EMPRO INSURANCE

Application

CHIROPRACTORS

Professional Liability Insurance

EmPRO INSURANCE COMPANY

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6345 / (833) 774-6625
Fax: (516) 684-2365

Rochester Office: 1200C Scottsville Road, Suite 195
Rochester, New York 14624

Telephone: (585) 328-8860 / (800) 329-8860
Fax: (585) 328-8686

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

PLEASE PRINT or TYPE all information and make sure all questions are answered in full. Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.
If you have had claims or suits filed against you, please make certain you have a completed claims information form for each open suit or closed suit in the past 10 years.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

FOR ASSISTANCE, APPLICANT MAY CALL OUR HOME OFFICE AT ANY ONE OF THE NUMBERS LISTED ABOVE.

PROFESSIONAL LIABILITY POLICY APPLICATION
TO: EmPRO INSURANCE COMPANY

CONSENT OPTION

EmPRO Insurance Company has obtained Insurance Department approval for a 5% premium reduction for policyholders who opt to forego the customary consent to settle any claim.

Please indicate by checking the appropriate box below, the option that you wish.

☐ **"NO CONSENT" OPTION**

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.

☐ **"CONSENT" OPTION**

I wish to maintain the terms of the policy which under Section I, Part 4 currently requires EmPRO to obtain my written consent prior to settling any claim on my behalf or appealing any judgment on my behalf.

Signed: _____ Date _____

Print Name: _____

Policy Number (if known): _____

(2020)

EmPRO INSURANCE COMPANY

APPLICATION FOR CHIROPRACTORS

A. **GENERAL INFORMATION** (Please type or print clearly in ink).

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

1. **Name** _____(_____) D.C.
First Middle Last Maiden

2. **Date of Birth**: _____

3. **Male** ☐ **Female** ☐

4. **Social Security #:** _____ **IRS Tax ID #:** _____

5. **NYS License #**: _____

List all non-NYS chiropractic licenses (if applicable):

a. _____ c. _____

b. _____ d. _____

If you have more than four non-NYS licenses, please list in Remarks #35 and explain.

6. **Home Address**:

_____ ( ) _____
Number Street Telephone

_____ ( ) _____
County State City Zip Fax

7. **Mailing address (choose one):** ☐ Home ☐ Primary Address

☐ Other (Specify) _____
(Explain in **Remarks #36**)

8. **E-Mail Address**: _____

(2020)

B. PRACTICE LOCATIONS

List all locations, other than hospitals and ambulatory surgery center, at which you currently render professional services. Include all office locations, nursing homes, urgent care clinics, and other non-hospital locations.

9. Primary address for which coverage is desired:

_____ ( ) _____
Number Street Telephone

_____ ( ) _____
County State City Zip Fax

This address is a (check one):

☐ Private office ☐ Clinic ☐ Other

Number of hours per week: _____ Number of patients per week: _____

10. Other address for this policy (if any):

_____ ( ) _____
Number Street Telephone

_____ ( ) _____
County State City Zip Fax

This address is a (check one):

☐ Private office ☐ Clinic ☐ Other

Number of hours per week: _____ Number of patients per week: _____

If this policy is for more than two locations, list other locations in **Remarks #36**.

C. TRAINING

11. a. **Chiropractic Education**:

_____ _____ _____
School State Graduation Date

b. Is your practice specialized? ☐ Yes ☐ No

If yes, please list specialty(ies). _____

_____

c. Are you board certified in these specialties? ☐ Yes ☐ No

If yes, list designations and certifying organizations.

Designation	Organization

d. Do you hold any other professional licenses/certificates in New York State?

☐ Yes ☐ No

If yes, please provide details.

_____

_____

_____

D. PROFESSIONAL & INSURANCE HISTORY

12. Practice Locations

List all locations at which you have practiced in the last ten (10) years. Explain any gaps in time and attach additional pages as needed.

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

13. Prior Insurance

Provide the 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. If you are applying for Prior Acts Coverage, please complete the following for the entire Prior Acts Coverage period. Attach additional pages as needed.

Name of Carrier	Policy No.	Coverage From/To:	Limits	# of Claims	Type: CM or OCC

14. Insurance History

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
If yes, explain in **Remarks #36.**

b. Have you **ever** had professional liability insurance refused, declined, canceled or accepted on special terms?

☐ Yes ☐ No
If yes, explain in **Remarks #36**.

c. Have you **ever** been required to pay an additional merit-rated premium or have you ever been involved in an appeal concerning the imposition of such a surcharge?

☐ Yes ☐ No
If yes, explain in **Remarks #36.**

E. COVERAGE OPTIONS

15. Limits of Liability

Please check the desired limits of liability:

☐ $100,000 per claim/ $300,000 Annual Aggregate

☐ $200,000 per claim/ $600,000 Annual Aggregate

☐ $500,000 per claim/ $1,000,000 Annual Aggregate

☐ $1,000,000 per claim/$3,000,000 Annual Aggregate

16. Coverage Type

EmPRO offers both Claims-Made and Occurrence coverage.

Select coverage type: ☐ Claims-Made ☐ Occurrence

17. Prior Acts Coverage

a. Is this policy to replace an existing Claims-Made Policy?

☐ Yes ☐ No

b. Do you wish to have prior acts coverage (nose) beginning on the initial issue date of your existing Claims-Made Policy?

☐ Yes ☐ No

c. Do you know of any incidents that may give rise to claims for chiropractic services which you provided during the period for which prior acts coverage is desired, and that you have not reported to your current carrier or carrier of record?

☐ Yes ☐ No

If yes, please explain: _____

For prior acts coverage, a Conversion Supplemental Application must accompany this application, along with a copy of your most recent declarations page.

18. Scope of Coverage

☐ I am requesting coverage for my entire chiropractic practice as described in this application.

☐ I do not want EmPRO coverage for the part of my chiropractic practice listed below.

Complete the following section to specify the part of your practice for which you do **not** want EmPRO coverage. **Please include the location(s)** of the practice(s) and proof of coverage from the professional liability carrier providing coverage for that aspect of your practice.

Practice/Location	Carrier/Limits	Dates
Practice/Location	Carrier/Limits	Dates

F. PROFESSIONAL CONDUCT INFORMATION

19. Governmental Action

a. Has any government agency **ever** investigated, suspended, revoked or taken any other action against your license to practice?

☐ Yes ☐ No
If yes, explain in **Remarks #36**.

b. Have you ever been convicted of a crime?

☐ Yes ☐ No
If yes, explain in **Remarks #36**.

20. Health

Do you have any health problem, illness or physical condition that impairs or may impair your ability to practice chiropractic?

☐ Yes ☐ No

If yes, please submit a letter from your treating health care practitioner addressing your state of health and whether any condition exists which could adversely affect your practice.

21. Claims/Suits

Have you **ever** been named as a defendant in a malpractice claim or suit, or are you presently involved in malpractice litigation?

☐ Yes ☐ No

If yes, submit a separate form for each case in the last 10 years. (See page 14)

G. PRACTICE ASSOCIATIONS

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

22. Practice Situation

a. Indicate all practice situations which apply to you:

- ☐ "Solo" Chiropractor
- ☐ Employed by another chiropractor
- ☐ "Solo" Professional Corporation
- ☐ Employs another chiropractor
- ☐ Professional Corp. with more than one chiropractic shareholder
- ☐ Limited Liability Partnership
- ☐ Chiropractic partnership
- ☐ Limited Liability Company
- ☐ Independent Contractor/Contractee
- ☐ MSO/MDDC arrangements
- ☐ Use of assumed name (DBA)

If you check any boxes above **other than** "Solo" chiropractor or "Solo" Professional Corporation, list below the name(s) of the applicable entity (ies) and/or the names of any chiropractors who are part of these organizations. **Please attach copies of your letterhead(s) to this application.**

Name of Entity(ies)	Name of Chiropractor Employer/Employee	Professional Liability Insurance Carrier

b. Do you desire coverage for any of the above entities? ☐ Yes ☐ No
If yes, which one(s):

Do you wish to purchase coverage for any of the above entities under a medical entity policy? If yes, please contact underwriting or marketing for an application and pricing.

23. Other Chiropractors

Do you practice with other chiropractors not listed above? ☐ Yes ☐ No

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

Chiropractor(s) Nature of Association

24. Other Professional Personnel

a. List number of professional classification of any chiropractic assistants or other ancillary staff you employ or lease:

Number Classification

b. Is coverage desired for these staff? ☐ Yes ☐ No

If yes, submit proof of training and list duties.

c. Do your chiropractic assistants provide any patient care without a chiropractor being present in the office? ☐ Yes ☐ No

If yes, please describe.

H. ADMINISTRATIVE AND TEACHING RESPONSIBILITIES

25. Additional Responsibilities

Do you have any administrative or teaching responsibilities outside of your practice?

☐ Yes ☐ No

If yes, complete questions a - d. Attach additional pages if necessary.

a. Name and address of entity:

_____

_____

_____

b. Your title: _____

c. Describe your responsibilities:

_____

_____

_____

d. Does the entity provide you with coverage for:

i) Your administrative responsibilities? ☐ Yes ☐ No

ii) Your direct patient care? ☐ Yes ☐ No

NOTE: Please be advised that coverage is not provided for any liability assumed solely as a result of your role as medical director of any facility. However, coverage is provided for direct patient care.

I. PRACTICE & PROCEDURES

26. Do you desire coverage for acupuncture? ☐ Yes ☐ No

If yes, provide copy of state certificate.

27. Which of the following techniques do you use in your practice? (Check all that apply.)

- ☐ Upper cervical specific
- ☐ Instrumental adjusting
- ☐ Applied kinesiology
- ☐ Direct non-force
- ☐ Sacro – occipital
- ☐ Diversified adjusting
- ☐ Logan Basic Technique
- ☐ Flexion Distraction
- ☐ Stressology
- ☐ Reflexology
- ☐ Surrogate
- ☐ Gonstead
- ☐ Manipulation under anesthesia

☐ Other (please list)

_____

_____

28. Do you provide any of the following treatments or use any of the following diagnostic methods?

a.	Use of magnets	☐ Yes	☐ No	
b.	Use of crystals	☐ Yes	☐ No	
c.	Treatment of animals	☐ Yes	☐ No	If yes, % of practice: _____
d.	Use of iridology	☐ Yes	☐ No	

29. Use of X-Rays

a.	Do you take diagnostic x-rays in your office?	☐ Yes	☐ No
	If yes, do you provide this service for outside practices?	☐ Yes	☐ No
	Are follow-up x-rays taken?	☐ Yes	☐ No
b.	Do you refer patients for x-rays, MRIs, CT scans?	☐ Yes	☐ No

30. Do you sell vitamins, herbs, homeopathic remedies or any other products?

If yes, please describe: ☐ Yes ☐ No

_____

_____

31. Do you make a differential diagnosis? ☐ Yes ☐ No

32. Referrals

a.	Do you refer patients to other health care providers?	☐ Yes	☐ No
b.	Do you send patients for blood tests?	☐ Yes	☐ No

33. List name(s) of all chiropractic association(s) of which you are a member:

_____

_____

_____

_____

34. Does your practice advertise? ☐ Yes ☐ No

Please provide copies of all advertisements.

35. Fees/Discounts

a. Do you charge case fees? ☐ Yes ☐ No

If yes, please describe the circumstances under which you do.

_____
_____
_____

b. Do you offer cash discounts? ☐ Yes ☐ No

36. No Remarks

Question # Remarks

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

37. 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: _____

I understand that in order to underwrite professional liability insurance, the COMPANY must have access to all possible 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 a policyholder of the COMPANY and a policy is issued to me, 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.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the COMPANY to issue coverage.

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 VIOLATION.

_____ _____

(Applicant's Signature): Date:

_____

PRINT

☐ **Please check box if you are submitting electronically only.**

☐ I fully understand that by checking this box I am accepting the terms and conditions stated above.

CLAIM INFORMATION

Be Sure to Answer All Questions Fully. Leave No Blanks

A. Name of claimant or plaintiff: _____

B. Date of alleged incident: _____

C. Name of Defense Counsel: _____

D. Name of Plaintiff's Counsel: _____

E. Location of Incident (County and State): _____

F. Date of Incident: _____

G. Report Date: _____

H. Issue or type of injury claimed - What was the objective issue contested in this Claim?

Injury: ☐ Emotional Only ☐ Cosmetic ☐ Temporary Disability
☐ Permanent Disability ☐ Death ☐ Injury with Economic Impact

Treatment Involved: _____

Please state allegations filed against you by patient: _____

_____

At what point in the treatment provided could this incident have been avoided either by a different action on your part or help from another treating chiropractor? Please be candid. _____
_____
_____

I. Were other Chiropractors involved as co-defendants: ☐ Yes ☐ No
If yes, please list their names: _____
_____
_____

If you were one of many defendants in this legal action and your treatment was criticized by any of the chiropractors involved, what were the allegations against you? _____
_____
_____

J. Name of the insurance company defending you: _____

K. Was claim or suit actually brought against you, merely threatened, or limited to claimant's attorney contact?
_____

L. If suit was filed, include the court docket number, if known: _____

M. Disposition of Claim: What happened to the claim?
* OPEN ☐ Current Status: _____
How much has the insurance company set aside in reserve for this claim? (if known) _____
* CLOSED ☐ Date Closed: _____
☐ Won by defense
Judgment ☐ Verdict ☐
☐ Won by claimant
Amount paid on your behalf? _____
Reason for payment on your behalf: _____

PHOTOCOPY THIS FORM AND SUPPLY US WITH A SEPARATE SHEET FOR EACH CLAIM, SUIT OR INCIDENT.

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 VIOLATION.

_____ _____

Signature Date

(2020)

SCHEDULE RATING QUESTIONNAIRE

Medical Equipment

1. Please list each piece of equipment utilized in your practice, including date of purchase, employees who operate them, and condition/quality(excellent, good, average, below average)

Equipment	Date of Purchase	Operators	Condition
1.			
2.			
3.			
4.			
5.			
6.			

2. Is your equipment industry approved by medical governing boards? ☐ Yes ☐ No

3. Is your equipment regularly maintained and serviced? ☐ Yes ☐ No

4. **Employees**

For each of the support personnel employed or contracted by you, or the group, please indicate the following:

Employee name	Date of hire	Years of experience	Education Background

4. Do each of the employees listed above participate in continuing education? ☐ Yes ☐ No

5. Do you provide training and/or supervision guidelines or manuals? ☐ Yes ☐ No

Record Keeping

6.	Do you take a complete medical history prior to initial treatment?	☐ Yes	☐ No
7.	Are the patients files documented every visit?	☐ Yes	☐ No
8.	Do you currently use an EMR system?	☐ Yes	☐ No

Emergency Backup

9.	Is each of your staff members trained in first aid procedures?	☐ Yes	☐ No
10.	Are procedures in place to provide aid to injured parties in the event of emergency?	☐ Yes	☐ No
11.	Do you have arrangements in place with Emergency Medical Facilities?	☐ Yes	☐ No
12.	Is your office within 10 miles from a hospital?	☐ Yes	☐ No

_____ _____

Signature Date

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.

Claims-made rates are computed by applying the following factors approved by the New York State Department of Financial Services to the corresponding occurrence rate, depending upon your year in the claims-made program: First 35.0%; Second 65.5; Third 90.0%; Fourth 97.5%; Fifth and later100.0%

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 32.2%; Two 60.3%; Three 82.8 %; Four 89.7 %; Five or more: 92.0%

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

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.