EMPRO INSURANCE

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

Physician & Surgeon Application

Requested Effective Date: _____

Section 1 - Personal Information

Name:		DOB:	Gender:
Last 4 Digits of SSN:	NPI:	Professional Designation:	
Primary Office Address:	City:	State:	Zip:
Practice Type (e.g., private office, hospital, urgent care, or nursing home, etc.):		Primary Office Phone:	Primary Office Fax:
Email Address:		Mobile Phone:	Website:
Mailing Address (if different from Office):	City:	State:	Zip:
Billing Address (if different from Office):	City:	State:	Zip:
Home Address (if different from Mailing/Billing):	City:	State:	Zip:

☐ This application is a request to become affiliated with an insured under policy #: _____

☐ This is a new application with EmPRO Insurance Company

Section 2 - Professional Education

Medical School:	Specialty:	State, Country:	Date Completed:
Residency:	Specialty:	State, Country:	Date Completed:
Fellowship:	Specialty:	State, Country:	Date Completed:

Please indicate your first date of practice after completing a residency or fellowship program or service in a federal government-funded healthcare program: _____

In what specialties are you board certified or board eligible? _____

Have you ever failed a specialty or sub-specialty exam? ☐ **Yes** ☐ **No** If "Yes," how many? _____

Section 3 - Licensure

Please indicate in which states you are presently licensed to practice, and what percentage of your total practice is spent in each. For surgeons or obstetricians, base your percentage on surgeries or deliveries.

State	License Number	Date of License	% of Total Practice

Section 3 - Continued

Licensing/Professionalism	Yes	No
1. Has your medical license in any state ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, limited, or have you ever been subject to a fine, reprimand, consent order, probation, and/or conditions or limitations by any state or professional licensing, registration, or certification board?	☐	☐
2. Are you currently under review, investigation or subject to an order issued by any state or professional licensing board or agency?	☐	☐
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked, limited, or voluntarily or involuntarily relinquished?	☐	☐
4. Has any hospital ever taken action to reprimand, deny, suspend, revoke, or restrict your hospital privileges or your reapplication for privileges?	☐	☐
5. Have you ever resigned from hospital privileges while under investigation or to avoid possible disciplinary action?	☐	☐
6. Have you ever been accused of sexual misconduct?	☐	☐
7. Have you ever been convicted, pled guilty, or pled nolo contendere in a criminal prosecution involving felony charges?	☐	☐
8. In the past 10 years, have you been convicted, pled guilty, or pled nolo contendere in a criminal prosecution involving misdemeanor charges?	☐	☐

If you answered "Yes" to any of the above questions, please explain further:

_____

_____

_____

Section 4 - Practice Information

Practice Organization

☐ Solo unincorporated

☐ Solo professional corporation

☐ Partner in a partnership

☐ Shareholder and employee in a professional or business corporation

☐ Employee or independent contractor for a professional corporation, hospital, clinic, or similar legal business entity

Name of Organization: _____

Number of Physicians, Dentists, and/or Podiatrists in your organization: _____

Note: If coverage is requested for any type of corporation or partnership other than a solo professional corporation, or if separate limits of insurance are desired for any corporation, please complete APP 008, Partnership & Corporation Application. Coverage will not take effect unless an application has been approved by EmPRO Insurance Company.

Practice Names and Locations

Practice Name: ______

Practice Address: ______

City ______ State ______ Zip ______

Practice Type:
☐ Private Office ☐ Hospital Setting ☐ Urgent Care
☐ Surgery Center ☐ Nursing/Long Term Care
Other: ______

% of Practice at this Location: ______

Practice Name: ______

Practice Address: ______

City ______ State ______ Zip ______

Practice Type:
☐ Private Office ☐ Hospital Setting ☐ Urgent Care
☐ Surgery Center ☐ Nursing/Long Term Care
Other: ______

% of Practice at this Location: ______

Practice Name: ______

Practice Address: ______

City ______ State ______ Zip ______

Practice Type:
☐ Private Office ☐ Hospital Setting ☐ Urgent Care
☐ Surgery Center ☐ Nursing/Long Term Care
Other: ______

% of Practice at this Location: ______

Do you practice at any other location where coverage is not required under this policy? ☐ **Yes** ☐ **No**

If "Yes," please provide location, entity name, hours per week, and insurance carrier name for that coverage:

______

______

Do you hold any position outside your principal medical or surgical practice (e.g., moonlighting in an E.R., serving part-time at a clinic, skilled nursing facility, or nursing home, etc.)? ☐ **Yes** ☐ **No**

If "Yes," please provide location, entity name, and hours per week: ______

______

Do you have separate insurance for this exposure? ☐ **Yes** ☐ **No**

If "Yes," please provide insurance carrier name for that coverage: ______

List all hospitals where you currently have or have applied for staff privileges or affiliation in any way (include courtesy staff privileges) and the percentage of your hospital practice:

Hospital	City/State	% of Practice

List all Risk Purchasing Groups, Medical Associations, and Societies to which you belong: ______

______

Your Practice Profile

Specialty you will be practicing while insured by EmPRO: _____

Average weekly patient load/surgical procedures: _____

Average number of practice hours per week (including office hours, administrative activities, direct patient care, surgery, consultation, etc.): _____

Number of Employees

Physician Assistants:	Medical Assistants:
Nurse Practitioners:	Lab Technicians:
Nurse Anesthetists:	Physical/Occupational Therapists:
Nurse Midwives:	Other Medical Employees:
Nurses:	Non-Medical Staff:

Are you currently involved in a collaboration agreement with any nurse practitioners functioning independently? ☐ **Yes** ☐ **No**

If "Yes", please advise the following:

Number Involved: _____ Number Working within Your Practice Location: _____

Please provide copies of any Joint Protocols or agreements that are in place.

Has any employee of yours ever been named in a claim or suit arising from professional services or from managed care services? ☐ **Yes** ☐ **No**

Has any employee of yours had any action taken against their license by any licensing board, regulatory authority, or ever been the subject of disciplinary proceeding by any hospital or employer? ☐ **Yes** ☐ **No**

If you answered "Yes" to either of the above two questions, please explain further: _____

Section 5 - Coverage Options

Coverage Type

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

Requested Limits of Liabililty

Per Claim/Aggregate: _____

Refer to Page 9, State Addendum, for Limits of Liability available in each state.

Section 6 - Professional Liability Insurance History

List all medical professional liability insurance policies you have had during the last 10 years, beginning with the most recent:

Coverage Period: _____ Insurance Carrier: _____

Coverage Type: _____ Retroactive Date (If Applicable): _____

Limits of Liability: _____

Section 6 - Continued

Coverage Period: _____ Insurance Carrier: _____

Coverage Type: _____ Retroactive Date (If Applicable): _____

Limits of Liability: _____

Coverage Period: _____ Insurance Carrier: _____

Coverage Type: _____ Retroactive Date (If Applicable): _____

Limits of Liability: _____

If any of your previous coverages were Claims-Made, was tail purchased? (Provide copies of all tail endorsements if purchased.) If "No," please explain: ☐ **Yes** ☐ **No**

_____

_____

Have you ever practiced without professional liability insurance? ☐ **Yes** ☐ **No**

Have you ever had professional liability insurance refused, declined, non-renewed, canceled (other than at your request), or accepted on special terms? ☐ **Yes** ☐ **No**

Have you ever been required to pay a premium surcharge or have you been involved in an appeal concerning the imposition of such a surcharge? ☐ **Yes** ☐ **No**

If you answered "Yes" to any of the above questions, please explain further: _____

_____

_____

Section 7 - Claim History

Note: This application will not be approved unless the Applicant provides complete claim information.

Have you ever been involved in a malpractice claim or suit, with an incident date, report date, or close date occurring within the last 10 years, or are you presently involved in malpractice litigation? ☐ **Yes** ☐ **No**

Are you aware of any suits or claims against you or any entity for which you have provided professional services that have not been reported to your prior or current insurer(s)? ☐ **Yes** ☐ **No**

Are you aware of any request for records from any patient and/or attorney related to an adverse outcome? ☐ **Yes** ☐ **No**

Are you aware of any correspondence from an attorney regarding your medical treatment of a patient? ☐ **Yes** ☐ **No**

Have you ever testified in an action alleging medical malpractice, other than as an expert witness? ☐ **Yes** ☐ **No**

Are you aware of any complications resulting in death, paralysis, or other significant disabilities related to a patient you treated? ☐ **Yes** ☐ **No**

Are you aware of patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ☐ **Yes** ☐ **No**

Have you reported all circumstances that might reasonably lead to an incident, claim, or suit, even if you believe it is without merit, to your prior or current insurer(s)? If "Yes," please attach documents of all such reports. ☐ **Yes** ☐ **No**

If you answered "Yes" to any of the above questions, please complete the attached Claims Information Addendum.

Section 8 - Procedure Information

Please check all of the following procedures that you will perform. Percentages and counts are understood to be approximate.

- ☐ Anesthesia (indicate type)
  - ☐ Local
  - ☐ Regional
  - ☐ Spinal
  - ☐ Caudal
  - ☐ Conscious sedation
  - ☐ Deep sedation
- ☐ Anorectal procedures (other than diagnostic)
  Describe:_____
- ☐ Arthroscopic surgery ____ % of total practice
- ☐ Assisting in major surgery
  - ☐ Own patients
  - ☐ Patients other than own
- ☐ Biopsies (list locations): _____
- ☐ Bronchoscopies ____ % of total practice
  - ☐ Diagnostic
  - ☐ Therapeutic
- ☐ Cataract Surgery_____% of total practice
- ☐ Cosmetic procedures
- ☐ Endscopic procedures
  - ☐ Upper GI
  - ☐ Lower GI
  - ☐ ERCP
  - ☐ Others (list types):

    _____

    _____
- ☐ Endovascular procedures (other than IV insertions or phlebotomy)_____% of total practice
  - ☐ Venous
  - ☐ Arterial
  - ☐ Cardiac
  - ☐ Non-cardiac
  - ☐ Angioplasty
  - ☐ Stenting
  - ☐ Embolization
- ☐ Fracture care
  - ☐ Closed reduction
  - ☐ Open reduction
  - ☐ Casting
- ☐ Glaucoma procedures
- ☐ Joint injection
  - ☐ Spinal
  - ☐ Non-Spinal
- ☐ Joint replacement
  - ☐ Shoulder ____% of total practice
  - ☐ Hip ____% of total practice
  - ☐ Knee ____% of total practice
- ☐ Laparoscopic surgeries
- ☐ Laparotomies
- ☐ Pain management procedures ____ % of total practice
- ☐ Procedures involving the breast (other than examination)
  Describe:_____
- ☐ Procedures on female genitalia (other than examination)
  Describe: _____
- ☐ Procedures on male genitalia (other than examination)
  Describe: _____
- ☐ Refractive eye surgery ____ % of total practice
- ☐ Retinal procedures
- ☐ Robotic surgery ____% of total practice
- ☐ Stem cell injections - indicate locations: _____

  _____
- ☐ Surgery involving
  - ☐ Biliary tree, liver, pancreas, or gallbladder
  - ☐ Colorectal
  - ☐ Esophagus, stomach, or small intestine
  - ☐ Head or neck
  - ☐ Kidneys, ureters, bladder, or prostate
  - ☐ Heart
  - ☐ Lungs, airway, or thorax
  - ☐ Skeletal, muscles, ligaments, or tendons
- ☐ Transurethral procedures
  Describe: _____
- ☐ Weight control medications ____% total practice
- ☐ Wound care ____% total practice

☐ Telemedicine ☐ Pathology ☐ Radiology

State where principal practice is located:_____

State(s) where medical service is delivered remotely/ electronically:

_____

_____

_____

Do you perform surgery?

☐ **No Surgery** Applies to both general practitioners and specialists who do not perform obstetrical procedures or surgery (other than the incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

☐ **Minor Surgery** Applies to general practitioners and specialists who perform minor surgery, or assist in major surgery on their own patients.

☐ **Major Surgery** Applies to general practitioners and/or specialists who perform major surgery, or assist in major surgery on patients other than their own.

Section 8 - Continued

Please indicate the percentage of your total practice performing the following surgical activities:

_____% Bariatrics
_____% Cardiac
_____% Colorectal
_____% Dermatology
_____% Gastroenterology
_____% Gynecology
_____% Neurosurgery
_____% Obstetrics
_____% Ophthalmology
_____% Orthopedic – Including Spine
_____% Orthopedic – No Spine
_____% Otolaryngology without Facial
_____% Otolaryngology with Facial Plastics
_____% Plastic Cosmetic
_____% Plastic Reconstructive
_____% Thoracic
_____% Trauma
_____% Urology
_____% Vascular
_____% Other:_____

Section 9 - Specialty Specific Information

Anesthesiology

1. Do you administer anesthesia in a non-hospital setting? ☐ Yes ☐ No
If "Yes," provide locations: _____

_____

2. Do you employ or supervise any Certified Registered Nurse Anesthetists (CRNAs)? ☐ Yes ☐ No
If "Yes," please advise the following:

Number Employed: _____ Number Supervised: _____

3. Do the CRNAs you employ give anesthesia while not under your personal direction, control, and supervision? ☐ Yes ☐ No
If "Yes," please describe:

_____

_____

Family Practice/Internal Medicine/General Practice
Percentage of your practice derived from treatment of patients under the age of 21 years: _____%

Obstetrical/Gynecological Care
Please indicate the count or percentage of your total practice performing the following surgical activities:

_____# 1st Trimester abortions - list settings (e.g. surgi-center):
_____
_____
_____# 2nd Trimester abortions - list settings (e.g. surgi-center):
_____
_____
_____% Prenatal practice – 1st Trimester
_____% Prenatal practice – 2nd Trimester
_____% Prenatal practice – 3rd Trimester
_____# Deliveries performed per year
_____% Vaginal delivery – performed per year
_____% VBAC delivery – performed per year
_____% C-Section delivery - performed per year
_____% Delivery outside of hospital setting -
Number performed per year:_____
_____# Hysterectomies
_____# Laparoscopic or open surgeries involving the ovaries, fallopian tubes, or uterus (other than hysterectomies)
_____# Hysteroscopic myomectomies
_____# Myomectomies other than hysteroscopic
_____# Endometrial ablation

Pediatrics

Percentage of your practice derived from neonatology: _____%

Percentage of your practice derived from treatment of adults: _____%

Physical Medicine/Pain Management

Do you perform any pain management procedures? ☐ Yes ☐ No

Section 9 - Continued

All Specialties

1. Do you own, operate, or use surgi-center facilities? ☐ Yes ☐ No
2. Do you perform surgical procedures in your office? ☐ Yes ☐ No
3. Do you participate in any medical research, clinical trials, or off-label use of drugs or devices? ☐ Yes ☐ No
4. Do you provide services at a correctional facility? ☐ Yes ☐ No
   If "Yes," please provide entity name, location, and hours per week:

Entity Name	Location	Hours Per Week

5. Do you provide services at a skilled nursing facility or nursing home? ☐ Yes ☐ No
   If "Yes," please provide entity name, location, and hours per week:

Entity Name	Location	Hours Per Week

State Addendum

New York

Limits of Liability Available: ● **$500K/$1.5M** ● **$1M/$3M** ● **$1.3M/$3.9M**

Excess Coverage:

Do you currently have Section 18 excess coverage through a hospital affiliation? ☐ **Yes** ☐ **No**

If you are eligible for Section 18 excess coverage, do you want to apply through EmPRO? ***If "Yes," please complete EXA 2023, Section 18 Professional Liability Insurance Application.*** ☐ **Yes** ☐ **No**

If not eligible for Section 18 excess, would you like to purchase direct excess coverage through EmPRO? ***If "Yes," please complete DPX 2023, Direct Pay Excess Insurance Application.*** ☐ **Yes** ☐ **No**

New York State Risk Management Program:

Are you currently receiving a premium discount as a result of having completed a New York State Department of Financial Services (NYDFS) approved Risk Management Course with your present carrier? ***If "Yes," please submit proof of completion.*** ☐ **Yes** ☐ **No**

New York State "No Consent" Option:

By checking "Yes," I hereby authorize EmPRO to act on my behalf to settle any claim reported, or to appeal any judgement against me without first obtaining my written consent. I understand that I will receive a 5% premium reduction by choosing this option. ☐ **Yes** ☐ **No**

Connecticut

Limits of Liability Available: ● **$500K/$1.5M** ● **$750K/$2.5M** ● **$1M/$1M** ● **$1M/$4M** ● **$2M/$5M**

Contact EmPRO if other Limits of Liability are required.

New Jersey

Limits of Liability Available: ● **$1M/$3M** ● **$2M/$4M** ● **$3M/$5M**

Contact EmPRO if other Limits of Liability are required.

In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from $5,000 to $1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy, the deductible may need to be fully collateralized. **Would you like more information on deductibles?** ☐ **Yes** ☐ **No**

Consent to Settle is automatically attached to all individual and group policies. It requires EmPRO to obtain your written consent before settling any claims brought against you. In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for 1% premium credit to your policy. **Would you like to remove this endorsement?** ☐ **Yes** ☐ **No**

Pennsylvania

Limits of Liability Available: ● **$500K/$1.5M (Mcare Participating Physician)** ● **$1M/$3M (non-Mcare Participating Physician)**

Have you ever practiced in Pennsylvania without participating in the Mcare fund?

If "Yes," please explain: _____

_____

_____

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 profesisonal 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.