



# Physicians Insurance Program Reciprocal Exchange

## Malpractice Insurance Program

OCCURRENCE AND CLAIMS-MADE COVERAGE AVAILABLE.

FOUNDED FOR THE PROTECTION OF PENNSYLVANIA PHYSICIANS.

PHYSICIAN OWNED COMPANY, OWNED BY POLICYHOLDERS.

PRIOR ACTS COVERAGE AVAILABLE.

REINSURANCE FROM A FINANCIALLY STABLE, GLOBAL REINSURER.

AGGRESSIVE CLAIMS DEFENSE.

CORPORATE COVERAGE AVAILABLE.

CREDITS SUCH AS NEWLY PRACTICING AND CLAIMS-FREE DISCOUNTS AVAILABLE.

LICENSED AND ADMITTED BY THE PENNSYLVANIA INSURANCE DEPARTMENT.

WILL NOT SETTLE A CLAIM WITHOUT THE PHYSICIAN'S CONSENT!!

### APPLICATION COVER SHEET INFO TO BE COMPLETED BY APPLICANT

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City state zip

Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

County: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Present Insurer: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Current Type of Policy:     Occurrence         Claims-Made

COVERAGE REQUESTED (please check)

Occurrence         Claims-Made with Retroactive Date as Follows: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Corporate Coverage Requested:     YES                     NO

EFFECTIVE DATE REQUESTED: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



**PROFESSIONAL LIABILITY**

**PRINT OR TYPE ALL INFORMATION**

20. Have you participated in any continuing education programs in the last five years? YES NO

If yes, provide details \_\_\_\_\_

\_\_\_\_\_

21. \_\_\_\_\_

Hospital Name where you practice County City

**UNDERWRITING INFORMATION:**

1. List all colleges and professional schools attended:

NAME YEARS ATTENDED DATE OF GRADUATION DEGREE

\_\_\_\_\_

\_\_\_\_\_

2. Postgraduate education:

(a) Internship: YES NO Hospital \_\_\_\_\_

Address (City & County) \_\_\_\_\_ Dates \_\_\_\_\_

(b) Residency/ Fellowship/ Preceptorship: YES NO Hospital \_\_\_\_\_

Address (City & County) \_\_\_\_\_ Dates \_\_\_\_\_

3. Board Certification: YES NO If yes, name of board \_\_\_\_\_ Year Certified \_\_\_\_\_

4. Current Licenses:

STATE LICENSE NUMBER DATE EXAM REQUIRED DTS TAKEN

\_\_\_\_\_

\_\_\_\_\_

5. Have you ever had a license revoked or suspended, or have you been put on probation? YES NO

If yes, please explain: \_\_\_\_\_

6. Have you ever had a narcotic license revoked or suspended, or have you been on probation? YES NO

If yes, please explain \_\_\_\_\_

7. Have you ever had your privileges denied, suspended, restricted, revoked or not renewed? YES NO

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION  
PROFESSIONAL LIABILITY**

**PRINT OR TYPE ALL INFORMATION**

8. List ALL malpractice carriers for the past 10 years

DATES	NAME	COVERAGE (occurrence/ claims made)
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

9. List ALL facilities where you do surgery or consultations:

NAME	ADDRESS	YEARS AT FACILITY	ADMINISTRATOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Please attach delineation of privileges at each facility. Do you ever perform surgery that is not your delineation? YES NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

11. Have you ever used any intoxicant, or other psychoactive or depressant drug to the extent that it has interfered with your ability to perform professional duties? YES NO

12. Have you ever had any professional liability insurance declined, cancelled or renewal refused, for reasons other than the company's withdrawal from your professional liability market? YES NO

13. Have you ever had professional liability insurance issued on a restrictive basis (i.e. reduced limits, assigned a deductible, restrictive coverage, surcharge rates)? YES NO

14. Have you ever been the subject of disciplinary proceedings or been reprimanded by an administrative agency, hospital or professional association? YES NO

15. Have you ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? YES NO

16. Have you ever been treated for alcoholism or drug addiction? YES NO If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

17. Have you ever been disabled or had an interruption of your practice because of a disability? Yes NO

18. Do you work for or in a prison? YES NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES PLEASE EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION  
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19. Do you administer any sedatives, analgesics or anesthesia (besides Xylocaine) in your office?

YES NO If yes please explain: \_\_\_\_\_

20. Do you participate in any of the following?

Sports medicine? NO YES Minimal incision surgery? YES NO Emergency room work? YES NO

Laser Surgery:

(a) Do you use a laser in your treatment of patients? YES NO

If yes, with what type of treatment? Explain: \_\_\_\_\_

(b) How many times a week do you use the laser? \_\_\_\_\_

(c) What type of training did you receive in the use of the laser? (check all that apply)

\_\_\_\_\_ Seminar \_\_\_\_\_ Course \_\_\_\_\_ Preceptorship \_\_\_\_\_ Hands-on \_\_\_\_\_ other

Please specify names of programs \_\_\_\_\_

21. Who obtains your informed consent? \_\_\_\_\_

22. How many patient contacts do you have PER week? \_\_\_\_\_

23. Have you attended a malpractice loss prevention program in the last 12 months? YES NO If yes, when, where and please describe: \_\_\_\_\_

24. Are you now or in the LAST 10 years been involved directly or indirectly in a claim, potential claim or suit arising out of the rendering of failing to render professional services? YES NO

If yes, how many? \_\_\_\_\_ Have these been reported to your insurer? YES NO

25. Do you have knowledge of any incident or unexpected adverse outcome resulting in injury or death, claim, potential claim or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may result in a claim? YES NO If yes, how many? \_\_\_\_\_ Have these been reported to your professional liability carrier? \*\* YES NO

\*\*If yes, please provide a copy of the reports and any information relative to any incidents to that which you are aware of but have not yet filed.

I hereby declare and represent that the above statements and particulars are true and complete. I have not withheld or misstated any information requested by the insurance company. I understand and agree that the information contained in this application is material; that it is being relied upon by the Exchange in considering my application for professional liability insurance; and, that it is the basis of any policy of insurance which may be issued to me. I also understand that this application shall be annexed to, and deemed a part of any policy of liability insurance issued to me by the insurance Exchange.

Any person who, knowingly and with the intent to defraud any insurance Exchange or other person, files an application for insurance containing any false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

IT IS FURTHER UNDERSTOOD AND AGREED TO BY ME THAT THERE SHALL BE NO COVERAGE FOR CLAIMS MADE OR CLAIMS ARISING FROM INCIDENTS OCCURRING DURING THE POLICY PERIOD WHICH IS ISSUED UPON THIS APPLICATION, IF ANY OF THE FOLLOWING CONDITIONS APPLY:

- (1) The claim arises out of the performance of any procedure or surgery not indicated by me in this application.
- (2) The claim arises from the rendering of the professional services outside the scope of the specialty or the sub-specialty stated by me in this application.
- (3) Knowledge of or notification of the claim or an incident has occurred prior to the date below of this application.
- (4) The claim arises from professional services rendered outside the classification applied for in this application as defined in the classification and rate sheet.

\_\_\_\_\_  
Date                      Print Name                      Signature

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize any person, company, insurer, hospital or other organization to release any and all information privileged or not, in their dominion, custody, or control regarding insurance application by me, professional liability insurance issued to me, claims made or suits brought against me, applications by me for hospital privileges, decisions, and notes of any credentials or disciplinary committees involving me, any employment of personal records involving me, any records involving me as well as any information obtained by any attorneys who are now representing, of have in the past represented me. I hereby authorize you to make copies of this application as you deem necessary and those copies shall be as valid as originals.

\_\_\_\_\_  
Date                      Name (Print or Type)                      Signature

REMINDER: EVERY QUESTION "MUST" BE ANSWERED!

**STATE STATUTORY REQUIREMENT**

**Note: All applicants must read and initial the following:**

**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.**

**Initial here:** \_\_\_\_\_

**PLEASE READ AND SIGN:**

**I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree to notify the Company if there is any material change in any answer to this application, including, without limitation, any change in my professional specialty, affiliation, or working arrangement with any physician, or dentist, firm or professional association.**

**I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RECALL IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.**

**I understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to be applicable and pertinent to this application and if issued, the contract of insurance issued, the contract of insurance issued hereunder.**

\_\_\_\_\_  
Date Signed                      Print or Type Name                      Signature

# PRACTICE AND PROCEDURES: GENERAL QUESTIONS

Please check the category that most closely describes your practice.

- Major Surgery:** Performing any operative procedure done under general, spinal or caudal anesthesia or assisting in “Major Surgery” on other than your own patients.
- Minor Surgery:** Performing any operative procedure other than as included in “Major Surgery” or assisting in “Major Surgery” on your own patients.
- No Surgery\*:** NOT performing any operative procedure including “Major Surgery” or “Minor Surgery”.  
\*Note: Incising of boils and superficial fascia, suturing of minor lacerations and removal of superficial skin lesions are not considered operative procedures for the purpose of this application.

Indicate percentage of time devoted to the following activities commonly associated with the following surgical specialties.

Percentage	Specialty	Percentage	Specialty	Percentage	Specialty
_____ %	Abdominal	_____ %	Hand	_____ %	Plastic
_____ %	Cardiac	_____ %	Head & Neck	_____ %	Thoracic
_____ %	Cardiovascular	_____ %	Laryngology	_____ %	Traumatic
_____ %	Colon & Rectal	_____ %	Neoplastic	_____ %	Urological
_____ %	Gastroenterology	_____ %	Otology	_____ %	Vascular
_____ %	Gynecology	_____ %	Otorhinolaryngology	_____ %	Other_____

Check any of the following applicable to your practice for which coverage is required.

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| <ul style="list-style-type: none"> <li><input type="checkbox"/> Abortions: Trimester: _____<br/>Where Performed: _____</li> <li><input type="checkbox"/> Administration of General, Spinal or Caudal Anesthesia</li> <li><input type="checkbox"/> Acupuncture (<i>please submit copy of certification</i>)</li> <li><input type="checkbox"/> Amniocentesis</li> <li><input type="checkbox"/> Angiograms</li> <li><input type="checkbox"/> Angioplasty    <input type="checkbox"/> Coronary    <input type="checkbox"/> Other _____</li> <li><input type="checkbox"/> Aspiration of Cyst of Breast</li> <li><input type="checkbox"/> Assisting in Major Surgery<br/>List Procedures: _____</li> <li><input type="checkbox"/> Blepharoplasty</li> <li><input type="checkbox"/> Breast Biopsy</li> <li><input type="checkbox"/> Bronchoscopy</li> <li><input type="checkbox"/> Cardiac Catheterization <ul style="list-style-type: none"> <li><input type="checkbox"/> Left Heart</li> <li><input type="checkbox"/> Swan Ganz</li> </ul> </li> <li><input type="checkbox"/> Cataract Surgery</li> <li><input type="checkbox"/> Cervical Cautery</li> <li><input type="checkbox"/> Chelation Therapy (other than for treatment of heavy metal poisoning)</li> <li><input type="checkbox"/> Chemabrasion/Dermabrasion</li> <li><input type="checkbox"/> Chemical Peel: Type: _____</li> <li><input type="checkbox"/> Chemotherapy</li> <li><input type="checkbox"/> Chorionic Villi Sampling</li> <li><input type="checkbox"/> Circumcision of Newborn/ Adult</li> <li><input type="checkbox"/> Closed Reduction of Fractures</li> <li><input type="checkbox"/> Colonoscopy</li> <li><input type="checkbox"/> Cosmetic Surgery of Breast</li> <li><input type="checkbox"/> Cryosurgery: Compound _____</li> <li><input type="checkbox"/> Culdocentesis</li> <li><input type="checkbox"/> D &amp; C</li> <li><input type="checkbox"/> Deep Radiation/ X-Ray Therapy</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Duodenoscopy</li> <li><input type="checkbox"/> Endometrial Biopsy</li> <li><input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography</li> <li><input type="checkbox"/> Esophagoscopy</li> <li><input type="checkbox"/> Excisional Punch Biopsy</li> <li><input type="checkbox"/> Foreign body removal from Eye</li> <li><input type="checkbox"/> Gastric Bubble</li> <li><input type="checkbox"/> Gastroscopy</li> <li><input type="checkbox"/> Hair Transplants: Type _____</li> <li><input type="checkbox"/> Hemorrhoidectomy</li> <li><input type="checkbox"/> Hydrocelectomy</li> <li><input type="checkbox"/> Injection of Radiopaque Dye</li> <li><input type="checkbox"/> Interventional Radiology Procedures</li> <li>_____</li> <li><input type="checkbox"/> Insertion of IUD</li> <li><input type="checkbox"/> Intestinal Surgery for Obesity</li> <li><input type="checkbox"/> Liposuction</li> <li><input type="checkbox"/> Laser Surgery: _____</li> <li><input type="checkbox"/> Nasal Polypectomy</li> <li><input type="checkbox"/> Needle Biopsy: Type _____</li> <li><input type="checkbox"/> Peripheral Nerve Block Anesthesia</li> <li><input type="checkbox"/> Peritoneal Dialysis</li> <li><input type="checkbox"/> Permanent Pacemakers</li> <li><input type="checkbox"/> Polypectomy by Endoscopy</li> <li><input type="checkbox"/> Prenatal Care</li> <li><input type="checkbox"/> Proctoscopy</li> <li><input type="checkbox"/> Radial Keratotomy</li> <li><input type="checkbox"/> Sigmoidoscopy</li> <li><input type="checkbox"/> Stress Testing</li> <li><input type="checkbox"/> Telemedicine</li> <li><input type="checkbox"/> Temporary Pacemaker</li> <li><input type="checkbox"/> Vein Stripping</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
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**PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION  
PROFESSIONAL LIABILITY**

**PRINT OR TYPE ALL INFORMATION**

**CLAIMS HISTORY SHEET**

FILL OUT A SEPARATE SHEET FOR EACH CLAIM FOR THE LAST "10" YEARS.  
MAKE ADDITIONAL COPIES OF THIS FORM, IF NECESSARY

Claimant: \_\_\_\_\_

Defendant(s): \_\_\_\_\_

Date suit filed: \_\_\_\_\_

City, County, State & Name of Court in which Suit was filed: \_\_\_\_\_

\_\_\_\_\_

Name & Address of defense attorney: \_\_\_\_\_

\_\_\_\_\_

Settlement amount (if any): \$ \_\_\_\_\_ Verdict amount (if any): \$ \_\_\_\_\_

Date case was closed: \_\_\_\_\_

Current status of claim: \_\_\_\_\_

\_\_\_\_\_

Name of involved insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_

Brief description of claim: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Brief description of defense: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

# APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

## APPLICANT'S INSTRUCTIONS:

1. If you have a Curriculum Vitae (resume) please attach it to the application and check here\_\_\_\_\_.
2. Answer all questions; if a question is not applicable, state "NOT APPLICABLE"
3. If Space is insufficient to answer any questions fully, attach a separate sheet.
4. The Application must be signed and dated by the applicant.
5. If the answer to any question is none, state "NONE".

(PLEASE TYPE OR PRINT IN INK)

### 1. GENERAL SURGERY:

- a. How many Laparoscopic Cholecystectomy procedures performed per month? \_\_\_\_\_
- b. How many Hernia procedures performed per month? \_\_\_\_\_
- c. How many Mastectomy / Lumpectomy procedures do you perform per month? \_\_\_\_\_

### 2. ORTHOPEDIC SURGERY:

- a. How many spine procedures do you perform per month? \_\_\_\_\_
- b. How many knee procedures do you perform per month? \_\_\_\_\_
- c. How many hip replacements do you perform per month? \_\_\_\_\_
- d. How many Arthroscopic surgical procedures do you perform per month? \_\_\_\_\_

### 3. CARDIO-THORACIC/THORACIC:

- a. How many by-pass procedures do you perform per month? \_\_\_\_\_
- b. How many Pulmonary Re-section (lobe-wedg) do you perform per month? \_\_\_\_\_
- c. How many Thoracoscopy procedures do you perform per month? \_\_\_\_\_
- d. How many Mediastinoscopy procedures do you perform per month? \_\_\_\_\_

### 4. VASCULAR SURGERY:

- a. How many Carotid Endorectomy procedures do you perform per month? \_\_\_\_\_
- b. How many Peripheral Artery By-pass procedures do you perform per month? \_\_\_\_\_
- c. How many Endo Vascular procedures (Abdominal Aorta, Peripheral Artery) do you perform per month? \_\_\_\_\_
- d. How many Open Abdominal Aortic Aneurysms do you perform per month? \_\_\_\_\_

### 5. NEUROSURGERY:

- a. How many Craniotomy procedures do you perform per month? \_\_\_\_\_
- b. How many Disc Fusions do you perform per month? \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PRINT SIGNATURE: \_\_\_\_\_

**APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR  
OBSTETRICIANS AND GYNECOLOGISTS**

**APPLICANT'S INSTRUCTIONS:**

1. If you have a Curriculum Vitae (resume) please attach it to the application and check here \_\_\_\_\_ .
2. Answer all questions; if a question is not applicable, state "NOT APPLICABLE"
3. If Space is insufficient to answer any questions fully, attach a separate sheet.
4. The Application must be signed and dated by the applicant.
5. If the answer to any question is none, state "NONE".
6. Please do not complete the application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. Name of Applicant: \_\_\_\_\_
2. How many deliveries have you performed in the last two (2) years? \_\_\_\_\_
3. Do you have knowledge or information of any potential or actual claim or suit that may be brought against you or of any incidents?  
\_\_\_\_\_ If yes, attach a full and complete explanation.
4. Have you received a request from a patient or from his or her representative requesting a copy of your records or those of the hospitals?  
\_\_\_\_\_
5. Attach a copy of your Declaration Page [it gives you the dates of coverage and limits] from the most recent policy issued to you.
6. Do you perform sex change operations? \_\_\_\_\_ If yes, describe:  
\_\_\_\_\_

- . Do you perform therapeutic abortions in the first trimester? \_\_\_\_\_
- . Do you perform therapeutic abortions after 12 weeks? \_\_\_\_\_
- . Total number of abortions performed monthly on your patients. \_\_\_\_\_
- . Total number of abortions performed monthly on other patients. \_\_\_\_\_
- . List hospitals, clinics, or other facilities where you perform abortions.  
\_\_\_\_\_

8. Do you perform surgery or surgical research? \_\_\_\_\_ If yes, describe: \_\_\_\_\_  
\_\_\_\_\_
9. Do you employ, contract with, or cover midwives? \_\_\_\_\_
10. Do you perform Suction Lipectomy? \_\_\_\_\_ If yes, attach confirmation of your training.
11. Do you perform home or non-hospital deliveries? \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

I declare that I Know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer".

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

PRINT SIGNATURE: \_\_\_\_\_

**PHYSICIAN'S INSURANCE PROGRAM RECIPROCAL EXCHANGE APPLICATION  
PROFESSIONAL LIABILITY**

**SUBSCRIBER'S AGREEMENT**

The undersigned subscriber to Physicians' Insurance Program Reciprocal Exchange (the Exchange), a Pennsylvania Reciprocal Insurance Exchange, agrees together with all other Subscriber's to the Exchange, and with Physicians' Insurance Program Management Company (the Company), a Pennsylvania corporation, as the Attorney-in-fact for the Exchange, as follows:

1. The undersigned agrees to pay its policy premiums and to exchange with the other Subscriber's to exchange, policies at the offices of the Company in Lansdale, Pennsylvania.
2. The undersigned appoints the Company as Attorney-in-fact with the power to (a) exchange insurance policies with other Subscribers to the exchange, (b) take any action necessary for the exchange of such insurance policies, (c) issue, change, nonrenew or cancel insurance policies, (d) obtain reinsurance (e) collect premiums, (f) invest and reinvest funds, (g) receive notices and proofs of loss, (h) appear for compromise, prosecute, defend, adjust service of process on behalf of the exchange as insurer and (j) conduct business and affairs of the exchange as set forth herein, in the Declaration or Organization of the Exchange power of attorney is limited to the purposes described in this Subscriber's agreement.
3. The undersigned agrees that as compensation to the Company for the Company (a) becoming and serving as Attorney-in-fact for the Subscribers to the Exchange, (b) managing the business and affairs of the Exchange as provided herein and (c) paying the general administrative expenses of serving as Attorney-in-fact for the Exchange, including sales commissions, salaries and employee benefits, rent, supplies and data processing, the Company shall retain up to 20% of the Exchange's gross direct written premium, less return premium. The remainder of all premiums written or assumed by the Exchange shall be used for losses, loss adjustment expenses, investment expenses, damage legal expenses, court costs, taxes, assessments, license fees, any other government fees and for other purposes the Company decides are to the advantage or the Subscriber's to exchange.
4. The undersigned agrees to contribute to the Exchange as capital an amount equal or up to 20% of the gross direct written premium, less return premium, charges to the undersigned for the first year, and up to 30% for each year thereafter.
5. The undersigned agrees that this Subscriber's Agreement, including the power of attorney set forth herein, shall apply to all insurance policies for which undersigned's coverages.
6. The undersigned agrees to sign and deliver to the company all papers required to carry out the Subscriber's Agreement.
7. The Subscriber's Agreement including the power of attorney set forth herein, shall not be affected by the undersigned subsequent disability or incapacity.
8. This Subscriber's Agreement and the Declaration of Organization of the Exchange are and shall be binding upon the Company and the undersigned and all of their respective executors, administrators, personal representatives, successors and assigns.

IN WITNESS WHEREOF, the undersigned subscriber hereto sets his hand and seal:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name