EMPRO INSURANCE

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

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.)

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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? If yes, submit a separate Claims Information Form for each case in the last 10 years (see page 14). ☐YES ☐NO

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).

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

		# of Annual Procedures
A. Do you perform any of the following 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? If yes, what percentage of your practice? _____%	☐YES ☐NO	

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

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 _____

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 ☐ Settlement:
☐ Suit threatened, no action taken Date Paid _____ Amount Paid _____
☐ Dropped by claimant MM/DD/YY
☐ Summary judgment in your favor ☐ Judgment:
☐ Court trial in your favor 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: _____

EMPRO INSURANCE

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
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EMPRO INSURANCE

(Appl. 2020)

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.