EMPRO INSURANCE

Dentists 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 ☐ Male ☐ Female	Social Security Number	Date of Birth

Email Address	Website
Contact Person/Insured Representative	**National Provider Identifier**

Office Address One
Percentage of practice: _____
Address One
Address Two
City State Zip
Phone Fax

Residence Address
Address One
Address Two
City State Zip
Phone Fax

Office Address Two
Percentage of practice: _____
Address One
Address Two
City State Zip

Mailing Address *(if different)*
Address One
Address Two
City State Zip

Office Address Three
Percentage of practice: _____
Address One
Address Two
City State Zip

Billing Address *(if different)*
Address One
Address Two
City State Zip

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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: _____

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)*

If you have a specialty practice, list the post-graduate program completed: _____ Month: _____ Year: _____

If an oral surgeon, indicate month/year residency completed. _____ / _____

Which professional organizations are you a member of? ☐ ADA ☐ State Dental Society ☐ Other _____

PART VI - CURRENT PRACTICE

Type of practice: ☐ Individual ☐ Partnership ☐ Solo Corporation ☐ Professional Corporation ☐ Locum Tenens

Separate Limit of Liability for Partnership or Corporation ☐ Yes ☐ No
Not available on solo corporations (except in PA). Current practice must be partnership or corporation.
(*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

PART VII - PRACTICE ACTIVITIES

Indicate your primary area of practice:

☐ General Dentistry ☐ Pediatric Dentistry ☐ Periodontist ☐ Oral Surgeon ☐ Orthodontist
☐ Endodontist ☐ Prosthodontist ☐ Other _____

Do you have current hospital privileges? ☐ Yes ☐ No

If yes, list where: _____

Do you perform general anesthesia on your patients? ☐ In hospital only ☐ In office only ☐ In both hospital and office locations

Do you ever perform anesthesia procedures on patients who are undergoing medical (vs. dental) procedures? ☐ Yes ☐ No

If anesthesia is performed in your office, either by you or others:

- Is Dantrolene available or treatment of malignant hypothermia? ☐ Yes ☐ No
- Do you use manual/electronic monitoring of blood pressure and heart rate? ☐ Yes ☐ No
- Do you use a pulse-oximeter? ☐ Yes ☐ No
- Do you have an Automatic External Defibrillator? ☐ Yes ☐ No

Which of the following methods do you use to control pain and apprehension in your practice (check all that apply):

☐ Local anesthesia ☐ Nitrous oxide/oxygen analgesia ☐ Halcion ☐ Oral sedation by the use of other drugs ☐ Other _____

Do you perform conscious sedation provided by subcutaneous, IM or IV injection on your patients? ☐ In hospital only ☐ In office only ☐ In both hospital and office locations

Please list any medical (vs. dental) procedures you perform:_____

_____

Do you or any of your employees perform cosmetic procedures (other than teeth whitening)? ☐ 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 perform oral surgery? ☐ Yes ☐ No

If yes, do you obtain a patient consent form prior to performing oral surgery procedures? (If yes, attach a copy of the consent form.) ☐ Yes ☐ No

Do you use the Sargenti Method when performing root canals? ☐ Yes ☐ No

Do you place implants? ☐ Yes ☐ No

(If yes, please attach documentation of training completed.)

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 at a correctional facility? ☐ Yes ☐ No

(If yes, list where: _____)

Do you participate in any telemedicine activities? ☐ Yes ☐ No

Do you bill Medicare/Medicaid? ☐ Yes ☐ No

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

PART VIII - EMPLOYEES/ADDITIONAL INSUREDS

If you employ **non-dentist employees**, please list job catefory and number of each. (If necessary, please attach additional sheets.)

Job Title/Specialty	Number of Employess

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**. This coverage cannot be purchased for employed dentists.*

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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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 dental license? ☐ Yes ☐ No

Has your dental 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 restrictions, suspension, revocation or privileges or probation? ☐ Yes ☐ No

Have you ever been suspended, restricted or put on probation by any governmental health program? ☐ Yes ☐ No

Has your DEA certification ever been restricted, suspended, revoked or voluntarily surrendered or has probation been invoked? ☐ 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

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
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. ☐ Yes ☐ No

Commercial General Liability
Do you wish to purchase Commercial General Liability coverage? ☐ Yes ☐ No
*(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)
- ☐ Copy of current dental license

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, COMPLETE, 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	