



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



Entity Professional Liability Insurance Application

Entity Information

- 1. Full entity name: _____
- 2. Doing business as (DBA): _____ FEIN: _____
- 3. Practice address: _____
- 4. Contact person: _____ Title: _____
- 5. Phone number: _____ Fax number: _____ E-mail Address: _____
- 6. Effective date: _____ Retroactive date: _____ Limits of liability: _____
- 7. Does this entity have current coverage? Yes No *If yes, complete #8*
- 8. Current carrier: _____ Current premium: _____

Practice Information

- 9. Primary specialty: _____ Percentage of practice: _____
- 10. Secondary specialty: _____ Percentage of practice: _____
- 11. Degree of surgery: No Surgery Minor Surgery (Complete Medical Procedures Form) Surgery (Complete Medical Procedures Form)
- 12. Number of hour entity is open per week: _____ Number of weekly patient encounters: _____
- 13. Number of healthcare professionals practicing at the entity: _____ Annual Revenue: _____
- 14. Please list all of your employed or contracted healthcare professionals (Please provide application for all providers covered under this policy):

Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Certification: _____	Requesting coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No
- 15. Are all the above licensed in accordance with state and federal regulations?
 Yes No *If no, explain in Remark Section*
- 16. Does the entity have a medical director requesting coverage?
 Yes No Please list name: _____
- 17. Does the entity have a Risk Management or Risk Control program in place?
 Yes No

Practice Information (Continued)

18. Is the entity involved or participate in any clinical research trials?

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

19. Does the entity provide services at any nursing home, assisted living, or correctional facility?

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

20. Does the entity provide addiction medicine services?

Yes No

21. Does the entity maintain any beds for overnight occupancy?

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

22. Has the entity 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*

23. Has the entity ever been investigated by, entered into any consent agreement with, or 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*

24. 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*

25. Has the entity 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

Medical Procedures

Please indicate every procedure performed by checking the box next to the procedure. If procedures not listed are performed, please list those procedures below.

Does any healthcare professional perform procedures they did not receive training in or that are outside the customary scope of practice for their specialty?

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

Total number of non-surgical procedures performed annually: _____

Total number of surgical procedures performed annually: _____

Please check all procedures that you perform:

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

Cardiology

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Coronary Angiography | <input type="checkbox"/> Coronary Angioplasty/Stent | <input type="checkbox"/> Other (Please List) |
|--|---|---|---|

Cosmetic/Plastic Surgery

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

Pain Management

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Block (Spine and non-spine) | <input type="checkbox"/> Cryoanalgesia | <input type="checkbox"/> Dorsal Column Stimulator Implant | <input type="checkbox"/> Kyphoplasty |
| <input type="checkbox"/> Epidural or Spinal Catheter | <input type="checkbox"/> Intra-Articular Block (joint injection) | <input type="checkbox"/> Intradiscal Electrothermal Therapy | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Myofascial Trigger Point Injections | <input type="checkbox"/> Nerve Root Injections | <input type="checkbox"/> Radio Frequency Neve Ablation | <input type="checkbox"/> M.I.L.D. |
| <input type="checkbox"/> Rapid Detoxification | <input type="checkbox"/> Spinal Infusion Implant | <input type="checkbox"/> Spinal Infusion Pump | <input type="checkbox"/> Other (Please List) |
| <input type="checkbox"/> Spinal Stimulation Implant | <input type="checkbox"/> Spinal Stimulation Programming | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Tattooing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser Wrinkle Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Microdermabrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Invasive Liposuction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thread Lifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Claim Information

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: _____

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 and with their consent, 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 representations for the entity 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 entity 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.

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: _____

Title: _____

Date: _____

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: _____

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: _____ Date: _____

Printed _____

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

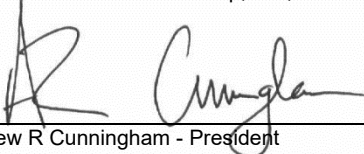
Signature: _____

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