HEALTHCARE PROFESSIONAL RISK RETENTION GROUP

A Exceptional Financial Stability Rating® Demotech, Inc.

Please submit the following with the application:
1. Curriculum Vitae (C.V.)
2. Current Certificate of Insurance (COI)
3. Current Loss Runs for all claims

Professional Liability Insurance Application

Applicant Information

1. Full Name: _____ Date of Birth: _____

2. Named Insured's SSN: _____Gender: ☐ Female ☐ Male E-Mail address: _____

3. Medical Degree: ☐ MD ☐ DO ☐ PA ☐ NP ☐ CRNA ☐ CNM Other _____ Medical License: _____

4. Primary practice address (Please list all locations and entities for which you are requesting coverage in the Remarks Section):

_____

5. Office phone number: _____ Office fax number: _____ Primary contact number: _____

6. This application is a: ☐ Request to join a physician or group already insured under policy number: _____ or

☐ New application with Healthcare Professional Risk Retention Group, Inc

7. Requested effective date: _____ Requested retroactive date: _____Requested limits of liability: _____

8. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier?

☐ Yes ☐ No *If no, please explain in Remarks Section*

Practice Information

9. Primary specialty: _____ Percentage of practice: _____

10. Secondary specialty: _____ Percentage of practice: _____

11. Are you Board Certified: ☐ Yes ☐ No If yes, list all specialties: _____

12. Degree of surgery: ☐ No Surgery ☐ Minor Surgery (Complete Medical Procedures Form) ☐ Surgery (Complete Medical Procedures Form)

13. Please indicate all states you hold medical licenses: _____

14: Please indicate your average number of practice hours per week that will be covered by this policy, including office hours, administrative activities, direct patient care, surgery, consultations, etc..: _____ Number of patients seen on a weekly basis: _____

15. Current carrier: _____ Current limits of liability: _____ Current premium: _____

16. Have you ever practiced medicine while you were uninsured?

☐ Yes ☐ No *If yes, please explain in Remarks Section*

17. Are you affiliated with any other doctor or group, including shared office space, employees, billing or letterhead?

☐ Yes ☐ No If yes, please list: _____

18. Do you serve as Medical Director at any location?

☐ Yes ☐ No If yes, please provide name and location: _____

19. Do you maintain ownership interest in any entity related to the practice of medicine?

☐ Yes ☐ No If yes, please list: _____

20. Please list all of your employed or contracted allied healthcare professional (Please note, if you are requesting coverage for a NP, PA, CRNA, CNM or Surgical Assistant an Additional Insured Application must be completed):

Name: _____ Certification: _____ Requesting coverage: ☐Yes ☐No

Name: _____ Certification: _____ Requesting coverage: ☐Yes ☐No

Name: _____ Certification: _____ Requesting coverage: ☐Yes ☐No

21. Do you supervise allied healthcare professionals who are insured elsewhere?

☐ Yes ☐ No *If yes, please provide proof of their coverage*

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22. Are you requesting coverage for any entity (Please note, if you are requesting coverage for an entity you must completed the Corporate Additional Insured Application)?

☐ Yes ☐ No If yes, please list: _____

Insurance Information

23. Please list all hospitals and healthcare facilities you have current privileges and the status of those privileges: _____

_____

_____

24. Are you involved or do you participate in any clinical research trials?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

25. Do you provide services at any nursing home, assisted living, or correctional facility?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

26. Are you now being or have you ever been evaluated for, diagnosed with, or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management issues, or any mental illness?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

27. Are you aware of any chronic illness or physical defect that impairs or could impair your ability to practice your specialty?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

28. Have you ever had professional liability insurance declined, nonrenewed, canceled, or restricted, or have you had an involuntary deductible or surcharge assessed against you?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

29. Have you ever appeared before, been investigated by, entered into any consent agreement with, or do you have any investigations currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental agency?

☐ Yes ☐ No *If yes, please provide copies of complaint and disposition documents*

30. Has your license to practice or your DEA/narcotics license ever been denied, revoked, suspended, placed on probation, or limited in any way?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

31. Have you ever been arrested, indicted, plead guilty to, or been convicted of any crime other than minor traffic violations?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

32. Has your participation in any governmental or nongovernmental health program ever been suspended, placed on probation, terminated, or limited in any way?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

33. Have your staff privileges at any hospital or healthcare facility ever been suspended, refused, revoked, placed on probation, or in any way restricted, or do you have an investigation relative to your staff privileges pending or in progress at any hospital or healthcare facility?

☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

34. Have you ever been accused of sexual misconduct?
☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

35. Are you aware of any circumstances that might be reasonably expected to lead to a claim or suit (even if you believe the possible claim or suit would be without merit) that have or have not been reported to your current or prior medical professional liability carrier?
☐ Yes ☐ No *If yes, please provide explanation in Remarks Section*

36. Have you ever been a party to a malpractice claim, suit, or incident?
☐ Yes ☐ No If yes, how many? _____ (Please provide a Claim Explanation Form for each claim)

Remarks Section

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Medical Procedures

Please indicate every procedure you perform by checking the box next to the procedure. If you perform any procedures not listed on this page, please list those procedures below.

If you do NOT perform any procedures, please check this box and move to the next page: ☐ **I do NOT perform procedures**

Do you perform any procedures you did not receive training in your residency or that are outside the customary scope of practice for your specialty?

☐ Yes ☐ No *If yes, please list the procedures:* _____

_____

Do you perform bariatric surgery?	☐ Yes ☐ No	How many per year? _____
Do you operate on the spine?	☐ Yes ☐ No	How many per year? _____
Do you perform deliveries?	☐ Yes ☐ No	How many per year? _____
Do you perform general surgery?	☐ Yes ☐ No	How many per year? _____
Do you operate on the brain?	☐ Yes ☐ No	How many per year? _____

Please check all procedures that you perform:

☐ Abortion	☐ Closed Reduction (other than simple)	☐ Hysterectomy	☐ Therapeutic Abortion
☐ Adenoidectomy	☐ Colonoscopy	☐ Laparoscopy	☐ Tonsillectomy
☐ Anal Fistulectomy	☐ Cryotherapy and LEEPs	☐ Myringotomy	☐ Tubal Ligation
☐ Analgesia, IV Conscious Sedation	☐ Culdocentesis	☐ Nasal Polypectomy	☐ Vasectomy
☐ Anesthesia (Spinal)	☐ Dilation and Curettage	☐ Normal Vaginal Delivery	☐ VBAC
☐ Appendectomy	☐ Elective Cardioversion	☐ Oophorectomy	☐ Vein Stripping
☐ Cesarean Section Delivery	☐ Endometrial Biopsy	☐ Orchiectomy	☐ Weight Loss
☐ Cholecystectomy	☐ Endoscopic Procedures	☐ Prenatal & Postnatal Care	☐ Other (**Please list**)
☐ Circumcision (adult)	☐ Hemorrhoidectomy	☐ Salpingectomy	
☐ Circumcision (Pediatric)	☐ Hydrocelectomy	☐ Tendon Repair	

Cardiology

☐ Cardiac Catheterization	☐ Coronary Angiography	☐ Coronary Angioplasty/Stent	☐ Other (**Please List**)

Cosmetic/Plastic Surgery

☐ Abdominoplasty	☐ Autologous Fat Injection	☐ Thermage
☐ Blepharoplasty	☐ Breast Augmentation	☐ Breast Reduction
☐ Coronal Lift	☐ Endoscopic-Assisted Forehead Lift	☐ Facial Laser Resurfacing
☐ Hair Implant	☐ Implants other than Breast	☐ "Lifestyle" Lift
☐ Liposuction	☐ Rhinoplasty (Cosmetic)	☐ Rhytidectomy
☐ Penile-Related Cosmetic Procedures	☐ Rhinoplasty (Functional Only)	☐ Sex Reassignment Surgery
☐ Vaginal-Related Cosmetic Procedures		☐ Other (**Please List**)

Pain Management

☐ Block (Spine and non-spine)	☐ Cryoanalgesia	☐ Dorsal Column Stimulator Implant	☐ Kyphoplasty
☐ Epidural or Spinal Catheter	☐ Intra-Articular Block (joint injection)	☐ Intradiscal Electrothermal Therapy	☐ Vertebroplasty
☐ Myofascial Trigger Point Injections	☐ Nerve Root Injections	☐ Radio Frequency Neve Ablation	☐ M.I.L.D.
☐ Rapid Detoxification	☐ Spinal Infusion Implant	☐ Spinal Infusion Pump	☐ Other (**Please List**)
☐ Spinal Stimulation Implant	☐ Spinal Stimulation Programming	☐ Stellate Ganglion Block	

Please indicate if you or any of your staff perform the following procedures:

	Physician	**Non-Physician Licensed Staff**	**Non-Licensed Staff**
Botox	☐	☐	☐
Chemical Peel	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Microdermabrasion	☐	☐	☐
Sclerotherapy	☐	☐	☐
Thread Lifts	☐	☐	☐

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Claim Information (Mark N/A or initial this page for leaving blank intentionally)

Please complete this form for each claim, suit or incident you've been involved in. Provide corresponding loss runs from the carrier involved in each claim. Please write legibly.

1. Name of Claimants: _____

2. Age: _____

3. Gender: ☐ Female ☐ Male

4. Relationship to Patient (i.e., attending physician, consulting physician, primary surgeon, assistant surgeon, other)

_____

5. Allegation: _____

_____

6. Date of Incident: _____

7. Location: _____

8. Insurance Carrier(s): _____

9. Other Defendants: _____

10. Present Status: ☐ Open Claim Indemnity Reserve: _____ Expense Reserve: _____

☐ Closed Claim Indemnity Paid: _____ Expense Paid: _____

Date closed: _____ ☐ Settlement ☐ Judgement

11. Conditions and diagnosis at time of incident: _____

_____

_____

_____

_____

12. Dates and description of professional services rendered: _____

_____

_____

_____

_____

13. Condition of patient subsequent to professional services: _____

_____

_____

_____

_____

14. Additional Comments: _____

_____

_____

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Disclaimer and Signature

GENERAL FRAUD WARNING: 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 fines and confinement in prison.

CALIFORNIA FRAUD WARNING: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a 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.

FLORIDA FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

TEXAS FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The undersigned, acting on behalf of all proposed Insureds, declare that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information from each Insured proposed for this insurance to facilitate the proper and accurate completion of this Application. The undersigned agree that the particulars and statements contained in this application and any material submitted herewith are their representations and are the basis of the insurance contract. The undersigned further agree that this application and any material submitted herewith shall be considered attached to and a part of the Policy. Any material submitted with this application shall be maintained on file (either electronically or paper) with the Insurer and shall be deemed to be attached hereto as if physically attached. It is further agreed that: (1) if any significant change in the condition of the applicant is discovered between the date of this application and the Policy inception date, which would render this application inaccurate or incomplete, notice of such change will be reported in writing to the Insurer immediately and, upon receipt of such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance; (2) any Policy, if issued, will be in reliance upon the truth of such representations and any misrepresentation by the Insured or the Insured's agent that is material to the acceptance of the risk will render the Policy null and void and relieve the Insurer from all liability herein; (3) this application has been completed as respects the entire Applicant; (4) the signing of this application does not bind the undersigned to purchase the insurance.

I understand that the information submitted herein becomes a part of the Applicant’s Professional Liability Insurance Application and is subject to the same representations and conditions.

Warranty

(This statement must be completed, signed and returned with the submitted application) My signature below confirms that:

1. The Insured has reviewed, or has had an opportunity to review, make necessary changes, or update the submitted application form to the Company that is being relied on for issuance of a Policy.

2. The Insured has conducted a diligent search and investigation as part of submitting the accompanying application and represents and warrants to the Company the following:

    a. All questions, statements or representations in the submitted application are **correct** as of the date this document is executed;
    b. All questions, statements or representations in the submitted application are **current** as of the date this document is executed;

3. To the extent ANY of the above statements or representations contained in Section 2 are untrue or inaccurate, the Insured acknowledges and agrees that the Company may seek to rescind or cancel the Policy and/or that the Policy may not afford coverage for any Claim, Occurrence, Medical Incident, fact, circumstance, or situation based on, arising out of, or in any way involving such untrue statements or representations, whether or not any Insured knew that the Application contained an untruthful or inaccurate disclosure.

4. The person signing this Warranty further represents and warrants to the Company the following:
    a. He / She is an authorized agent of the entity(ies) and/or individual(s) seeking insurance from the Company; and
    b. He / She is authorized to complete this Warranty on behalf of the entity(ies) and/or individual(s) seeking insurance from the Company.

Signature: _____

Print Name: _____

Date: _____

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Proxy

I hereby appoint the Secretary of the Company, my lawful proxy to vote and act in my name at all annual, regular, and special meetings of the Subscribers of Healthcare Professional Risk Retention Group, Inc.

This proxy is solicited on behalf of the management of Healthcare Professional Risk Retention Group, Inc. and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Directors and such other business as may properly come before any annual, regular, or special meeting of Subscribers.

This proxy, unless revoked or replaced by substitution, shall remain in force indefinitely.

You may revoke this proxy by giving Healthcare Professional Risk Retention Group, Inc. written notice of your revocation at least 10 days before the date of any annual, regular, special meeting at which proxy is to be exercised. If you attend a meeting, you may revoke this proxy if you choose to vote in person.

The signing of this proxy is not a condition of completion of this application and your signature, or your failure or refusal to sign, will not be considered in connection with the underwriting of your application.

Signature

Signature: _____

Print Name: _____

Date: _____

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Stock Subscription and Shareholder Agreement

For and in consideration of similar agreements executed or to be executed by other Subscribers and of the benefits of the exchange of such agreement, Subscriber agrees to the below-stated terms and conditions.

1. The Company is a company, duly organized and existing under the laws of the State of North Carolina and the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986 (15 U.S.C. §3901 et seq.). The Company maintains a captive insurance license from the State of North Carolina.
2. Upon acceptance by the Company of an application for insurance, each insured policyholder hereby agrees to purchase Shares from the Company, and the Company hereby agrees to sell Shares to the insured policyholder, pursuant to the terms and conditions set forth herein and in the Company's Certificate of Incorporation and Bylaws.
3. Prior to the issuance of the first insurance policy by the Company, Common Stock shall be issued at $1.00 per share. After the Company begins issuing insurance policies, Common Stock shall be issued at $10.00 per share. Shareholder shall make an annual capital contribution in the amount of 15% of each year's annual premium at $10.00 per share, for each year they are insured by the Company.
4. No Shareholder shall sell, transfer, assign or make any other disposition of its shares. Any purported transfer shall be void *ab initio* and of no force and effect.
5. Subscribership begins with the commencement of the policy period of the liability insurance policy issued by Healthcare Risk Retention Group, Inc. and ends upon cancellation or other termination of the policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After cancellation or other termination, subscriber shall have no further rights and will forfeit all shares back to Healthcare Professional Risk Retention Group, Inc., with no return of capital.
6. The parties hereto agree that this Agreement shall be construed, enforced and governed by the laws of North Carolina, without regard to its conflicts of laws principles.
7. Except for Founding Members, defined as a shareholder of Corporation purchasing shares of the Corporation prior to and separate from the Corporation's issuance of any insurance policy to any member, the Shareholder understands that if the shareholder is no longer insured by the Company, all outstanding shares held by shareholder will revert to the Company with no return of capital made to the former shareholder.
8. **THE SHARES ARE ISSUED TO AN INSURED POLICYHOLDER OF THE COMPANY AND ARE SUBJECT TO THE TERMS AND CONDITIONS OF THE COMPANY'S BYLAWS AND A STOCK SUBSCRIPTION AND SHAREHOLDER AGREEMENT. COPIES OF THE BYLAWS AND THE STOCK SUBSCRIPTION AND SHAREHOLDER AGREEMENT WILL BE FURNISHED BY THE COMPANY TO THE HOLDER HEREOF UPON WRITTEN REQUEST AND WITHOUT CHARGE.**
9. **PURSUANT TO THE FEDERAL PRODUCT LIABILITY RISK RETENTION ACT OF 1981, AS AMENDED BY THE RISK RETENTION AMENDMENTS OF 1986, THE SHARES ARE EXEMPTED FROM REGISTRATION UNDER THE SECURITIES ACT OF 1933, AS AMENDED (THE "ACT") AND STATE SECURITIES LAWS. ACCORDINGLY, THESE SHARES HAVE NOT BEEN REGISTERED UNDER THE ACT, OR ANY STATE SECURITIES LAW. NO TRANSFER OF THE SHARES MAY BE MADE (A) EXCEPT PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE ACT AND UNDER APPLICABLE STATE SECURITIES LAW OR (B) UNTIL THE COMPANY HAS BEEN FURNISHED WITH AN OPINION OF COUNSEL FOR THE HOLDER, WHICH OPINION SHALL BE IN FORM AND SUBSTANCE AND FROM COUNSEL SATISFACTORY TO THE COMPANY, TO THE EFFECT THAT SUCH TRANSFER IS EXEMPT FROM THE REGISTRATION PROVISIONS OF THE ACT AND ANY APPLICABLE STATE SECURITIES LAWS.**

IN WITNESS WHEREOF, the parties hereto have executed this Stock Subscription and Shareholder Agreement as of the day and year first set forth below.

Subscriber Signature

Signature: _____

Print Name: _____

Date: _____

Acceptance

Healthcare Professional Risk Retention Group, Inc., a North Carolina corporation, hereby accepts this Stock Subscription and Shareholder Agreement.

Signature: _____

Andrew R Cunningham - President

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