Application

PHYSICIANS & SURGEONS

Professional Liability Insurance

NOTICE REQUIRED BY THE NEW YORK INSURANCE LAW

THIS POLICY PROVIDES INSURANCE ON A CLAIMS-MADE BASIS.

This policy does not provide coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated on the declarations page. The policy covers only claims or incidents reported to the COMPANY while the policy remains in effect and all coverage under the policy, except for the 60-day extended reporting period, ceases upon the termination of the policy unless the Named Insured purchases optional extended reporting endorsement coverage. The length of such optional extended reporting endorsement coverage under this policy shall be for an unlimited time period.

During the first several years of claims-made insurance, claims-made rates are comparatively lower than occurrence rates for the same coverage. However, the annual premium for claims-made insurance is subject to increases independent of overall rate level increases until the claims-made exposure reaches maturity.

In accordance with New York Insurance Regulations, claims-made rates are computed by applying the following factors to the corresponding occurrence rate, depending upon your year in the claims-made program: First 31%; Second 64%; Third 85%; Fourth 94%; Fifth 99%; Sixth 102%; Seventh 104%; Eighth and later 105%.

In accordance with New York Insurance Regulations, rates for optional extended reporting coverage are computed by applying the following factors to the corresponding occurrence rate, depending upon years completed in the claims-made program: One 74.8%; Two 122.1%; Three 146.4 %; Four 162.4 %; Five 173.3%; Six 181.0%; Seven 186.7%; Eight or more 190.6%.

These factors may change in future years in response to changes in applicable laws or regulations.

EmPRO Insurance Company
1800 Northern Boulevard
Roslyn, NY 11576
Toll Free (833) 774-6625
www.myempro.com

SUBSCRIBER'S AGREEMENT

By these presents, we, the undersigned "Subscribers", holders of an insurance policy issued by Physicians' Reciprocal Insurers ("PRI" or the "Exchange") or by a wholly owned subsidiary of the Exchange hereby appoint PRIMMA LLC as our Attorney-in-Fact for the Exchange.

POLICIES OF INSURANCE

The Attorney-in-Fact shall have power to:

1. Sign non-assessable policies of medical liability insurance in its name on our behalf, insuring against liability for claims arising from alleged incidents of medical malpractice.

2. Sign any other papers by one signature of its own name as acting for all Subscribers interested therein.

3. Issue policies of medical liability insurance to Subscribers only and make any such policies subject to such terms as it shall deem proper, change or modify such terms, and cancel all or any portion of any such policy.

4. Reinsure any portion of any policies of medical liability insurance issued by the Exchange as permitted by law, provided that the terms of all collective reinsurance shall be subject to approval by the Board of Governors.

FURTHER POWERS AND DUTIES OF THE ATTORNEY-IN-FACT

Further Powers. The Attorney-in-Fact shall have full power to:

5. Defend, institute or prosecute any suit or other legal proceedings taken upon, or in relation to, any transaction in which we may be liable, or make by it in virtue hereof or by direction of the Board of Governors and compromise and settle with same in accordance with the terms of the policy of liability insurance.

6. Bring suit, in its own name or otherwise, to enforce payment of any premium due at the Exchange should we fail to immediately comply with its request to make good on any such payment.

7. Accept, or appoint itself or any other person, including officials of state or provincial insurance departments, to accept service of process in any action, suit or proceeding arising as a result of any policy, agreement or transaction to the Exchange.

8. Charge against our account and pay therefrom our proportion of all losses sustained and of all taxes, fees, expenses, and other operating costs incurred.

9. Deduct from moneys received by it, its compensation.

10. Do and execute, for us in our name, every other act and thing by virtue hereof which we could do or execute personally.

11. Determine what constitutes a single risk, and adjust and settle losses in all respects in accordance with the terms of the policy of liability insurance.

Duties. The Attorney-in-Fact shall:

12. Keep a separate account in our name of all financial transactions in which we are involved in pursuance hereof.

13. In April of each year render to us a statement showing a summary of collective transactions of the Exchange during the preceding calendar year, and also a statement of our separate account made up as of the end of said calendar year.

14. Deliver to the Board of Governors, its bond in such form and amount as shall be approved by said Board.

15. Keep a record of active Subscribers which, during office hours, shall be available for inspection by Subscribers.

16. Before resigning, give to the Board of Governors at least 180 days written notice of its intention to do so.

BOARD OF GOVERNORS

17. There shall be a Board of Governors consisting 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.

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

19. In case the Exchange shall for any reason cease to grant insurance to a member of its Board of Governors, or his firm or corporation, such person shall thereupon cease to be a member of said Board.

20. 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 his own malfeasance.

POWERS AND DUTIES OF THE BOARD OF GOVERNORS

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

21. Adopt such rules and regulations for the Exchange and the Attorney-in-Fact, not inconsistent herewith, as it shall see fit.

22. Fix the compensation for the Attorney-in-Fact as provided in the Management Agreement.

23. Direct the Attorney-in-Fact in the safeguarding of all moneys and other assets and in making and changing of investments.

24. Suspend, remove and terminate the Attorney-in-Fact for good cause per the Management Agreement.

25. Establish and maintain a reserve for contingencies, to be accumulated out of current income and used at its discretion for the benefit of all Subscribers.

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

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

28. 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.

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

Duties. The Board of Governors shall:

30. Elect officers, which shall include a Chairman.

31. Take into its own charge and keeping all securities owned by the Exchange and all moneys received by the Attorney-in-Fact for accounts of said Exchange, after deduction therefrom by said Attorney-in-Fact of its compensation and such other funds as it may retain to meet fees, taxes, losses, expense, and liquidation of Subscribers' accounts, together with any other funds which the Board of Governors may direct it to retain.

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

33. Call annual meetings, and may call 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.

34. 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 our name and on our behalf 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 us to the aforesaid PRIMMA, LLC. without any further action on our part; and the Board of Governors shall mail to us timely notice of each and every such change made.

35. Determine what acts, incapacity or failure to act shall constitute a disqualification of any Subscriber to act further as such, and adopt regulations concerning the closing or liquidation of the account of any Subscriber so disqualified.

GENERAL PROVISIONS

36. The Exchange herein designated shall maintain at all times such minimum surplus and such guaranty surplus and other funds as are required by law.

37. No person, firm or corporation may become a Subscriber of the Exchange without the approval of a majority of the Board of Governors of the said Exchange.

38. There shall be an Annual Meeting of Subscribers at which each Subscriber shall have one vote, either in person or by proxy. Said Meeting shall be held at the place in the State of New York and at that time designated in the Notice of Meeting on the second Monday in June each year.

   A. Every Subscriber will be sent a proxy by first class mail on or before the 30th of April of each year which will contain therein the names and addresses of the Board of Governors' (Board) nominees.

   B. The Board of Governors' nominations shall be made by a majority of the Board adopting a resolution nominating qualified candidates for election to the Board to fill a vacancy or vacancies that shall have occurred or which may occur in the year of the election. The said resolution shall be made on or before the 15th of March of the year of the election.

   C. Any group of 5% or more of the Subscribers who are in good standing may nominate a proposed director or directors for election to fill a vacancy or vacancies at the annual meeting of the Subscribers to challenge the Board's nominations.

   D. Additional nominations may take place only under the following rules and regulations:

      a) All petitions for membership to the Board shall be filed on or before the 10th of May of the year in which the election of Board Members is to take place.

      b) The petition shall be sent by certified mail, return receipt requested, addressed to the Chairman of the Board at the offices of the Exchange and shall contain a postmark that will contain a date that is prior to the 10th of May of the year in which the election is to take place.

      c) The petition shall be in the following form:

      i) The petition shall state the name or names and addresses of the proposed candidates for election, the candidate's PRI policy number and the dates of the policy's inception and expiration.

      ii) The petition shall have an affirmation under oath by at least five percent (5%) of PRI's Subscribers, not including the nominee, affirming that they are insureds of PRI, their policy numbers, the date of their policy's inception and expiration and that they are Subscribers in good standing for the remainder of the term of their policy. The candidate or candidates shall make a similar affirmation under oath.

      d) The Chairman shall examine the petition and if he finds that the petition does not comply with the requirements stated herein, then he must reject the petition no later than five days after receipt thereof, in writing, stating the specific objections to the petition. The said objections shall be sent to the address of the candidates by certified mail, return receipt requested. Failure to send such objection by the Chairman shall be deemed an acceptance of the petition and the nomination. Nothing contained herein shall waive any statutory requirement for serving on the Board.

      e) Objection by the Chairman as above shall disqualify the nomination and the petition.

      f) If the petitioners dispute the objection they may petition the Board in writing, stating their reason and requesting a review of the objection. This request shall be sent by certified mail, return receipt requested, within five days of the receipt of the Chairman's objection. The Board shall grant the petitioners a hearing to take place within five days of the receipt of the said request. The Board shall make a determination and notify the nominees named in the petition or their designees by certified mail, return receipt requested, within two days of the hearing and the decision of the Board shall be final.

      g) If the Board finds that the objections are proper, then the petition shall be a nullity.

   E. If the petition is not objected to, or the Board overrules the objection of the Chairman, then the election of the members of the Board shall take place and as a requisite for the election, a quorum of no fewer than 1,500 subscribers voting in person or by proxy shall be required.

      If no quorum is present then the election shall be adjourned by the Chairman for an alternative date no more than 30 days from the scheduled date of the election. If at the adjourned date there is still no quorum present, then the Chairman shall adjourn the date of the election for a period at his discretion, which period shall not be longer than 60 days.

      All proxies that were valid at the date scheduled for the election shall be considered valid for the adjourned date.

      The Board of Governors shall appoint two proctors to examine and declare that there is or is not a quorum present and if a quorum is present, to tally the proxies and make a report as to the tally and the election results. The proctors shall not be members of the Board nor employees or Board Members of PRI's Attorney-in-Fact, and as a condition to acting as

proctors they shall take an oath to act and report the tally fairly and objectively. If the Board shall fail to appoint proctors on or before the date of election, then the Chairman may appoint such proctors.

F. If there are no nominating petitions or a petition is declared a nullity then the election of the Board shall take place and all proxies not returned shall be deemed to designate the Chairman as the proxy holder of the non-responding Subscribers. The Chairman will then conduct the uncontested election and certify the election of the Subscribers nominated by management.

39. A policy or policies of liability insurance shall be granted by the Exchange to each Subscriber upon application, but not such Subscriber shall assume any liability as an insurer in any policy so granted to him.

40. Each Subscriber shall insure each and every other Subscriber at said Exchange. Therefore, in each policy of liability insurance granted by the Exchange, and in force as of any date, each Subscriber of record on such date shall underwrite for an amount which shall be that proportion of the total amount of said policy of liability insurance, which his own annual premium bears to the total annual premiums of all such underwriting Subscribers at said Exchange in force as of such date.

41. We hereby assume our proportionate share of all outstanding or future underwriting liability on policies of liability insurance which the Exchange has granted, or may in the future grant, but it is understood that such liability, and any other the Attorney-in-Fact is authorized to incur on our behalf, shall in every case be several, and not joint with any other Subscriber.

42. No Subscriber shall be or become liable for any default, failure or neglect on the part of any other Subscriber.

43. The Subscriber reserves the right to revoke this Agreement and the Power of Attorney herein contained as of the end of any calendar quarter upon written notice to the Attorney-in-Fact. As of such date, such Subscriber shall cease to assume any liability as an insurer in any policy of insurance thereafter issued by the Exchange and the Subscriber's liability as an insurer in all policies of insurance issued prior thereto shall terminate with respect to claims filed after such date. It is expressly understood that such Subscriber remains liable as an insurer on all policies issued prior to the date of revocation with respect to claims filed prior to such date, such liability being discharged by the surrender charge set forth in Paragraph 44. The Subscriber's revocation of this Agreement shall be construed as simultaneously ordering cancellation of all outstanding policies of insurance granted to him/her. The provisions of this paragraph shall be applicable in the case of any withdrawal whether voluntary or at the direction of the Exchange.

44. Within one year after receipt of notice of revocation by the Attorney-in-Fact, one-half of the amount in the Subscriber's separate account, representing such Subscriber's share of the earnings of the Exchange during his term as a Subscriber, less surrender charges of twenty-five percent, shall be paid to the Subscriber. The remainder of such earnings shall be paid to such Subscriber not later than two years after the revocation of the Agreement by the Subscriber.

45. It is understood that the license of the Exchange and all other papers, books and records used in conducting the business of such Exchange are and shall remain the property of the Subscribers.

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

47. Any personal pronoun used herein to refer to the Attorney-in-Fact shall apply regardless of whether the Attorney-in-Fact is a firm, corporation or one or more individuals. The personal pronouns, we, our, us, when used herein refer to the Subscriber.

48. 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.

49. In consideration of the premises, we do hereby covenant and agree that we will fully and faithfully carry out, execute and perform everything in which the Attorney-in-Fact shall by virtue hereof bind us, and in the same manner we hereby ratify and confirm all that he may lawfully do or cause to be done by virtue hereof.

50. 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 said 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.

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6345 (833) 774-6625

Fax: (516) 684-2365

Visit us on the web at MYEMPRO.com or email us at CONTACT-US@MEDMAL.COM

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and, a binder or Declarations Page together with any applicable endorsements has been issued to the named insured.

**We want to process your application as quickly as possible.
You can help us do this by:**

Completing this form online or print legibly, return by email, fax or mail.

Answering each question, if the answer is "not applicable" please record (N/A).

Please use the "**Remarks**" section to explain your answers where requested

If you have ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten years, or are presently involved in malpractice litigation, then complete the claims information form for each case in the last ten years (See page 14.)

Signatures are required on page 12 & 13.

Incomplete answers and/or missing attachments will delay our processing of the application.

Required Attachments:

- ❐ Please attach a copy of your Curriculum Vitae (CV) if available.
- ❐ Please enclose a copy of your Declarations page and loss runs from your current policy.
- ❐ Proof of coverage and/or a copy of your I.D. badge if you are currently employed and covered elsewhere.

Thank you for choosing EmPRO Insurance Company. We are here to assist you, for questions, please call either of our offices at any one of the numbers listed above.

A. Personal Information

If my application is approved, make coverage effective on _____/_____/_____ *(if possible)* otherwise on any other date set by the COMPANY.

1. Name: ____ ❒ MD ❒ DO (Check One)
   First Middle Last
2. Date of Birth: ______________________ Gender ❒ Male ❒ Female NPI#______________________
3. Social Security Number: ______________________ I.R.S. Tax I.D. Number: ______________________
4. N.Y.S. License Number: ______________________

   License Type * ❒ Permanent ❒ Temporary

   Do you have any other non-NY State License?* ❒ Yes ❒ No

   List all non-N.Y.S. Medical License(s) (if applicable):

   a. ______________________________ c. ______________________________
   State Lic. # Status State Lic. # Status

   b. ______________________________ d. ______________________________
   State Lic. # Status State Lic. # Status

   If you have more than four non-N.Y.S. licenses, explain in **Remarks #10**.
5. Home Address: ______________________________ ( ) ______________
   Number & Street Home Phone

   ______________________________ ( ) ______________
   City State Zip Code Fax
6. Mailing Address (choose one): ❒ Home ❒ Primary Office ❒ Other (specify) ______________

   Billing Address (For Invoice ONLY): ______________________________ ( ) ______________
   Number & Street Phone

   ______________________________ ( ) ______________
   City State Zip Code Fax
7. E-Mail address (es) ______________________________________

B. Coverage Options

1. Limits of Liability (Please check the desired limits of liability)

   ❒ $500,000 per claim/$1,500,000 Annual Aggregate ❒ $1,300,000 per claim/$3,900,000 Annual Aggregate

   ❒ $1,000,000 per claim/$3,000,000 Annual Aggregate
2. Coverage Type (Select coverage type :)

   ❒ Claims-Made (A Claims-Made policy covers claims which arise and are made while the policy is in force.)

   ❒ Occurrence (An Occurrence policy covers you against any claim arising during your policy period irrespective of when the claim is reported.)

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3. Prior Acts

If your expiring policy is on a Claims-Made basis, an extended reporting period endorsement (Tail Coverage) is generally available as an option of your expiring Claims-Made policy.

a. Are you purchasing extended reporting (tail) coverage from your prior carrier? ❒YES ❒NO
If yes, please provide proof of tail coverage. If no, please explain in **remarks #10**.

b. If no, do you want EmPRO to provide coverage for prior acts? ❒YES ❒NO
(claims or incidents which may have occurred but, as yet, no indication has been made to you that a patient will bring a claim/suit).
If yes, a Conversion Supplemental application must accompany this application along with a copy of your most recent declarations page.

Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

4. Excess Coverage

Do you currently have section 18 excess coverage through a hospital affiliation? ❒YES ❒NO

a. If you are eligible for section 18 excess coverage, do you want to apply through EmPRO? ❒YES ❒NO
b. If not eligible for section 18 excess coverage, would you like to purchase direct excess coverage through EmPRO? ❒YES ❒NO

C. Practice Information

1. Primary office location for which coverage is desired: ❒ Private Office ❒ Clinic ❒ Hospital

____

Number & Street City State Zip Code % of Practice

____

Telephone # Name of contact person Fax # Cell Phone #

2. Other practice location for which coverage is desired, *if any,* including all other offices, nursing homes, urgent care clinics and other non-hospital locations:

____

Number & Street City State Zip Code % of Practice Type of Location

____

Telephone # Name of contact person Fax # Cell Phone #

If this policy is for more than two locations, indicate other location(s) in **Remarks #10.**

3. Please answer the following in reference to the practice location where EmPRO coverage is desired including office hours, administrative activities, direct patient care, surgery, consultation, etc… (excluding on call)

a. What is your average weekly patient load? ______________________________

b. What are your total weekly hours of practice time? _______

c. If semi-retired or practicing part-time, indicate approximate monthly practice time. __________________________________

d. When did you begin practicing on a part-time basis? _____________________
(mm/dd/yy)

e. Do you use an electronic health record system? ❒YES ❒NO
If yes, which software do you use and when did you begin utilizing this system? ___________________________

f. If no, are you planning to convert to EMR? ❒YES ❒NO

g. Do you e-prescribe? ❒YES ❒NO
What software do you utilize and when did you begin e-prescribing? ______________________________

4. a. List all hospitals where you currently *have* or *have applied for* staff privileges (include courtesy staff privileges) and percentage of your hospital practice. (Note: EmPRO Policy information, including cancellation, will be released to these facilities.)

Hospital	City/State	% of practice
Hospital	City/State	% of practice
Hospital	City/State	% of practice

b. If you do not have admitting privileges, please describe in detail your mechanism for handling your patients who may require immediate in-patient care.

____

____

5. Scope of Coverage

I do not want coverage under this policy for the part of my medical practice listed below.

Practice Name	Address	City	State	Zip Code
Practice Name	Address	City	State	Zip Code

6. Specialty:

a. Specialty for which you want coverage with EmPRO*______________________

D. Medical Training

1. Medical Education: ______________ Medical School ______ State ______ Country ______ Graduation Date

2. Postgraduate Medical Training:

a. Internship ____
Hospital From: Mo. /Yr. To: Mo. /Yr.

b. Residency: ____ Completed? ❒YES ❒NO
Hospital From: Mo. /Yr. To: Mo. /Yr.

Specialty: ____

c. Fellowship: ____ Completed? ❒YES ❒NO
Hospital From: Mo. /Yr. To: Mo. /Yr.

______________________ Type of Fellowship ______________________ City State

d. Explain any additional years spent in a residency program: ______________________________

____

e. Explain any gaps in time from date of medical school graduation to completion of residency: ______________

____

3. Board Certification:

Are you American Board certified in your Specialty? ❐YES ❐NO Date Certified: __________
Are you American Board certified in your Sub-specialty? ❐YES ❐NO Date Certified: __________
Are you American Board eligible in your Specialty? ❐YES ❐NO Date Eligible: __________
If Board Eligible, give date eligibility expires: ______________________________

E. Professional and Insurance History

1. Practice Locations
List all locations at which you have practiced in the last ten (10) years. (Do not list training locations from section D.)

Name of Practice/Employer	Address	From Mo./Yr.	To Mo./Yr.

2. Changes in Practice
Has your practice, procedures, specialty, location(s), etc., changed in the past ten years? ❐YES ❐NO
If yes, please explain noting dates of changes: ______________________________

____

3. Do you have prior insurance coverage?* ❐ Yes ❐ No

Provide name(s) of professional liability carrier(s), policy number(s), and coverage period(s) of all professional liability insurance policies under which you have been insured in the past ten (10) years.

Policy Period From / To Mo. /Yr. Mo. /Yr.	Insurance Carrier	Policy #	Medical Specialty	Type of Policy CM/OCC	No. of Claims

4. Insurance (If yes to a, b, c, or d explain in **Remarks #10.**)

a. Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? ❐YES ❐NO
b. Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms? ❐YES ❐NO
c. Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge? ❐YES ❐NO
d. Have you ever withdrawn an application for professional liability insurance? ❐YES ❐NO

F. Medical Conduct Information

1. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten years, or are you presently involved in malpractice litigation? ❒YES ❒NO
   If yes, submit a separate Claims Information Form for each case in the last 10 years (see page 14).

2. a. Has any government agency ever investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice medicine? ❒YES ❒NO
   b. Have you ever been convicted of a crime? ❒YES ❒NO
   c. Have you ever had privileges at any hospital or other institution reduced, revoked, restricted, or suspended? ❒YES ❒NO
   d. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? ❒YES ❒NO
   If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

   If yes to a, b, c or d above, explain in **Remarks #10.**

3. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?
   a. A request for records from a patient and/or attorney related to an adverse outcome? ❒YES ❒NO
   b. A letter from an attorney regarding your medical treatment of a patient? ❒YES ❒NO
   c. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ❒YES ❒NO
   d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ❒YES ❒NO
   e. Have all circumstances that might reasonably lead to an incident, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current, OR, prior professional liability carrier? ❒YES ❒NO
   If yes, how many _______, AND please attach documents of all such reports.
   If no, please explain (i.e. none to report, uninsured, etc.): ____________________

If yes to any of the above, please explain in **Remarks #10** and attach any additional documentation. The Incident/Claim Information Form on page 14 must be completed for each incident, potential claim, claim, or suit.

G. Physician Underwriting Information

REMINDER: Answers to the questions in this section should reflect your intended practice as of the date you wish this policy to become effective.

1. Practice Situation

   a. Indicate all practice situations that apply to you:

   - ❒ "Solo" Physician
   - ❒ "Solo" Medical Corporation
   - ❒ Medical Corporation with more than one physician shareholder
   - ❒ Medical Partnership
   - ❒ Independent Contractor/Contractee
   - ❒ Use of assumed name (DBA)
   - ❒ Employed by another physician
   - ❒ Employ another physician
   - ❒ Other ______________________________

   If you check any boxes above *other than* "Solo" Physician or "Solo" Medical Corporation, list below the name of the applicable entity(ies) and/or any physician(s).

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Name of Entity(ies)	Name of Physician Employer or Employee	Professional Liability Insurance Carrier
___________________________	____	______________________
___________________________	____	______________________
___________________________	____	______________________

b. Do you wish to purchase coverage for any of the above entities under a medical entity policy? ❐YES ❐NO

If yes, please contact Underwriting or Marketing for an application and pricing.

2. Other Physicians: Do you practice with other physicians not listed above? ❐YES ❐NO

If yes, list the physician(s) with whom you practice and describe the association.

Physician(s)	Association

3. Discounts:

a. Are you currently receiving a premium discount as a result of having completed a New York State Department of Financial Services (NYSDFS) approved Risk Management Course with your present carrier? ❐YES ❐NO
If yes, submit proof of completion of such course, including date discount became effective.

b. **"No Consent" Option** ❐YES ❐NO

By checking yes, I hereby authorize EmPRO to act on my behalf to settle any claim reported, or to appeal any judgment against me without first obtaining my written consent. I understand that I will receive a 5% premium reduction by choosing this option.

c. Have you had continuous insurance and no claims open, pending or paid within the last 5 years? ❐YES ❐NO
d. Have you had continuous insurance and no claims open, pending or paid within the last 10 years? ❐YES ❐NO

e. Medical Associations or Societies to which you belong____

4. Do you participate in telemedicine or teleradiology? ❐YES ❐NO

For purposes of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual as a result of transmission of data by electronic means".

Please describe your telemedicine/teleradiology activities:
____

5. Do you provide "concierge" practice services? ❐YES ❐NO
If yes, please describe the services you provide, hours of availability, etc.____

H. Practice and Procedures

1. Non-Hospital Procedures

a. Do you perform procedures in a non-hospital setting where anesthesia/sedation is administered? ❐YES ❐NO

If yes, check type used:

❐ General Anesthesia ❐ Deep Sedation/Analgesia ❐ Moderate Sedation/Analgesia ("Conscious Sedation") ❐ Minimal Sedation (Anxiolysis)

If yes:

i) Location ❒Surgicenter ❒ Office ❒Other Non-Hospital Facility

ii) Who administers the anesthesia? ____

b. Is the office or facility accredited? ❒YES ❒NO
If yes, by what agency? ________________________________

c. For Surgicenters or other Non-Hospital Facilities, please provide the name and address of each.

____

d. List the surgical procedures you perform in your office or other non-hospital facility:

Procedure	# Weekly	Where Performed
________________________	________________	____
________________________	________________	____
________________________	________________	____

e. Do you maintain a full emergency cart in your office? ❒YES ❒NO

i) Do you follow a protocol for checking the cart on a regular basis? ❒YES ❒NO
ii) Are the checks documented? ❒YES ❒NO

2. Do you perform procedures or use equipment that are not customarily used within your practice specialty but for which you believe you are trained and credentialed to perform? ❒YES ❒NO
If yes, please describe: ____

3. Do you perform any aesthetic and or cosmetic procedures or employ or contract with anyone who does? ❒YES ❒NO
If yes, please describe: ____

4. Do you own, operate, or have any legal affiliation with a Medi-Spa? ❒YES ❒NO
If yes, what it your average # of visits per week______ and average # of hours worked per week______?

5. Weight Control

a. Does your practice involve weight reduction or control, other than prescribing exercise? ❒YES ❒NO
(Percentage of patients exclusively for weight reduction or control: ____%.)

If yes, please explain fully, including names of medication(s) prescribed or dispensed, or surgery performed:

____

____

b. Do you solicit or advertise for weight control patients? ❒YES ❒NO
If yes, submit copies of all advertisements.

6. Experimental and Investigative Procedures

Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? ❒YES ❒NO

If yes, indicate which of the following applies and *attach a detailed, narrative outline, IRB approval, indemnification agreement and a copy of the patient consent form*.

❒ Use of experimental drug, device or material under U.S. Food and Drug Administration or other governmental agency investigational protocol and licensure.

❒ Other experimental, investigative or unconventional drug or therapy.

Please describe: ____

7. Please indicate with an 'X' below which of the following procedures, techniques or practices you perform or contemplate performing.

❒ Acupuncture *(Please submit copy of NYS Certification.)*
❒ Angiograms
❒ Angioplasty
❒ Aspiration of cyst of breast
❒ Assisting in Major Surgery
❒ Botox
❒ Breast biopsy
❒ Bronchoscopy
Cardiac catheterization
❒ Left Heart
❒ Swan Ganz
❒ Cervical biopsy
❒ Cervical cautery
❒ Chelation therapy (other than for the treatment of heavy metal poisoning)
❒ Chemobrasion
Type____________________
❒ Chemotherapy
❒ Chorionic villus sampling
❒ Circumcision of adults

❒ Closed reduction of fracture (other than temporizing)
❒ Colonoscopy
❒ Culdocentesis
❒ D & C
❒ Dermabrasion
❒ Duodenoscopy
❒ Endometrial biopsy
❒ Esophagoscopy
❒ Gastroscopy
❒ Hair transplants
❒ Hemorrhoidectomy
❒ Hydrocelectomy
❒ Hydrogen peroxide therapy
❒ Hysterectomy
❒ Injection of bursa
❒ Insertion of IUD
❒ Laser therapy (explain type)
____
❒ Nasal polypectomy
❒ Needle biopsy (explain type):
____

❒ Pain Management (If yes, explain in **Remarks #10**)
❒ Peritoneal dialysis
❒ Permanent pacemakers
❒ Phalloplasty
❒ Polypectomy by endoscopy
❒ Prenatal care
❒ Restylane
❒ Scalp reductions
Sclerotherapy
❒ Superficial
❒ Deep vein
❒ Stress testing
❒ Suction lipectomy *(submit* proof *of training if outside of residency)* (explain type)
____
❒ Temporary pacemaker
❒ Ultraviolet light therapy
❒ Vein stripping

8. Non-Hospital Births:

Do you provide direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? ❒YES ❒NO
If yes, give full details: ____
____

9. Termination of Pregnancy:

a. Do you perform terminations of pregnancy? ❒YES ❒NO
If yes, please provide the following information:

Location		# Performed Monthly at Each Location	Maximum Gestational Age at Each Location
Office	❒	________________	________________
Hospital	❒	________________	________________
Other	❒	________________	________________

b. List hospitals, clinics, or other facilities where you perform terminations of pregnancy:

____
____

SPECIALTY SPECIFIC INFORMATION (PLEASE ANSWER ALL THAT APPLY TO YOUR PRACTICE)

Anesthesiology

1. Do you administer anesthesia in a non-hospital setting? ❒YES ❒NO
   If yes, state location(s): ____

2. Do you employ or supervise any CRNAs? ❒YES ❒NO
   If yes, please complete the following: Number employed _____ Number supervised _____

3. Do the CRNAs give anesthesia while not under your personal direction, control, and supervision? ❒YES ❒NO
   If yes, please describe: ____

Family Practice/Internal Medicine/General Practice

1. Percentage of your practice derived from treatment of children _____% (i.e. treatment of patients under age 21)

Nurse Practitioner

1. Are you currently involved in a collaboration agreement with a nurse practitioner? ❒YES ❒NO
   If yes, if this nurse practitioner is not employed by you and not currently insured through EmPRO, coverage is available to protect you from liability you incur as a result of this collaboration agreement.

   Are you interested in obtaining this coverage? ❒YES ❒NO

Obstetrics and Gynecology

1. Do you limit your practice to gynecology only? ❒YES ❒NO
   If yes, is your practice strictly office based? ❒YES ❒NO

2. Do you render prenatal care exclusive of delivery? ❒YES ❒NO

3. How many deliveries do you perform annually? ____________

   What percentage of your deliveries are done at a birthing center outside the hospital setting? ____________

Ophthalmology (Surgery)

1. How many major surgical procedures (excluding laser refractive surgical procedures) have you performed in the last 12 months as the primary surgeon? _____________

2. How many laser refractive surgical procedures have you performed in the last 12 months as primary surgeon? _____________

Physical Medicine and Rehabilitation/Pain Management

A. Do you perform any of the following procedures?		# of Annual Procedures
1. Cervical epidural injections?	❐YES ❐NO	__________
2. Thoracic epidural injections?	❐YES ❐NO	__________
3. Celiac plexus blocks?	❐YES ❐NO	__________
4. Epidural-caudal, translumbar or selective injections?	❐YES ❐NO	__________
5. Facet-cervical or Lumbar injections?	❐YES ❐NO	__________
6. Sacroiliac joint and gleno-humeral joint injections?	❐YES ❐NO	__________
7. Hip joint injections? If yes, explain ___________________________	❐YES ❐NO	__________
8. Insertion of spinal stimulator wires in the epidural space?	❐YES ❐NO	__________
a) Do you go higher than vertebral level T4?	❐YES ❐NO	__________
9. Insertion of epidural catheter for drug infusion? (Do not include post-op epidural for acute pain management)	❐YES ❐NO	__________
a) Do you go higher than vertebral level T4?	❐YES ❐NO	__________
10. Insertion of intrathecal catheter for drug infusion?	❐YES ❐NO	__________
a) Do you go higher than vertebral level L2?	❐YES ❐NO	__________

B. Does your practice include chronic pain management? ❐YES ❐NO
If yes, what percentage of your practice? ______%

Pediatrics

1. Percentage of your practice derived from neonatology _____%

2. Percentage of your practice derived from treatment of adults _____% (i.e. treatment of patients age 21 and above)

The following section should be completed by all physicians who perform surgical procedures.

Surgery

1. List the number of major surgical procedures performed in the last 12 months
   a) As primary surgeon ______________
   b) As assisting surgeon ______________

2. Indicate the percentage of surgical time devoted to the following surgical activities:

_____% Bariatrics
_____% Cardiovascular
_____% Gynecology
_____% General
_____% Other _____________
_____% Hand
_____% Orthopedic
_____% Otorhinolaryngology
_____% Cosmetic-Reconstructive
_____% Thoracic
_____% Urological
_____% Vascular
_____% Plastic

EMPRO INSURANCE

10. REMARKS

Question #	Remarks

EMPRO INSURANCE

(Appl. 2020)

I. Authorization

11. You may appoint a policy administrator authorized to receive all communications, make requests and give instructions on your behalf with regards to your policy, except for consenting to settlement of a claim if such consent is required by the policy. Please identify the policy administrator by completing the below:

Name: ____

Title: ____

Address (mailing) ____

____

Phone _______________________________________

Fax _______________________________________

E-mail _______________________________________

EMPRO INSURANCE

I understand that in order to underwrite professional liability insurance, the COMPANY must have access to all pertinent information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the COMPANY pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information may be wrong.

I understand and agree that, if I am approved as policyholder of the COMPANY and a policy is issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.
This application shall be deemed appended to and a part of any policy of insurance issued to me based on this application.

My signature on this application shall be deemed to be a concurrent execution of the attached Subscriber's Agreement of Physicians' Reciprocal Insurers ("PRI"). I understand that in order to maintain my status as a policyholder of EmPRO Insurance Company, I must maintain my status as a subscriber of PRI. Termination of either contract shall result in the automatic termination of the other.

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: ____ Authorization Date: ________________
(Applicant's Signature)

____
PRINT NAME

Please check box if you are submitting electronically only.

By checking this box, I understand and agree that I am signing this application electronically. I understand and agree that the electronic signature is the legal equivalent of my manual signature.

Please make additional copies of this page, as necessary

CLAIM INFORMATION

1. Name of patient ____
2. Age ______
3. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): ______________________
4. Details of allegation(s): ____
5. Date of incident __________________________ 6. Report date __________________________
7. Insurance carrier ____
8. Other defendants ____
9. Location of Incident ____
10. Condition and diagnosis at time of incident ____
____
11. Dates and description of treatment rendered ____
____

Condition of patient subsequent to treatment (including DATES OF FOLLOW-UP TREATMENT)

____
____

12. Present status of claim (check applicable answer and fill in amounts where requested):

☐ Precautionary/Incident report only
☐ Suit threatened, no action taken
☐ Dropped by claimant
☐ Summary judgment in your favor
☐ Court trial in your favor

☐Settlement:
Date Paid _________ Amount Paid _________
MM/DD/YY

☐Judgment:
Date Paid _________ Amount Paid _________
MM/DD/YY

Was the corporation under which you provided medical care sued? ☐Yes ☐No
Was payment made on its behalf? ☐Yes ☐No If Yes, amount paid: $_________________

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.

Signed: ____________________________________ Date Signed: ________________________

Please take a moment to complete this brief survey, please check one.

How did you hear about EmPRO?

- ☐ I was contacted by EmPRO
- ☐ I was referred by a colleague
- ☐ I am joining a group that uses EmPRO_____________________________________
  Group Name
- ☐ I met a marketing representative at a convention
- ☐ I saw an advertisement in a trade magazine_____________________________
  Publication Name
- ☐ EmPRO's website/Submitted a quick quote
- ☐ I was referred by a broker _____________________________
  Broker of origin
- ☐ I received a mailing
- ☐ Other___________________

We are always looking for ways to improve at EmPRO. If you have any suggestions regarding products/services we can offer which will enhance your practice, please let us know.

____

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Thank you for your interest in EmPRO, we appreciate your business and as always if you have any questions please do not hesitate to contact us at 516-365-6345 or visit us on the web www.MYEMPRO.com.

EMPRO INSURANCE