



**Allied Healthcare Professional (AHP)
Professional Liability Application**

PART I - PRODUCER INFORMATION

Agency Name		Submitted By	
Agency License Number	State	Telephone	Most Recent Carrier

PART II - APPLICANT INFORMATION

First Name	Middle Initial	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Email Address				Website	
Contact Person/Insured Representative				National Provider Identifier	
Office Address One			Residence Address		
Address One			Address One		
Address Two			Address Two		
City		State	Zip		
Phone		Fax			
Office Address Two			Mailing Address <i>(if different from office address one)</i>		
Address One			Address One		
Address Two			Address Two		
City		State	Zip		
Office Address Three			Billing Address <i>(if different from office address one)</i>		
Address One			Address One		
Address Two			Address Two		
City		State	Zip		

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any part of your practice that is covered by any other professional liability? Yes No

If yes, please provide details and copy of declaration page of policy: _____

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART IV - COVERAGE INFORMATION

Type of Coverage (choose one)
 Occurrence Claims Made Retroactive date desired* _____
 Moonlighting Only *(When selected, please complete and submit APP 017, Moonlighter Credit Addendum.)*

Coverage Effective Date
 From _____ To _____

Do you wish to purchase Prior Acts Coverage? Yes No *(If yes, please complete and submit APP 015, Prior Acts Application.)*
 Do you participate in the Indiana Patient Compensation Fund? Yes No

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability
 Each Claim \$ _____ Annual Aggregate \$ _____

For New Jersey Applicants Only

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

PART V - EDUCATION

Country	State/Province	School of Graduation	Type of Degree: Graduated: _____ (month) _____ (year)
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List any post-graduate programs completed: _____ Month: _____ Year: _____
 Have you participated in any CEU programs within the last five years? If yes, please attach a description or a copy of a certificate of completion. Yes No
 Which professional organizations are you a member of? ACNM National Nursing State Nursing Other _____
 Are you certified by an approved specialty board? Yes No _____ (month) _____ (year)
 If so, list specialty and attach a copy of the certificate(s): _____ Date Certified: _____ / _____

PART VI - CURRENT PRACTICE

Type of practice: Individual Partnership Solo Corporation Professional Corporation or Association Locum Tenens
 Do you practice as an employee or are you self-employed? Employee Self-employed

Separate Limit of Liability for Partnership or Corporation
 Not available on solo corporations (except in PA). Current practice must be partnership or corporation. Yes No
(If yes, please complete and submit APP 008, Partnership & Corporation Professional Liability Application.)

Partnership or Corporation (complete this section)
 Name of Partnership or Corporation _____
 Name of partner(s) or other members _____

Are you covered by the Federal Tort Claims Act? *(If yes, please complete and submit APP 024, FTCA Restricted Coverage.)* Yes No
 Do you practice less than 21 hours per week in direct patient care services? *(If yes, please complete and submit APP 020, Limited Practice Credit.)* Yes No
 Do you hold a full time teaching appointment with regular clinical supervision responsibilities? Yes No
 Do you use Locum Tenens? Yes No
 If yes, indicate the number of days per year: _____ days

PART VII - PRACTICE ACTIVITIES

Nurse Practitioners, please indicate your practice activities below:
 ___ Specialize in Adult, Adult Oncology, Family Planning, Geriatric, Gynecology or Women's Healthcare
 ___ Specialize in Psychiatric Care
 ___ Specialize in Acute Critical Care, Family Practice, School Nurse, Pediatric or Neonatal Care
 ___ Specialize in Acute Critical Care OB/GYN, Obstetrics/Gynecology or Perinatal Care

If your specialty is OB/GYN, are you responsible for any labor or delivery? Yes No N/A
 Do you perform any invasive surgical procedures? Yes No
 If yes, please list procedures: _____
 Do you have a written collaborative agreement with the physician(s) with whom you practice? Yes No N/A

Physician Assistants, please indicate your practice activities below:
 ___ PA 1: Carry out duties generally performed by a licensed physician and practice under the direction and supervision of a licensed physician to assist in the diagnosis and treatment of patients. No surgical procedures.
 ___ PA 2: Select if your practice includes any of the following:
 Assist a licensed physician in surgery, have any practice exposure in an operating room other than for observation; practice 10 hours a week or less in trauma/emergency room; provide obstetrical-prenatal or postnatal care only; assist a physician in anesthesiology.

PA 3: Select if your practice includes any of the following:

Assist in surgery; practice 10 hours or more per week in trauma/emergency room; provide obstetrics including prenatal/postnatal care and delivery room responsibilities; have contact or exposure with cardiac catharization labs; assist in cosmetic/aesthetic procedures.

Does your supervising physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? Yes No

Do you want employee coverage under separate limits? Yes No

Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete APP 026, Employee Limit of Liability Application.

Nurse Practitioners and Physician Assistants, please answer the following questions:

Have you completed a risk management course in the last 12 months? (If yes, please attach a copy of the certificate) Yes No

Do you or any of your employees perform cosmetic procedures? Yes No

If yes, please provide a list of all the procedures performed and documentation of the training received to perform the procedures.

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? Yes No

(If yes, please complete and submit APP 040, Clinical Trials Addendum)

Do you provide services in a correctional facility? Yes No

If yes, please list the name of the facility: _____

Do you participate in any telemedicine activities? Yes No

Do you bill Medicare/Medicaid? Yes No

If yes, what percentage of your total billing is for Medicare/Medicaid? _____%

PART VIII - EMPLOYEES/ADDITIONAL INSURED

Please list the following for any **physicians, surgeons** or **certified nurse midwives** you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete **APP 041, Independent Contractor Addendum**.

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
EmPRO Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applying for EmPRO Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty				
Surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery
Assisting with Surgery	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Other's patients
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Graduation Date	month year	month year	month year	month year
Residency Date	month year	month year	month year	month year
Fellowship Date	month year	month year	month year	month year

If you employ **non-physician healthcare providers**, please list job category and number of each. If you employ nurses, please specify between RNs, LPNs, Nurse Practitioners, etc.

Job Title/Specialty	Number of Employees

PART IX - HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	From	To	From	To	From	To	From	To
Insurer								
Policy #								
Coverage								
Premium								
Tail Purchased	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retroactive Date								
Limit								
Facility								
State								
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If yes, attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

Have you ever been denied a nursing license or been denied certification by a specialty board? Yes No

Has your professional license ever been restricted, suspended, voluntarily surrendered or revoked in any state? Yes No

Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges or probation? Yes No

Have you ever been involved in or are you aware of any future involvement in an investigation by a regulatory agency or peer review board? Yes No

Have you ever had a complaint or claim brought against you for sexual misconduct? Yes No

Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree? Yes No

Have you ever been indicted and/or convicted of a crime other than minor traffic violations? Yes No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? Yes No

If you answered yes to any of the above questions, you must provide a detailed written narrative.

Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such? Yes No

If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status. This letter should be from your treating physician or institution.

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? Yes No
(If yes, please list company, date and reason for this action below.)

Company	Date	Reason
_____	_____	_____
Company	Date	Reason
_____	_____	_____

PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

Professional Contractual Liability (not available in PA or VA) Yes No

Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance.* There is a charge based on a percentage of your professional liability premium.

Commercial General Liability Yes No

Do you wish to purchase Commercial General Liability coverage?
(If yes, please complete and submit **APP 007, Commercial General Liability Application.**)

For New Jersey Applicants Only - Consent to Settle

This endorsement is automatically attached to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. In accordance with the New Jersey Medical Care Access and Responsibility and Patients First Act, you may choose to remove this endorsement for 1% premium credit to your policy.

Would you like to remove this endorsement? Yes No

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- Copy of current Declaration Page
- Curriculum vitae (C.V.) for applicant and each employed or contracted physician
- A narrative of all past claims - a *Claim Information Form* may be used when necessary
- Signed Notice to New Applicants (APP 028 or 029) for claims made policies
- Signed Anti-Fraud Statement (Maine and New Jersey)
- Copies of license to practice and board certification

Read Carefully Before Signing

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.*

No obligation to issue or purchase insurance

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

Authorization to obtain information

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATED AGENCIES.

DISTRICT OF COLUMBIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAINE APPLICANTS: THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL. IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW HAMPSHIRE APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

WASHINGTON APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN WASHINGTON UNLESS THE INSURED(S) OR SOMEONE ACTING ON BEHALF OF THE INSURED(S) INTENTIONALLY CONCEALS OR MISREPRESENTS A MATERIAL FACT OR CIRCUMSTANCE RELATING TO THIS INSURANCE. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

ALABAMA, ALASKA, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, NEW MEXICO, NEW YORK, OHIO, RHODE ISLAND, TENNESSEE, TEXAS, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

THIS APPLICATION SHALL BE DEEMED APPENDED TO AND A PART OF ANY POLICY OF INSURANCE ISSUED TO YOU BASED ON THIS APPLICATION.

YOUR SIGNATURE ON THIS APPLICATION SUBSCRIBES YOU TO MEMBERSHIP IN THE RECIPROCAL EXCHANGE OF PHYSICIANS' RECIPROCAL INSURERS ("PRI"), THE PARENT COMPANY OF EMPRO INSURANCE COMPANY, AND ALL OF THE BENEFITS OF THE EXCHANGE AND SHALL BE DEEMED TO BE A CONCURRENT EXECUTION OF THE ATTACHED SUBSCRIBER'S AGREEMENT OF PRI. SUBSCRIBERSHIP BEGINS WITH THE COMMENCEMENT OF THE POLICY PERIOD OF THE LIABILITY INSURANCE POLICY ISSUED BY EMPRO AND ENDS UPON CANCELLATION OR OTHER TERMINATION OF THAT POLICY.

SIGNATURE OF APPLICANT

TITLE

PRINTED NAME

DATE

SIGNATURE OF PRODUCER (*signature is required for N.H. producers only*)

DATE

PRINTED NAME OF PRODUCER