transactions relating to or arising out of the operations of PRI, subject to such limitations as may be lawfully provided, including, but not limited to, the issuance of non-assessable policies of professional liability insurance and ancillary general liability insurance issued to policyholders insuring against liability for claims arising from alleged incidents of malpractice on behalf of the Exchange as well as the authority to reinsure any portion of the policies of liability insurance issued by the Exchange as permitted by law.

3. The Subscriber hereby acknowledges and agrees that service of summons or other legal process on PRIMMA or on any persons appointed by PRIMMA to receive such process, shall, in any action, suit or proceeding arising out of any contract, agreement or transaction of the Exchange, be equivalent to personal service of such summons or other legal process on each and every Subscriber.

POWERS AND DUTIES OF PRIMMA

4. PRIMMA shall have the duty to provide all services necessary and appropriate to operate and administer the day-to-day affairs of PRI as provided by law and the Management Agreement between PRI and PRIMMA, including, but not limited to, marketing, procuring and underwriting insurance business; collecting premiums; and administering, investigating and defending claims arising from policies of insurance issued by the Exchange.

5. In April of each year, PRIMMA shall render to Subscribers a statement showing a summary of collective transactions of PRI during the preceding calendar year.

BOARD OF GOVERNORS

6. PRI shall be governed by an advisory committee, known as the "Board of Governors," which shall have ultimate power and responsibility for the management and control of the affairs of PRI. The Board of Governors shall consist of not less than nine persons elected by the Subscribers, at least two-thirds of whom are Subscribers or officers of Subscribers and not more than one-third of whom may be the Attorney-in-Fact or any person designated by the Attorney-in-Fact. Each member of the Board of Governors shall serve for a term of three years, and not more than one-third of the Board members shall be elected at each annual meeting of Subscribers.

7. There shall be an Annual Meeting of Subscribers held in New York State, a place and time to be chosen each year by the Board of Governors and designated in a Notice of Meeting sent to all Subscribers no less than 30 days prior to such meeting, and at which meeting each Subscriber shall have power to vote in person or by proxy for all members of the PRI Board of Governors to be chosen or appointed at such time. Each Subscriber will be sent a ballot which will contain the names and addresses of the Board of Governors' nominees.

8. At the Annual Meeting, the election of the Board shall take place and all ballots not returned shall be deemed to designate the Chairman as the proxy holder of the non-responding Subscribers. The Chairman will then conduct the election and certify the election of the nominated Subscribers.

9. A majority of the members of the Board of Governors shall constitute a quorum for the transaction of business.

10. If the Exchange should for any reason cease to grant insurance to a Subscriber member of PRI's Board of Governors, or their firm or corporation, such person shall thereupon cease to be a member of said Board.

11. No member of the Board of Governors shall as such incur any personal liability for any loss of any kind, from any cause, save only such loss as may be incurred by reason of their own malfeasance.

POWERS AND DUTIES OF THE BOARD OF GOVERNORS

12. The Board of Governors shall have full power and authority to:

    a. Adopt such rules and regulations for PRI and PRIMMA, as Attorney-in-Fact for PRI, not inconsistent herewith, as it shall see fit, including, but not limited to, fixing the compensation of PRIMMA, as the Attorney-in-Fact for PRI as provided in the PRI-PRIMMA Management Agreement, and directing PRIMMA in the safeguarding of all moneys and other assets and in making and changing of investments of PRI.

    b. Suspend, remove, and terminate PRIMMA, as Attorney-in-Fact, for good cause pursuant to the terms of the the PRI-PRIMMA Management Agreement.

    c. Fill any vacancy which may occur in the office of the Attorney-in-Fact at any time, by selecting and appointing a successor and executing thereto in the name and on behalf of each Subscriber such power of attorney, designation or other instrument as may be necessary or proper to enable it to act as Attorney-in-Fact with all the powers and authority herein given by the Subscribers to the aforesaid Attorney-in-Fact, without any further action on the part of Subscribers; and the Board of Governors shall mail to each Subscriber timely notice of each and every such change made.

    d. Fill for the unexpired term any vacancy which may occur for any reason in the Board of Governors.

    e. Fix its own fees from time to time within such limits as hereafter may be provided in the regulations adopted by it.

    f. Appoint sub-committees of the Board of Governors and delegate to such sub-committees authority to exercise any or all of its own powers except as herein otherwise provided.

    g. Fix the time and places of its own meetings.

    h. Elect officers, which shall include a Chairman.

    i. Select auditors who shall examine the books and accounts of PRI and report thereon to said Board.

    j. Call annual meetings or special meetings of Subscribers at any time, by mailing to the last known address of each timely notice thereof stating when and where said meetings are to be held.

    k. Determine what acts, incapacity or failure to act shall constitute a disqualification of any Subscriber to act further as such.

SUBSCRIBER RIGHTS, PRIVILEGES AND OBLIGATIONS

13. The Subscriber shall have the following rights, privileges and obligations as an underwriter of PRI, subject to the terms of the insurance contracts required or permitted by law to be issued:

    a. The Subscriber hereby agrees to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in the form and containing terms and conditions as are approved by the Exchange, but no Subscriber shall assume any liability as an insurer in any policy so granted.

    b. Upon application and acceptance, the Subscriber shall receive a policy of liability insurance and a copy of this Agreement appended thereto.

c. The Subscriber shall have the right to vote at all meetings of Subscribers, either in person or by proxy. All meetings of Subscribers shall be noticed by mail to all Subscribers not less than thirty (30) days prior to such meeting. The notice may include ballot materials concerning any matters requiring a vote at such meeting, which ballots must be completed and returned to PRI as noticed. On the scheduled date of a meeting of Subscribers, a vote on all previously noticed transactions shall take place and all ballots not returned shall be deemed to designate the Board of Governors, voting by a simple majority, as the proxy holder of the non-responding Subscribers.

d. The Subscriber reserves the right to revoke this Agreement and the Power of Attorney granted to PRIMMA herein as of the end of any calendar quarter upon written notice to PRIMMA.

e. In the event that PRI shall declare and make a Distribution to Subscribers and Non-Subscriber Policyholders, each Subscriber and Non-Subscriber Policyholder shall receive its Pro Rata Share of such Distribution. "Pro Rata Share" means, as of any date of determination, a percentage determined by dividing (i) the amount of annual premium payable under the Subscriber's or Non-Subscriber Policyholder's policy then in effect, by (ii) the total amount of annual premium payable under all policies issued by PRI and its subsidiaries then in effect, unless governing law provides otherwise. The date for determining the Pro Rata Share shall be established by the Board of Governors in conjunction with the authorization of any Distribution and shall, to the extent required, be approved by the New York State Department of Financial Services. "Distribution means a dividend, a cash payment, or any benefit inuring to Subscribers in conjunction with any restructuring of PRI. "Non-Subscriber Policyholder" means holders of policies issued by any subsidiary of PRI in a state in which policyholders are not permitted by applicable insurance law or regulation to be Subscribers, but have been allowed by applicable insurance law to economically participate in a Distribution as if they were Subscribers.

GENERAL PROVISIONS

14. PRI shall maintain a surplus to policyholders at least equal to the amount required to be maintained by Section 4103 of the New York Insurance Law for a similarly licensed stock property/casualty insurance company.

15. It is understood that the license of PRI and all other documents, data systems, books and records used in conducting the business of the Exchange are and shall remain the property of PRI.

16. This Agreement and the Power of Attorney herein contained shall supersede all previous Agreements and Powers of Attorney, if any, executed by all Subscribers, but any and all outstanding policies of liability insurance written under powers so superseded shall continue in full force and effect.

17. It is hereby expressly stipulated that this Power of Attorney shall be and hereby is strictly limited to uses contemplated by and expressed in this Agreement and no other.

18. All amendments, modifications or changes to this Agreement must be approved by the Board of Governors, may not be inconsistent with New York Insurance Law or any regulation thereto, and must be approved, in writing, by the Superintendent of the New York State Department of Financial Services prior to making such amendment, modification or change.

19. Every amendment, modification or change to this Agreement shall be submitted to all Subscribers contemporaneously in accordance with New York Insurance Law Section 6107(d)(4) and shall take effect as to all Subscribers who have not objected within sixty (60) days after the date of such submission. Failure of any Subscriber to object within sixty (60) days shall constitute such Subscriber's acceptance of such amendment, modification or change. Any Subscriber who objects, in writing, within sixty (60) days from the date of submission to such amendment, modification or change shall be deemed to have withdrawn from membership of the PRI and said Subscriber's liability insurance policy(s) with the Exchange shall be cancelled concurrent with such withdrawal.

20. In consideration of the foregoing, the Subscriber does hereby covenant and agree that Subscriber will fully and faithfully carry out, execute and perform everything in which PRIMMA shall, by virtue hereof, bind Subscriber, and in the same manner Subscriber does hereby ratify and confirm all that PRIMMA may lawfully do or cause to be done by virtue hereof.

21. This Agreement shall be governed by the laws of the State of New York.

22. Pursuant to Section 6106(a)(2) of the New York Insurance Law, the acceptance of a policy or binder of insurance with this Agreement printed thereon preceded by the words: "The acceptance of this policy or binder, shall constitute that execution and delivery by the insured of the Subscriber's Agreement, which is appended to this policy or binder, and hereby made a part thereof," shall constitute the execution and delivery of this Subscriber's Agreement by that insured as fully and to the same extent as though this Agreement has been signed and acknowledged by the insured.