

SERFF Tracking Number: MEIC-125877924 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-110508-IF FORM
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Form Filing/AR-110508-IF Form

Filing at a Glance

Company: Medicus Insurance Company
Product Name: Medical Professional Liability Insurance SERFF Tr Num: MEIC-125877924 State: Arkansas
TOI: 11.1 Medical Malpractice - Claims Made Only SERFF Status: Closed State Tr Num: #? \$?
Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations Co Tr Num: AR-110508-IF FORM State Status: Fees not received
Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Edith Roberts
Author: Paula Battistelli Disposition Date: 11/13/2008
Date Submitted: 11/05/2008 Disposition Status: Approved
Effective Date Requested (New): On Approval Effective Date (New):
Effective Date Requested (Renewal): On Approval Effective Date (Renewal):
State Filing Description:

General Information

Project Name: Initial Form Filing Status of Filing in Domicile: Not Filed
Project Number: AR-110508-IF Form Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 11/13/2008 Deemer Date:
State Status Changed: 11/05/2008
Corresponding Filing Tracking Number:
Filing Description:
Please see the property transmittal document under the supporting documentation tab.

Company and Contact

Filing Contact Information

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Paula Battistelli, Regulatory Compliance pbattistelli@medicusins.com
Coordinator
8500 Shoal Creek Blvd, Ste 3, Bldg 200 (512) 879-5128 [Phone]
Austin, TX 78757 (877) 686-0558[FAX]

Filing Company Information

Medicus Insurance Company CoCode: 12754 State of Domicile: Texas
8500 Shoal Creek Blvd, Bldg 3, Ste 200 Group Code: 11 Company Type:
Austin, TX 78757 Group Name: Property and State ID Number:
Casualty
(866) 815-2023 ext. [Phone] FEIN Number: 20-5623491

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Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	11/13/2008	11/13/2008

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Disposition

Disposition Date: 11/13/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Self Certification	Approved	Yes
Form	Dec Page	Approved	Yes
Form	Application	Approved	Yes
Form	Policy	Approved	Yes
Form	Additional Professional Office Locations	Approved	Yes
Form	Amend Professional Office Location	Approved	Yes
Form	Amend Policy Date	Approved	Yes
Form	Amend Limits of Liability	Approved	Yes
Form	Amend Insured Name on Declarations Page	Approved	Yes
Form	Additional Insured	Approved	Yes
Form	Non-Physician Healthcare Providers (Shared Limits of Liability)	Approved	Yes
Form	Change of Rate	Approved	Yes
Form	Change of Specialty	Approved	Yes
Form	Locum Tenens	Approved	Yes
Form	Deletion of Locum Tenens	Approved	Yes
Form	Exclusion of Outside Practice	Approved	Yes
Form	Exclusion of Procedure	Approved	Yes
Form	Medical Director Coverage-Limited	Approved	Yes
Form	Limited Coverage to Specific Employment	Approved	Yes
Form	Suspension of Insurance	Approved	Yes
Form	Deletion of Suspension of Insurance	Approved	Yes
Form	Deductible Endorsement	Approved	Yes
Form	Cancellation Endorsement	Approved	Yes
Form	Inclusion of Procedures	Approved	Yes
Form	Former Insured Coverage	Approved	Yes
Form	Slot Coverage	Approved	Yes
Form	Cancel Additional Insured Slot Position	Approved	Yes
Form	Extended Reporting Endorsement	Approved	Yes

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Form	Insured Entity Shared Limit	Approved	Yes
Form	Insured Entity Separate Limit	Approved	Yes
Form	Schedule of Physicians	Approved	Yes
Form	Non-Physician Healthcare Providers	Approved	Yes
	Endorsement (Separate Limits of Liability)		
Form	Lower Limits of Liability for Prior Acts	Approved	Yes
Form	Change of Sole Agent	Approved	Yes
Form	Exclusion of Services to Obstetrical Patients	Approved	Yes
Form	Liability Exclusion-Public Health Officer	Approved	Yes
Form	Amend Limits of Liability	Approved	Yes
Form	Excluded Persons or Entities	Approved	Yes
Form	Coverage for Charitable Services	Approved	Yes
Form	Nuclear Energy Liability Exclusion	Approved	Yes
Form	Amend Reporting of Medical Incident	Approved	Yes
Form	Amend Retroactive Date	Approved	Yes
Form	Delete Insured	Approved	Yes
Form	Amend Policy Territory Limitation of Coverage	Approved	Yes
Form	Cancel Policy	Approved	Yes
Form	Vicarious Liability Coverage for Entity	Approved	Yes
Form	Definition of Limits of Liability	Approved	Yes
	Endorsement		
Form	State Amendatory Endorsement	Approved	Yes
Form	Certificate of Insurance	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Dec Page	002	11/02/07	Declaration News/Schedule		0.00	Dec Page.pdf
Approved	Application	MD-App	09/08	Application/ New Binder/Enrollment		0.00	MD-APP.pdf
Approved	Policy	001	01/25/08	Policy/Coverage Form		0.00	OH Policy.pdf
Approved	Additional Professional Office Locations	A001	10/22/07	Endorsement/Amendment/Conditions		0.00	A001.pdf
Approved	Amend Professional Office Location	A002	10/22/07	Endorsement/Amendment/Conditions		0.00	A002.pdf
Approved	Amend Policy Date	A003	10/22/07	Endorsement/Amendment/Conditions		0.00	A003.pdf
Approved	Amend Limits of Liability	A004	10/22/07	Endorsement/Amendment/Conditions		0.00	A004.pdf
Approved	Amend Insured Name on Declarations Page	A005	10/22/07	Endorsement/Amendment/Conditions		0.00	A005.pdf
Approved	Additional Insured	A006	10/22/07	Endorsement/Amendment/Conditions		0.00	A006.pdf
Approved	Non-Physician Healthcare	A007	10/22/07	Endorsement/Amendment		0.00	A007.pdf

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Providers (Shared Limits of Liability)	ent/Condi ons						
Approved	Change of Rate	A008	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A008.pdf	
Approved	Change of Specialty	A009	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A009.pdf	
Approved	Locum Tenens	A010	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A010.pdf	
Approved	Deletion of Locum Tenens	A011	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A011.pdf	
Approved	Exclusion of Outside Practice	A012	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A012.pdf	
Approved	Exclusion of Procedure	A013	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A013.pdf	
Approved	Medical Director Coverage-Limited	A014	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A014.pdf	
Approved	Limited Coverage to Specific Employment	A015	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A015.pdf	
Approved	Suspension of Insurance	A016	10/22/07	Endorseme New nt/Amendm ent/Condi	0.00	A016.pdf	

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Approval	Description	Code	Date	Action	Amount	File
Approved	Deletion of Suspension of Insurance	A017	10/22/07	Endorsement/Amendment/Conditions	0.00	A017.pdf
Approved	Deductible Endorsement	A018	10/22/07	Endorsement/Amendment/Conditions	0.00	A018.pdf
Approved	Cancellation Endorsement	A019	10/22/07	Endorsement/Amendment/Conditions	0.00	A019.pdf
Approved	Inclusion of Procedures	A020	10/22/07	Endorsement/Amendment/Conditions	0.00	A020.pdf
Approved	Former Insured Coverage	A021	10/22/07	Endorsement/Amendment/Conditions	0.00	A021.pdf
Approved	Slot Coverage	A023	10/22/07	Endorsement/Amendment/Conditions	0.00	A023.pdf
Approved	Cancel Additional Insured Slot Position	A024	10/22/07	Endorsement/Amendment/Conditions	0.00	A024.pdf
Approved	Extended Reporting Endorsement	A025	05/2007	Endorsement/Amendment/Conditions	0.00	A025.pdf
Approved	Insured Entity Shared Limit	A026	10/22/07	Endorsement/Amendment/Conditions	0.00	A026.pdf
Approved	Insured Entity	A027	10/22/07	Endorsement/Amendment/Conditions	0.00	A027.pdf

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	Separate Limit			nt/Amendm ent/Condi ons		
Approved	Schedule of Physicians	A028	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A028.pdf
Approved	Non-Physician Healthcare Providers Endorsement (Separate Limits of Liability)	A029	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A029.pdf
Approved	Lower Limits of Liability for Prior Acts	A030	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A030.pdf
Approved	Change of Sole Agent	A031	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A031.pdf
Approved	Exclusion of Services to Obstetrical Patients	A032	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A032.pdf
Approved	Liability Exclusion-Public Health Officer	A033	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A033.pdf
Approved	Amend Limits of Liability	A034	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A034.pdf
Approved	Excluded Persons or Entities	A035	10/22/07	Endorseme New nt/Amendm ent/Condi ons	0.00	A035.pdf
Approved	Coverage for	A036	10/22/07	Endorseme New	0.00	A036.pdf

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	Charitable Services			nt/Amendm ent/Condi tions		
Approved	Nuclear Energy Liability Exclusion	A041	10/24/07	Endorseme nt/Amendm ent/Condi tions	0.00	A041.pdf
Approved	Amend Reporting of Medical Incident	A042	2006	Endorseme nt/Amendm ent/Condi tions	0.00	A042.pdf
Approved	Amend Retroactive Date	A043	2006	Endorseme nt/Amendm ent/Condi tions	0.00	A043.pdf
Approved	Delete Insured	A044	2006	Endorseme nt/Amendm ent/Condi tions	0.00	A044.pdf
Approved	Amend Policy Territory Limitation of Coverage	A045	2006	Endorseme nt/Amendm ent/Condi tions	0.00	A045.pdf
Approved	Cancel Policy	A046	03/01/08	Endorseme nt/Amendm ent/Condi tions	0.00	A046.pdf
Approved	Vicarious Liability Coverage for Entity	A049	06/06/07	Endorseme nt/Amendm ent/Condi tions	0.00	A049.pdf
Approved	Definition of Limits of Liability Endorsement	A058	05/20/08	Endorseme nt/Amendm ent/Condi tions	0.00	A058.pdf
Approved	State Amendatory Endorsement	A060		Endorseme nt/Amendm ent/Condi tions	0.00	AR A060.pdf

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ons

Approved Certificate of Insurance 10/08 Certificate New

CERTIFICATE OF INS-5.pdf



Medicus Insurance Company

Declarations Page

Claims Made

PHYSICIANS AND SURGEONS LIABILITY INSURANCE POLICY

This form provides claims made coverage. Please read the entire policy carefully.

Policy Number:

Policy Period:

Effective Date: at 12:01 am

Expiration Date: at 12:01 am

Standard time at the Insured's address above

Name and Professional Office Location:

Insured Named on Policy:

Name	Specialty	Retroactive Date	Limits
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(except as provided by the endorsement)

Medical Corporation, Partnership, Association, Limited Liability Partnership or Entity:

Per Claim Limit of Liability:

Annual Aggregate Limit of Liability:

Medical Board Defense:

Per Claim Limit of Liability: \$25,000

Annual Aggregate Limit of Liability: \$25,000



Medicus Insurance Company
Declarations Page Cont'd
Claims Made

PHYSICIANS AND SURGEONS LIABILITY INSURANCE POLICY

Deductible: **Applicable to all claims under all coverage:**

Per Claim Limit of Liability:
Annual Aggregate Limit of Liability:
Total Policy Aggregate:

Premium: \$

Coverage under your **policy** is subject to the terms and conditions of the **policy** of the following **endorsements**:

Authorized Representative

Producer/Agent:

Issue Date:



Agency/Broker: _____

Address: _____

Application for Coverage – Physicians/Surgeons

I. Personal Information

Full Name

_____ MD DO
First Middle Last

Date of Birth: _____ Social Security Number: _____

II. Address

Office Address

Street City County State Zip Code

Office Phone: _____ Office Fax: _____ Office E-mail: _____

Website(s): _____

Home Address

Street City County State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Which is best way to contact you? Home Office Cell Phone

III. Corporation Information

Name of Corporation (if applicable) FEIN Number

Type of Corporation: Individual/Solo Corporation Partner/Shareholder/Employee

Is there any other name under which you practice (i.e. DBA)? _____

Is your corporation requesting coverage? Y N If yes, Shared or Separate Limits _____

Do you or your corporation have a website(s): _____

IV. Limits of Liability

Texas Only: \$200,000/\$600,000 \$500,000/\$1,000,000 \$1,000,000/\$3,000,000

Kansas Only: \$200,000/\$600,000

Indiana/Nebraska: \$250,000/\$750,000 \$1,000,000/\$3,000,000

Remainder of States: \$1,000,000/\$3,000,000

Requested **Effective Date**: _____ Requested **Retroactive Date**: _____

Are you purchasing tail coverage from your current carrier? Y N If yes, please provide Medicus with a copy.

V. Medical Licensure

State: _____
License #: _____
Expiration Date: _____

State: _____
License #: _____
Expiration Date: _____

DEA License Number: _____

Have you ever had your license revoked, limited, refused, suspended or denied? Y N
If yes, give details _____

VI. Certification

Are you American Board Certified? Y N Eligible – until when? _____

Name of Specialty Board(s): _____ Year _____ Recertified _____

Have you ever failed to pass a Board Examination? Y N
If yes, give details: _____

Are you certified in ACLS ATLS PALS Other _____

Have you ever been denied certification? Y N
If yes, give details: _____

VII. Education/Training

Please complete section or attach copy of most current CV.

Medical School

Medical School: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Degree: _____

Are you a Foreign Medical School Graduate? Yes No If yes, please provide a copy of your USMLE.

Internship

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Residency

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

VII. Education/Training (cont'd)

Fellowship

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Specialty: _____

Please explain any gap in training. _____

Are you entering private practice for the first time following your residency, training, military services or an academic position?
 Yes No

VIII. Current Practice and Practice History

Current Practice

Primary Specialty: _____ Percentage of Practice: _____

Secondary Specialty: _____ Percentage of Practice: _____

Average number of hours worked per week? _____

Average number of patients seen per week? _____

Percentage of practice outside of an office location; please provide details: _____

Have there been significant changes in your practice in the past five-years (i.e. changes in specialty, addition or deletion of procedures)? Y N If yes, please explain: _____

Practice Locations—Please provide ten (10) years of practice history from most recent, attach additional page if necessary:

Current Practice Locations:

Location 1: _____ From: _____ To: _____

Location 2: _____ From: _____ To: _____

Location 3: _____ From: _____ To: _____

Location 4: _____ From: _____ To: _____

Location 5: _____ From: _____ To: _____

Historic Practice Locations:

Location 1: _____ From: _____ To: _____

Location 2: _____ From: _____ To: _____

Location 3: _____ From: _____ To: _____

Location 4: _____ From: _____ To: _____

Location 5: _____ From: _____ To: _____

VIII. Current Practice and Practice History (cont'd)

Do you practice at a prison, correctional facility or on inmates? Y N

If yes, what is the total percentage of your practice and where are you practicing? _____

Do you see patients in a Nursing Home? Y N

If yes, what is the total percentage of your practice and where are the Nursing Homes located? _____

Do you practice as a Hospitalist? Y N

If yes, what is the percentage, and at what hospitals are you practicing as a hospitalist? _____

Do you have another practice for which you carry separate coverage or coverage is provided for you? Y N

If yes, please attach a copy of a declarations page or certificate of insurance.

Did you practice with other physicians in an employer-employee relationship, implied or formal partnership, professional association or Medical Corporation during the period for which you are requesting prior acts coverage? Y N

If yes, please list the full name of the entity(ies)/physician(s) with whom you practiced and the period of each such association.

Name of Entity	Name of Physician	Dates: From - To
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IX. Medical Staff

Do you employ/contract/supervise any of the following personnel? Indicate the number of the following non-physician healthcare providers utilized by you or your group? Employ Contract Supervise N/A

	CRNA		CNM		Laboratory Technician	
Other Physicians	Nurse Practitioner		Occupational Therapist		Optician	
Interns	Optometrist		Orthodontist		Pharmacist	
Residents	Physical Therapist		Physician's Assistant		Podiatrist	
Fellows	Psychologist		Respiratory Therapist		Speech Therapist	
	Social Worker		Audiologist/Udiologist		X-Ray Technician	
Other (please explain)						

Are you requesting the above to be covered by Medicus Insurance Company? Y N

If yes, should the ancillary be covered on a shared or separate limit of liability? _____

Are any of the above ancillary staff independent contractors? Y N

If yes, please provide declarations page or certificate of insurance.

Do any of the ancillary staff have his/her own coverage? Y N

If yes, please provide declarations page or certificate of insurance.

X. Additional Professional Information

Please provide a complete explanation for each question answered "Yes".

- A. Has membership of any Professional Association or Society ever been refused, revoked or limited in any way? Y N
- B. Have you ever had a complaint filed, been censured or had a private reprimand with a County or State Medical Society? Y N
- C. Have you ever been treated for alcoholism, narcotic addiction or mental impairment? Y N
If yes, please provide details of rehabilitation program including dates of treatment.
- D. Have you ever been indicted, charged or convicted of a felony other than a minor traffic violation? Y N
- E. Do you work as an emergency room physician, other than for maintaining hospital privileges? Y N
If yes, do you have separate coverage for this exposure? Y N
- F. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician at any of the following?

<input type="checkbox"/> Hospital	<input type="checkbox"/> Sanitarium	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Surgi-Center
<input type="checkbox"/> Clinic	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Blood Bank	<input type="checkbox"/> Prepaid Health Plan
<input type="checkbox"/> HMO	<input type="checkbox"/> Other Medical Facility		

If you checked any of the above, please list the names of the facility and your affiliation with them.

<u>Name</u>	<u>Affiliation</u>	<u>Who Provides Coverage for this</u>	<u>Limits</u>
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Do you practice medicine at the above institutions? Y N

If yes, are you looking for coverage for this exposure? Y N

G. Do you ever enter into arbitration or similar agreements with your patients? Y N If yes, please attach a copy of the agreement(s).

EXPLANATION OF QUESTION(S) ANSWERED 'YES'

XI. Hospital Privileges Currently Held

<u>Hospital Name</u>	<u>Location</u>	<u>Privileges</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Have your hospital privileges ever been surrendered, limited or revoked, whether voluntarily or involuntarily? Y N

If yes, please give details

Have your hospital privileges been expanded in the last 12 months to include procedures for which you completed additional training required by the State Licensing Board and/or you Specialty Board? Y N

If yes, please explain.

XII. Medical Procedures

Please check the appropriate box, indicating the extent of surgery you perform:

- No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing or minor lacerations
- Minor Surgery includes most procedures performed under local anesthesia
- Assisting in Major Surgery on your own patients # Annually _____
- Assisting in Major Surgery on patients other than your own # Annually _____
- Major Surgery includes all procedures done under general, spinal or caudal anesthesia, and specifically includes tonsillectomy, appendectomy, D&C cesarean section, abortion and open reduction of fractures

Please check the procedures, which you perform for which you are requesting coverage. Please check any procedure you have performed in the last three years.

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Abortion (indicate trimesters)
<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Acupuncture or Acupressure <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Anesthesia - General <input type="checkbox"/> Angiography, Angioplasty, Arteriography <input type="checkbox"/> Appendectomy <input type="checkbox"/> Banding Hemorrhoids <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Cardiac Catheterization
<input type="checkbox"/> Left Heart <input type="checkbox"/> Right Heart <input type="checkbox"/> Cesarean Section _____ # per year <input type="checkbox"/> Chelation Therapy <input type="checkbox"/> Chemabrasion/Dermabrasion <input type="checkbox"/> Cosmetic Plastic Surgery or Procedures (elective) Please list

_____ <input type="checkbox"/> Cryosurgery <input type="checkbox"/> D&C <input type="checkbox"/> Endoscopic Procedures - Please list

_____ <input type="checkbox"/> ERCP <input type="checkbox"/> Experimental Surgery – Please list

_____ <input type="checkbox"/> Other _____
_____ | <ul style="list-style-type: none"> <input type="checkbox"/> Fertility/Infertility Treatment <input type="checkbox"/> Gastric By-Pass/Stapling or Bariatrics <input type="checkbox"/> Hair Growing or Transplants <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernias <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Injection or Implants in Breasts <input type="checkbox"/> Insertion of Intrauterine Contraceptive Devices <input type="checkbox"/> LAP BAND Procedures _____ # per year <input type="checkbox"/> Laparoscopy – Please list

_____ <input type="checkbox"/> Laser used in Therapy or Surgery
Type of Laser used _____
Please list type of therapy or surgery _____

_____ <input type="checkbox"/> Liposuction, SAL <input type="checkbox"/> Needle Biopsy - <input type="checkbox"/> Breast <input type="checkbox"/> Kidney <input type="checkbox"/> Lung
<input type="checkbox"/> Prostate <input type="checkbox"/> Other <input type="checkbox"/> Obstetrical Deliveries at other than a licensed Acute Care Hospital _____
_____ <input type="checkbox"/> Pre-Natal Care (indicate trimesters)
<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Pain Management (other than oral analgesics)

_____ <input type="checkbox"/> Other _____
_____ | <ul style="list-style-type: none"> <input type="checkbox"/> Radial Keratotomy, LASIK or PRK <input type="checkbox"/> Radiation Therapy, -X-Ray <input type="checkbox"/> Reconstructive Plastic Surgery <input type="checkbox"/> Shock Therapy (ECT) <input type="checkbox"/> Spinal Anesthesia <input type="checkbox"/> Swan Ganz <input type="checkbox"/> Telemedicine – Please list Specialty and where

_____ <input type="checkbox"/> Thoracic Surgery <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vascular Surgery <input type="checkbox"/> VBACS _____ # per year <input type="checkbox"/> Weight Control Medicine – Please list

_____ <input type="checkbox"/> Weight Control Surgery – Please list

_____ <input type="checkbox"/> Administering or Injecting Silicone Fluid <input type="checkbox"/> Use of Laetrile Therapy <input type="checkbox"/> Use or Administration of Human Chronic Gonadotropin (HGG) in the treatment of Obesity or Weight Control <input type="checkbox"/> Use of Blood or Blood By-Products that have not been tested for HIV <input type="checkbox"/> Sex Change Operations <input type="checkbox"/> Other _____
_____ |
|---|--|---|

XIII. Previous Insurance – Please provide ten (10) years of previous insurance information

Current Carrier	Effective Date _____ Expiration Date _____ Retroactive Date _____	Limit of Liability _____ Type of Coverage _____ Premium _____
Prior Carrier	Effective Date _____ Expiration Date _____ Retroactive Date _____	Limit of Liability _____ Type of Coverage _____ Premium _____
Prior Carrier	Effective Date _____ Expiration Date _____ Retroactive Date _____	Limit of Liability _____ Type of Coverage _____ Premium _____
Prior Carrier	Effective Date _____ Expiration Date _____ Retroactive Date _____	Limit of Liability _____ Type of Coverage _____ Premium _____

XIV. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? Y N

If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims: _____ Open/Reserved: _____ Closed: _____

Any change in your practice as a result of claims? _____

Warranty

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by Medicus Insurance Company (Company) as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

Acknowledged and Agreed:

Applicant Signature

Date

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

Fraud Warnings:

General Fraud Statement (not applicable in Colorado, Hawaii, Nebraska, Ohio, Oklahoma, Oregon, Utah and Vermont)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia insurance benefits may also be denied.

Notice to Colorado Applicants: This Notice is A Part of Your Application for Professional Liability Insurance: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any 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 for the purpose of defrauding or attempting to defraud the policy holder 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 Regulatory Agencies.

Notice to Hawaii Applicants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Utah Applicants: For your protection, Utah law requires the following to be included in this application: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.”

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature

Date

Printed Name

Title

This application is not valid without your complete signature, date, printed name, and title above.

Medicus Insurance Company SUPPLEMENT TO APPLICATION CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ Male Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

Suit Demand for Money Incident Only
 Notice of Intent to Sue Request for Records Other _____

3. Summary of condition/diagnosis at time of incident

4. Description of treatment rendered, including dates.

5. Allegation

6. Other physicians or entities involved

7. Status/Disposition of Claim:

- Closed without indemnity payment
 Settled
 Judgment/Verdict
 For the defense
 For the plaintiff

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

Open—please provide current status and defense strategy: _____

8. Has there been a change in practice as a result of this claim(s)? Yes No

If yes, what has been the change? _____

I understand this information is part of my Application for Physician/Surgeon Medical Professional Liability Insurance.

Please print your name _____

Signature _____ Date _____

MEDICUS INSURANCE COMPANY™

A STOCK INSURANCE COMPANY

**HOME OFFICE:
8500 SHOAL CREEK BOULEVARD
BUILDING 3, SUITE 200
AUSTIN, TEXAS 78757**

Physicians and Surgeons

Liability Insurance Policy

NOTICE:

This is a **claims made policy**. The **coverage** of this **policy** is limited to liability for only those **claims** that are first made against the **Insured** and reported to the Company while the **policy** is in force. This **policy** is not assessable, nor subject to a surplus contribution.

Please review the policy carefully and discuss the coverage with your insurance agent, broker or Medicus representative.

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INSURING AGREEMENT

Medicus Insurance Company, hereinafter called the Company, agrees with the **insured** as stated on the **Declarations Page** in consideration of the payment of the **premium** and in reliance upon the statements made in the application and the **Declarations Page**, and subject to all of the terms of the **policy** as follows:

The **coverage** provided in this **policy** is written on a **claims-made** basis. **Coverage** is limited to liability for those **claims** that are a result of **medical incidents** occurring subsequent to the **retroactive date** stated on the **Declarations Page** and defined in the **policy**. **Claims** must be first made against the **insured** and reported in writing to the Company during the **policy period**. The **claims-made** date for any **claim** shall be the date that the matter is received in writing by the Company. The Company will defend and indemnify according to the terms and conditions of the **policy** and according to the **Policy Limits** stated on the **Declarations Page**, all sums for which the **insured** becomes legally obligated to pay as **damages** because of **medical incidents**. The **medical incidents** must be covered under this **policy**, have occurred subsequent to the **retroactive date**, be reported in writing to the Company during the **policy period**, and have occurred within the territory covered by this **policy** as defined.

Failure to comply with any conditions of this contract may give the Company the right to deny coverage, cancel or rescind the policy.

In consideration of the payment of **premium** and the statements contained on the **Declarations Page**, and made a part hereof, and subject to the **limits of liability**, Exclusions, Conditions, **Endorsements** or Amendments, the Company agrees with the **insured** to the following terms and conditions:

By acceptance of this **policy** the **insured** represents that the statements on the **Declarations Page** are true and correct and acknowledges that this **policy** is issued by the Company in reliance upon the truth. Such representations as appear upon the application and any attachments, affirms that this **policy** embodies all agreements existing between the **insured** and the Company relating to this **policy**.

The Company will have the right and duty to defend any **claim** or any **suit** covered under this **policy** against the **insured** even if the allegations are groundless, false or fraudulent. The Company will not be obligated to pay any **claim** or judgment, or defend any **suit** after the applicable **limits of liability** have been exhausted by indemnification.

The Company will require the written consent of the **insured** to make or conclude any offer of settlement or offer of judgment. Such consent will not be unreasonably withheld by the **insured**. The Company is not required to pursue appeal of any judgment or **suit**. The Company will have the right but not the obligation to appeal.

The Company will not provide defense or **indemnity** for any **medical incident, claim** or potentially compensable event that has been reported to or should have been reported to any previous insurance companies. This includes **medical incidents** the **insured** should have reasonably foreseen or should have known may result in a **claim**.

The Company will notify the **insured** as required by law prior to the **effective date** of cancellation of the **policy**. In the event of a determination by the Company not to renew the **policy**, notification to the **insured** will be provided as required by law prior to the end of the **policy period**.

The Company will pay on behalf of the **insured** all sums up to the applicable **policy** limit for which the **insured** becomes legally obligated to pay as **damages** covered under this **policy**. The Company will also pay all reasonable **claim expenses** and/or **defense costs** incurred in addition to the **policy limits of liability** as stated on the **Declarations Page**, subject to the **retroactive date**, under the following **coverage**:

COVERAGE A: INDIVIDUAL PROFESSIONAL LIABILITY

The Company will pay, on behalf of the **insured**, either individually or as a Solo Professional Association, all sums for **claims** for which the **insured** becomes legally obligated to pay as **damages** because of **medical incidents** rendered, or which should have been rendered, by the **insured** or anyone for whose **professional services**, acts or omissions the **insured** is legally responsible under **Coverage D**. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**. (See Conditions, **Coverage A**)

COVERAGE B: MEDICAL CORPORATION, PARTNERSHIP, ASSOCIATION, LIMITED LIABILITY PARTNERSHIP OR ENTITY

The Company will pay all sums for **claims** for which the **insured** as an Entity, Professional Corporation, Association, Partnership, or Limited Liability Partnership becomes legally obligated to pay as **damages** because of **medical incidents** arising from **professional services** rendered or which should have been rendered by its employees or **additional insureds**. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**. The Company will not provide **coverage** for **claims** of professional negligence of the individual physician shareholders, associates or partners unless named on the **Declarations Page** of the **policy** or by **endorsement**. **Additional Insureds** and Employees of the Corporation are covered on a shared limits basis, provided an additional **premium** is paid. **Limits of liability** are shared with all other **insureds** under the **policy**, regardless of the number of persons covered, and are not on an individual basis. In no event will any healthcare provider be covered unless scheduled by **endorsement** on the **policy**. (See Conditions, **Coverage B**)

COVERAGE C: INDIVIDUAL PROFESSIONAL LIABILITY FOR EMPLOYED PHYSICIANS AND SURGEONS:

The Company will pay all sums for **claims** for which the employed physician or surgeon becomes legally obligated to pay as **damages** because of **medical incidents**. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**. The Company will provide **coverage** for **claims** of professional negligence of the employed physician or surgeon only after application has been made and approved by the Company and additional **premium** has been paid. **Coverage** is provided for each **insured** physician and surgeon under **Coverage C** once added to the **insured's policy** by **endorsement**. The **endorsement** states each **insured's** name, specialty, **retroactive date**, and an individual per **claim** and aggregate limit of liability. These **limits of liability** are shared with all **insured** entities under **Coverage B** and all **insured** non-physician employees under **Coverage D** regardless of the number of persons covered. (See Conditions, **Coverage C**)

COVERAGE D: EMPLOYEES AS INSUREDS OR AS PROTECTED PERSONS

The Company will pay all sums for **claims** for which the **insured** becomes legally obligated to pay as **damages** resulting from **professional services** rendered by employees of the **insured**. **Professional services** must have been rendered while in the course and scope of employment and under the supervision of the **insured**. These acts or omissions must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**. **Limits of liability** are shared with all other **insureds** under the **policy**, and not on an individual basis. In no event will **Coverage D** apply to physicians or surgeons employed by the **insured**. (See Conditions, **Coverage D**)

COVERAGE E: MEDICAL BOARD DEFENSE

The company will defend but not indemnify the **insured** solely for disciplinary actions arising out of proceedings instituted by the Medical Board of the state in which **coverage** has been approved under this **policy**. These acts or omissions must arise because of a **claim** involving **professional services**, have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**.

The **coverage** is subject to all the terms and conditions of this **policy**. The **limit of liability** for defense is stated on the **Declarations Page**.

SUPPLEMENTAL PAYMENTS

The Company will pay, in addition to the **limits of liability**:

- A. All expenses incurred by the Company, and all costs taxed against the **insured** in any **claim** or **suit** defended by the Company and for which **coverage** is provided under this **policy**. The Company will pay interest on a judgment up to the applicable **policy** limit which accrues after the entry of the judgment and before the Company has paid, tendered or deposited in court that part of the judgment which does not exceed the limit of the Company's liability thereon.
- B. The Company will not pay assessments, penalties or fines levied because of contempt of Court, failure to comply with Court Orders, or any act of the **insured** resulting in or giving rise to such penalties, cost assessments or fines.
- C. The Company will reimburse the **insured** for reasonable expenses, incurred while participating at the Company's request in the Company's defense of a **claim**, at trial or arbitration. These expenses shall not exceed the Company's allowance rates in effect at the time of trial or arbitration.

DEFINITIONS

ADDITIONAL INSURED: Means a physician, surgeon or non-physician healthcare provider added to the **insured's policy** by **endorsement**.

BODILY INJURY: Means physical injury, sickness, disease, disability, or death to an individual, other than the **insured**, the employees of the **insured**, or any other persons covered by this **policy**.

CLAIM EXPENSES or DEFENSE COSTS: Means all reasonable and necessary costs incurred in the investigation, defense, negotiation and settlement of any **claim** or **suit**. They include, but are not limited to, attorney fees, witness fees, expert fees, court costs, expenses of investigation, expenses for medical examinations or investigative reports, expenses of telephone charges, clerical and offices expenses. **Claims** expenses are in addition to **limits of liability**.

CLAIM: Means notice to the Company, in writing, by an **insured**, of a **medical incident**, demand received for money or **damages** including the service of **suit**, letter of intent to sue, or arbitration or screening panel proceeding against any **insured** arising out of a **medical incident** and reported during the **policy period**. A **claim** shall be deemed first made when received in writing by the Company.

COVERAGE: Means the scope of the insuring agreements provided under a contract of insurance.

DAMAGES: Means only those actual or compensatory **damages** resulting from **bodily injury**, sickness, disability or death. **Damages** do not include punitive, exemplary, statutory, **damages** or other fines.

DECLARATIONS PAGE: Means that portion of the contract stating information such as the **insured's** name, address and specialty, the **policy period**, the **limits of liability**, other supplemental representations by the **insured** and various **coverage** terms.

EFFECTIVE DATE: Means the date on which the **policy** becomes effective and from which date and time **coverage** is in force.

ENDORSEMENT: Means a form attached to the **policy** bearing language necessary to change or clarify the **policy** to fit special circumstances. In some instances, additional **premium** is required.

EXPIRATION DATE: Means the date upon which the **policy** will cease to provide **coverage** or protection, unless previously canceled.

INDEMNITY: Means loss costs reflecting payments to claimants and their attorneys for **damages** as a result of a **claim** or **claims**.

INSURED: Means any person, firm, corporation, professional association or organization specifically designated and listed on the **Declarations Page** or subsequent **endorsement**. **Insured** may also mean any **additional insured**, Employed Physician and Surgeon, Employed **Non Physician Healthcare Provider**, or Employed **protected person**. (See Conditions)

LIMITS OF LIABILITY: Means the maximum amount of **indemnity** payments the Company agrees to pay per **claim** and for all **claims** under the **policy**. In the case of **Coverage E**, it is the maximum amount of **defense costs** the Company agrees to pay for Medical Board Defense. **Coverage E limits of liability** are in addition to the limits defined below:

1. Per **Claim**: The **limit of liability** stated “per **claim**”, as appears on the **Declarations Page** or by **endorsement**, is the limit of the Company’s liability for all **bodily injury** or **damage** arising out of, or in connection with, the same or related **medical incident** or **claim**.
2. Aggregate: Subject to the Per **Claim limit of liability**, the total limit of the Company’s liability for all **bodily injury** or **damages** under this **policy** shall not exceed the **limit of liability** stated as “aggregate” as appears on the **Declarations Page** or by **endorsement**.

MEDICAL INCIDENT: Means an event due to **professional services**, acts or omissions arising out of treatment to a **patient** which could or did result in **bodily injury**, sickness, disease, disability or death to any person for which **damages** may reasonably be expected or should have known to be sought against the **insured**. Written notice to the Company is required.

NON PHYSICIAN HEALTHCARE PROVIDERS: Means employees including but not limited to: advanced registered nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, physician assistants, opticians, social workers, optometrists, physical therapists, X-ray and lab technicians, psychologists, surgical assistants, radiology technicians and OR technicians, while acting within the scope of their duties to the **insured**, for whom **premium** has been paid.

PATIENT: Means a person to whom any **insured** has become obligated by law as a healthcare provider. A woman **patient** and her unborn fetus or fetuses shall be deemed to be only one **patient**.

PEER REVIEW ACTIVITIES: Means activities of any **insured** as a member of or as a participant in a formal accreditation, peer review, or similar professional board or committee of the **insured**, or as a person charged with the duty of executing directives of any such board or committee.

POLICY: Means the written contract including the application, **Declarations Page**, all **endorsements**, amendments or papers attached and made a part thereof.

POLICY PERIOD: Means the period of time specified on the **Declarations Page**, beginning on the **effective date** and ending on the **expiration date**. All dates shown start and end at 12:01 a.m. Standard Time according to the **insured's** address as stated on the **Declarations Page**.

PREMIUM: Means monetary consideration paid for the contract of insurance.

PROFESSIONAL SERVICES: Means 1) the rendering of or failure to render diagnosis, medical or surgical treatment or opinion necessary to the practice of the **insured's** specialty as stated on the **Declarations Page** or by **endorsement**; or 2) any **Peer Review Activities** on behalf of the **insured** listed on the **Declarations Page**. However, such **professional services** shall not be deemed to include any act or omission which the **insured** knows, or reasonably should have known, may result in **damages** or a **claim** or **suit**.

PROTECTED PERSON: Means employees including, but not limited to, clerical employees, medical technicians, licensed nurses, registered nurses and volunteers of the **insured**, while acting within the scope of their duties to the **insured**. No **premium** is required.

RETROACTIVE DATE: Means the date stated on the **Declarations Page**. This is the first day on which **coverage** will be afforded by the Company for **claims** first made.

SUIT: Means written notice to the Company of legal action, and includes arbitration proceedings, to which the **insured** is required to submit or has submitted at the Company's request. **Suit** does not mean an administration hearing of any kind whatsoever.

CONDITIONS

Each of the following is an **insured** under this **policy** to the extent set forth below:

1. Under **Coverage A**: Individual Professional Liability for the **insured** physician or surgeon named on the **Declarations Page**, or by **endorsement**. The **endorsement** shall state each **insured's** name, specialty, **retroactive date** and an individual per **claim** and aggregate **limit of liability**. These limits are shared with all **insured** entities under **Coverage B** and all **insured non-physician healthcare providers** under **Coverage D**, regardless of the number of persons covered. Also, under **Coverage A**, professional liability for the individual **insured** as a Solo Professional Association, corporation or entity at shared **limits of liability**.
2. Under **Coverage B**: Medical Corporation Liability, the Entity, Corporation, Partnership, Association or Limited Liability Partnership, as described on the **Declarations Page**, for which a **premium** has been paid. The Company will not provide liability for the professional negligence of the individual physician shareholders, associates, or partners. **Limits of liability** are shared and not individual, regardless of the number of persons covered under this **policy**.
3. Under **Coverage C**: Employed physicians and surgeons are not provided **coverage**, even as employees, unless an application has been submitted and approved by the Company and additional **premium** has been paid. These physicians and surgeons are provided individual **coverage** and separate **limits of liability**. They are added to the **insured's policy** by **endorsement**.
4. Under **Coverage D**: Employed **Non-Physician Healthcare Providers**, including but not limited to advanced registered nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, physician assistants, opticians, social workers, optometrists, physical therapists, X-ray and lab technicians, psychologists, surgical assistants, radiology technicians and OR technicians are not provided **coverage**, even as employees, unless an application has been submitted and approved and additional **premium** has been paid. **Coverage** is provided on a shared limits basis, and while working within the course and scope of their assigned duties and under the direct supervision of the **insured**. These healthcare providers are added to the **insured's policy** by **endorsement**.
5. Under **Coverage D**: Employees, including but not limited to licensed nurses, registered nurses, medical technicians, clerical employees and volunteer workers, are **protected persons** if and when they are employed by the **insured** and working within the course and scope of their assigned duties and under the direct supervision of the **insured**. Limits are shared and no additional **premium** must be paid.

Sole Agent

The **insured** named on the **Declarations Page** will act on behalf of all **insureds** in the giving and receiving of notices including cancellation, and is responsible for accepting **endorsements**, paying **premiums** and receiving return **premiums**.

INSUREDS' DUTIES IN THE EVENT OF CLAIMS

If there is a **medical incident, claim or suit** involving an **insured** under this **policy**, all **insureds** agree to comply with the following or the Company will have no duty or obligation to defend or indemnify:

The **insured** must tell the Company what happened, as soon as possible, even though no **claim** has been made. The **insured** must provide the Company with full disclosure. Each **insured** covered under this **policy** agrees to notify the Company in writing of the following information, including but not limited to:

- a. Date, time and place of the event, and
- b. The persons involved, and
- c. The specific nature of the incident or events, and
- d. The type of **claim** that may result as well as the services that were provided.

The **insured** must include the names and addresses of any witnesses or injured persons. This must be provided in writing to the Company within ten (10) working days of the incident. The **insured** must send to the Company within ten (10) days of receipt, copies of all demands, notices, summons, notices of intent, documents or papers, **suit** papers or any legal documents.

No **insured** covered under this **policy** shall admit any liability, make any voluntary payments or assume any obligation without the Company's written authorization. Doing so will result in the Company denying reimbursement of the payment even though the cost may be otherwise covered by this **policy**.

In order to protect the interests of any **insured** covered under this **policy**, as well as the interest of the Company, all **insureds** must fully cooperate with the Company and the attorney provided throughout the pendency and review process of the **claim**. Issues of information that arise at a later date may prejudice the defense. Cooperation includes, but is not limited to, attendance at meetings with attorneys or members of the Company, participation in enforcing any rights of subrogation, contribution or **indemnity**, giving evidence, meeting with experts and attendance at trials or settlement conferences.

The **insured** should respond to the Company's request for a meeting within 5 days of the request. All **insureds** covered under this **policy** must also maintain all medical records, and must not create, make or add to, alter, modify or improperly dispose of any medical, hospital or other records pertinent to any **claim** or **suit**.

ACTION AGAINST THE COMPANY

The **insured** agrees not to sue the Company to recover under this **policy** unless the **insured** has complied with all the rules and conditions presented in this **policy** and the amount of the **insured's** obligation to pay shall have been finally determined by judgment against the **insured** after actual trial, arbitration, or by written agreement by the **insured**, the claimant and the Company. Bankruptcy or insolvency of the **insured** or the **insured's** estate shall not relieve the Company of its obligations to defend and indemnify within the limits of the **policy**.

POLICY TERRITORY LIMITATION OF COVERAGE

The **coverage** afforded under this **policy** is for **damages** as a result of **professional services** rendered, or which should have been rendered, in the world, as long as the suit is brought in the United States, its territories or possessions.

OTHER INSURANCE

Coverage provided by this **policy** is excess over any other valid and collectible insurance or any other source of indemnification or reimbursement of **damages** applicable to the **insured** for **professional services** rendered or which should have been rendered. This insurance will not apply until the limits of any other such insurance or other sources have been exhausted. If the **insured**, under **Coverage A, B, C or D**, has other insurance for a **claim** or loss covered by this **policy**, then this **policy** shall be purely excess over all such insurance.

SUBROGATION

In the event of any payment under this **policy**, the Company shall be subrogated to the **insured's** rights of recovery against any person or organization. The **insured** shall execute and deliver instruments and papers and do whatever is necessary to secure and enforce such rights. The **insured** shall do nothing after the loss to prejudice such rights.

CHANGES IN INSURED'S PRACTICE

If the location, nature or scope of the **insured's** practice has changed from that stated on the original application or renewal application, including but not limited to the changes described in Items 1-6 below, the **insured** must inform the Company immediately in writing of such changes. No changes will be effective until a written request is received, approved by the Company and an **endorsement** is issued reflecting the requested change. The **insured** must notify the Company of:

1. Any change in the **insured's** practice.
2. Any change in the **insured's** specialty.
3. Any change in services provided.
4. Any change in the location of the **insured's** practice.
5. Any change in physician, surgeon or **non-physician healthcare provider** employees.
6. Any change which may increase or decrease risk in activities or services provided.

Changes may result in conditions that would not be covered by this **policy**. It is important that the **insured** notifies the Company so that the Company can advise the **insured** of any such condition.

LOSS CONTROL

It is the duty of the **insured** or any person covered under this **policy** to implement reasonable loss control methods. Discovery of willful or grossly negligent acts, omissions, events or any violation of state or federal laws or regulations establishing safety, health and occupational standards will be grounds for cancellation of the **policy**. It is also the duty of the **insured** to fully cooperate with the Company Risk Management and Loss Prevention Programs. The Company has the right, but not the obligation, to make inspections and surveys during the **policy period**, and to engage services and organizations acting on behalf of the Company. The **insured** will be provided any reports on conditions found and recommended changes. These inspections and surveys relate only to insurability and **premiums** charged.

ASSIGNMENT

The interest of any **insured** under this **policy** is not assignable or transferable. In the event of the death of the **insured** or a physician or surgeon **insured** under this **policy**, the estate of the **insured** will be the **insured** under the **coverage**, if applicable under the Extended Reporting **Endorsement**.

COMPLIANCE WITH STATE LAWS

Any provision or condition in this **policy** that is in conflict with the laws of the State shown on the **Declarations page** or **endorsement** is understood and declared by the Company to be amended to conform to such laws or statutes.

PREMIUMS

Premiums are payable in full as of the **effective date of coverage**, unless the Company offers the **insured** an alternate plan of payment. All **coverage** will expire automatically at the end of the period for which the Company has received payment. The Company may increase **premium** by giving at least 90 days written notice to the **insured**, as named on the **Declarations Page**, and shall state in the notice the amount of the increase. In the event of non-payment of **premium**, the **expiration date** of the **policy** will then become the date that **premium** paid was exhausted and is calculated on an earned basis.

RENEWAL

From time to time, the Company will provide a renewal questionnaire to the **insured** prior to the **expiration date of coverage**, unless a prior non-renewal notice was mailed to the **insured**. After receipt of the completed and signed renewal questionnaire, and upon approval of insurability, the Company will send the **insured** a new **Declarations Page**, and all applicable amendments and **endorsements**. **Premium** for the current **policy** year must be paid in full as of the **effective date** of the renewal of the **policy**. Failure to pay renewal **premium** by the **effective date** of the renewal will be the **insured's** notice to the Company of intent to allow the **policy** to expire.

CANCELLATION AND NON RENEWAL

The **insured**, as appears on the **Declarations Page**, may cancel this **policy** at any time. Notice must be furnished to the Company in writing in advance of the requested cancellation date. Any unused portion of **premium** paid will be calculated on an unearned basis, subject to a short rate penalty, and **premium** returned. Tendering unearned **premium** shall not be a condition of cancellation. If the **insured** cancels this **policy**, the **insured** has an opportunity to purchase an Extended Reporting **Endorsement** in accordance with the Extended Reporting **Endorsement** provision of this **policy**.

The Company may cancel or non renew this **policy**, other than for non payment of **premium** or because the **insured** is no longer licensed, by giving at least 90 days written notice to the **insured** and shall state in the notice the reason for cancellation or non-renewal. Such notice of cancellation may only be given within the first 90 days from the **effective date** of the **policy**. The Company may not cancel or refuse to renew this **policy** based solely on the fact that the **insured** is an elected official. Any unused portion of **premium** will be calculated on an un-

earned basis and returned. Tendering unearned **premiums** shall not be a condition of cancellation. This notice will be mailed to the **insured** at the last address on record with the Company of the **insured**.

If cancellation by the Company is due to non-payment of **premium** or cancellation, revocation or suspension of the medical license, the Company need only give the **insured** 10 days' notice prior to cancellation of the **policy**. This notice will be mailed to the **insured** consistent with cancellation above. The **expiration date** of the **policy** will then become the date that **premium** paid was exhausted, calculated on an earned basis.

EXTENDED REPORTING ENDORSEMENT

The **insured**, as appears on the **Declarations Page**, or an **additional insured**, shall receive an automatic 30-day extended reporting period upon termination of the **policy**. The automatic 30 day extended reporting period does not reinstate or increase the **limits of liability**. The automatic 30 day extended reporting period will not apply to any **claim** that is covered under any subsequent insurance, or that would be covered but for the exhaustion of the amount of insurance available to such **claim**.

The **insured**, as appears on the **Declarations Page**, or an **additional insured**, shall also have the opportunity to purchase an Extended Reporting **Endorsement** upon termination of this **policy**. The minimum term of the Extended Reporting **Endorsement** offered shall be at least one year and an unlimited term Extended Reporting **Endorsement** shall also be available for purchase. To exercise this option, the **insured** must:

1. Inform the Company of its desire to purchase this **coverage**, in writing and within 30 days of the **expiration date** of the **policy**.
2. Pay the applicable **premium** in full within 30 days of the expiration of the **policy**.

Premium for the Extended Reporting **Endorsement** is developed and calculated according to rules, rates, rate plans and **premiums** applicable for the State shown on the **Declarations Page**, or subsequent **endorsement**.

If the **insured** attains age 55, completely retires from the practice of medicine and has been **insured** for five (5) consecutive **claims** made years with the Company, an Extended Reporting **Endorsement** will be provided at no additional charge.

In the event of the death of any physician or surgeon **insured** under the **policy**, an Extended Reporting **Endorsement** will be issued, at no additional charge, to provide **coverage** for the estate. The **insured's** estate must notify the Company within 60 days of the death of the **insured** that this **coverage** is desired. Customary written proof of date of death must be provided in order for the Extended Reporting **Endorsement** to be issued.

In the event a physician or surgeon **insured** becomes permanently disabled from sickness or accidental **bodily injury** for a period of at least one (1) year, and stops the practice of medicine altogether, an Extended Reporting **Endorsement** will be provided at no additional charge. The **insured** must provide written medical proof of total and permanent disability, including the date the disability occurred and certified by the **insured's** attending physician.

The **limits of liability** stated under this **policy** at the time of termination, death or disability will be the **limits of liability** applying to the Extended Reporting **Endorsement**.

EXCLUSIONS – NO DEFENSE OR INDEMNIFICATION

Unless otherwise indicated on the **Declarations Page** or by any **endorsements** to the **policy**, the Company will not provide **coverage** for liability, defend or indemnify any **insured** or any employee acting within the course and scope of employment for the following:

1. Liability of any **insured** related to any Partnership, Corporation, Professional Association, Limited Liability Partnership, or legal business entity, whether expressed or implied, other than those specifically stated on the **Declarations Page** of the **policy** or added by **endorsement** to the **policy** and for which a **premium** has been charged and paid.
2. Liability of any **insured** related to conduct as an owner, administrator, officer, director, medical director, attending physician, stockholder, board member, member, superintendent or trustee of any health maintenance organization, ambulatory surgical center, free standing clinic, hospital, sanitarium, clinic with bed and board facilities, nursing home, laboratory or any other business enterprise, or committees thereof.
3. Liability of others assumed under contract. This exclusion does not apply to liability assumed in contract with a:
 - A. Health Maintenance Organization;
 - B. Preferred Provider Organization
 - C. Independent Practice Association; or
 - D. Any other similar organization;but only for such liability as is attributable to the **insured's** alleged negligence.
4. Liability for any **claim** if an **insured** has participated in any conspiracies, unlawful, fraudulent, intentional, or criminal acts.

5. Liability for any **claim** if an **insured** has participated in any antitrust violation, restraint of trade, unfair competition, misappropriation of trade secrets, interference with advantageous relationship, unfair trade or business practices.
6. Liability for any **claim** that arises from the guarantee or warranty of the results of **professional services** or products.
7. Liability for any **claim** against any **insured** for acts, omissions, **medical incidents** or **claims** of any employed physician unless individually **insured**, either by the Company or by another company acceptable to the Company. Proof of insurance must be provided to the Company. A certificate of insurance or other proof of **coverage** must be approved by the Company.
8. Liability for any **claim** or obligation for which the **insured** may be held liable under workers compensation law or regulation.
9. Liability for any **claim** related to libel, slander, defamation, malicious prosecution, false arrest, improper detention or improper imprisonment by any **insured** or abuse of process.
10. Liability for any **claim** arising out of or related to wrongful discharge or discrimination or for any **claims** arising out of employer/employee relationships.
11. Liability for any **claim** resulting from professional medical services rendered or which should have been rendered, while the **insured** was under the influence of alcohol, narcotics, hallucinogenic agents, drugs or intoxicants of any nature, or is mentally impaired.
12. Liability of the **insured**, or anyone covered under this **policy**, for failure to maintain all medical records in original condition, or for creating, making or adding, altering, modifying or improperly disposing of any medical, hospital or other records related to any **claim** or person related hereto. Liability for any **claim** will be denied if any medical record related to any person involved has been modified, altered, corrected, changed, substituted, replaced, revised, or arranged to reveal information in a fashion other than the original medical record content.
13. Liability for any **claim** arising out of **professional services** rendered, or that should have been rendered, prior to the **retroactive date** stated on the **Declarations Page** of this **policy**, or in connection with any **claim** whereby the **professional services** related to a condition which should have been diagnosed or treated prior to the **retroactive date**, or the **insured** knew or should have reasonably foreseen that **professional services** would result in a **claim** or potentially compensable event, or which has been reported under any other **policy** of insurance.
14. Liability of any **insured** related to:

- A. Defamatory or disparaging material;
 - B. Publication or utterance in violation of an individual's right to privacy;
 - C. Any utterance, materials or matters released in the course of or related to advertising, broadcasting, newspaper, periodical or magazine publication;
 - D. Any utterance through telecasting activities in which the **insured** participates or conducts.
15. Liability of any **insured** for any **claims**, actions, omissions, conduct, injury, disability or death while an **insured's** medical license or DEA authorization is suspended or revoked or subsequent to an adjudication of mental incompetence.
16. Liability for any **claim** related to any service on peer review or utilization review committees of hospitals or other committees associated with hospitals, health maintenance organizations or similar medical care groups, health cost insurers or government agencies providing health cost benefits, unless prior approval from the Company has been granted and is so endorsed onto the **policy**.
17. Liability for any **claim** for any action, conduct or omission which violates state or federal laws or regulations.
18. Liability of any **insured** for any **claims** or acts, conduct, or omission related to **professional services** on behalf of the United States Government or any military service of the United States Government, or on behalf of, to or in any sovereign nation not subject to the laws of the states of the United States of America.
19. Liability of any **insured** for **claims** related to the use of any drug or device not yet approved by the FDA for treatment on human beings.
20. Liability of any employee of the **insured**, unless endorsed onto the **policy** or expressly stated in **Coverage D**.
21. Vicarious liability of any **insured** except as expressly stated in **Coverage A, B, C and D**.
22. Liability for any **claim** against any **insured**, arising out of allegations of transmission or failure to utilize proper precautions to prevent the transmission of fatally contagious disease, where any **insured** knew or had reason to know of infection and failed to notify the Company and the **patient** in advance of rendering treatment.
23. Liability of any **insured**:

- A. For any **damages** or property damage which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants at any time, or
- B. For any loss, cost or expense arising out of any request, demand, order or legal requirement that such **insured** or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of pollutants; or
- C. For any **claim** or lawsuit by or on behalf of a governmental authority or private party for **damages** because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of pollutants.

“Pollutants” means any solid, liquid, gaseous, or thermal irritant or contaminant including smoke, vapor, soot, fumes, acid, alkalis, chemicals and waste. Waste includes material to be recycled, reconditioned or reclaimed.

- 24. Liability of any **insured**: (a) relating to any premises where such **insured** practices all or part of his or her medical profession; or (b) covered under a general liability, worker's compensation, automobile, or fire insurance **policy**, or insurable under such a **policy**.
- 25. Liability of any **insured** for any **damages** arising from any Internet website owned, operated, or sponsored by the **insured**, or others trading under the name of such **insured** or on behalf of such **insured**, including but not limited to, the sale or **endorsement** of any products or goods or the **endorsement** or referral to any physician or healthcare provider other than the **insured**. A person using the **insured's** Internet website shall not be considered such **insured's patient** because of the use of such website. There is no **coverage** relating to the diagnosis, treatment, care or consultation regarding a **patient's** medical condition provided by the **insured** through the use of the Internet or other electronic media system to a **patient** at a distant site who was not seen by an **insured** covered under this **policy** in a face-to-face, in-person visit that took place before the Internet or other electronic communication. This does not include electronic communication or consultation with another healthcare professional, provided such healthcare professional is in the **Policy Territory** and has seen the **patient** in a face-to-face, in-person visit that took place before the Internet or other electronic communication.

EXCLUSIONS – DEFENSE ONLY NO INDEMNIFICATION

Unless otherwise indicated on the **Declarations Page** or on any **endorsements** to the **insured's policy**, the Company will defend but not indemnify you against any **claim** or **suit** that

includes 1 or 2 below but only if that **claim** or **suit** includes allegations of professional liability otherwise covered under this **policy**:

1. Any **claim** for punitive or exemplary **damages**, statutory fines or any other fines.
2. Any **claim** resulting from sexual intimacy, sexual molestation, sexual harassment, sexual exploitation or sexual assault.

We will investigate and defend on behalf of the **insured** any civil **suit** brought against an **insured** seeking amounts that would be covered if this exclusion did not apply. In such case we will pay only the fees, costs and expenses of such defense until such time as no other covered causes of action exist or the allegations have been proven true.

EXCLUDED PROCEDURES - NO DEFENSE OR INDEMNIFICATION

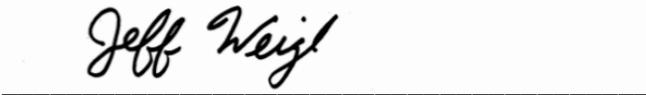
The Company will not provide **coverage** for liability, defend or **indemnify** any **claim** against the **insured** or any **insured** under this **policy** for any of the following procedures:

1. Administering general anesthesia unless specified on the **Declarations Page** as the specialty of Anesthesiology or Certified Registered Nurse Anesthetists.
2. Administering or injecting silicone fluid.
3. Use of chelation therapy.
4. Use of laetrile therapy.
5. Any surgical procedure that will affect obesity or weight control.
6. Any use or administration of Human Chorionic Gonadotropin (HCG) in the treatment of obesity or weight control.
7. Use of any blood or blood by-product that has not been tested for HIV.
8. Sex change operations.

In witness whereof, Medicus Insurance Company, has caused this **policy** to be signed by its President and Secretary:



President



Assistant Secretary



A001 - Additional Professional Office Locations

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that the following Professional Office Locations are added to those listed on the **Declarations Page**:

<u>Location</u>	<u>Effective Date</u>	<u>Cancellation Date</u>
-----------------	-----------------------	--------------------------

Revised Total Policy Premium:

Under no circumstance does this **endorsement** add **coverage** for liability of any **insured**: (a) relating to any premises where such **insured** practices all or part of his or her medical profession; or (b) covered under a general liability, worker's compensation, automobile or fire insurance policy, or insurable under such a policy.

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A002 – Amend Professional Office Location

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that this endorsement amends the professional office location to read:

Location	Effective Date	Cancellation Date
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Revised Total Policy Premium:

Under no circumstance does this **endorsement** add **coverage** for liability of any **insured**: (a) relating to any premises where such **insured** practices all or part of his or her medical profession; or (b) covered under a general liability, worker's compensation, automobile or fire insurance policy, or insurable under such a policy.

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A003 – Amend Policy Date

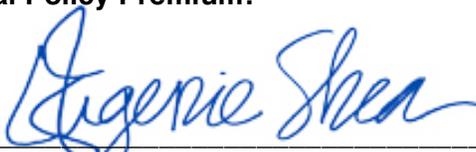
Effective Date:
Endorsement Number:
Policy Number:

In consideration of the **premium** charged it is understood and agreed that one or more of the **policy** dates as shown on the **Declarations Page** is amended to read:

Policy Effective Date _____
Policy Cancellation Date _____
Retroactive Date: _____

This **endorsement** applies to:

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A004 – Amend Limits of Liability

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that the **limits of liability** shown on the **Declarations Page** or subsequent **endorsement** are amended as follows:

Insured's name as shown on the **Declarations Page**:

Limits of Liability

Professional Liability-per Claim: _____
Annual Aggregate: _____

Medical Board Defense-per Claim: _____
Annual Aggregate: _____

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A005 – Amend Insured Named on Declarations Page

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that this **endorsement** amends the **Insured** named on the **Declarations Page** to read:

Insured	Effective Date	Retroactive Date	Cancellation Date
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Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A006 – Additional Insured Endorsement

Effective Date:
Endorsement Number:
Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement** adds/deletes the following individuals as **insureds** under this **policy** as follows:

Name:	Insured's Specialty:	Effective Date:	Retroactive Date:	Cancellation Date:	Limits of Liability:	Premium:
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Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A007 – Non-Physician Healthcare Providers Endorsement (Shared Limits of Liability)

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement adds/deletes** the following **non-physician healthcare providers** as **insureds** under this **policy**, sharing **limits of liability** with other **insureds** under Coverages A, B, C and D.

However, if the **insured** named on the **Declarations Page** is afforded separate **limits of liability**, the **non-physician healthcare providers** named below will not share **limits of liability** with other **insureds** under Coverages A, C or D. Such providers will share **limits of liability** only with **insureds** under Coverage B.

<u>Name</u>	<u>Specialty</u>	<u>Effective Date</u>	<u>Retroactive Date</u>	<u>Limits of Liability</u>
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Professional services must have been rendered while in the course and scope of employment and under the supervision of the physician or surgeon **insured**.

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A008 – Change of Rate

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood that the following **Insured** shall be re-rated to the following rate as of the **endorsement effective date**:

Insured: _____

Rate: _____

It is further agreed that **coverage** is canceled for the prior rate of the above **Insured**, except as to **claims** first reported to the Company after this **endorsement** effective date that arise from **professional services** rendered or which should have been rendered during the **policy period** prior to this **endorsement** effective date.

Revised Total Policy Premium:

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A009 – Change of Specialty

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood that the following **Insured** shall be re-rated to the following Specialty as of the **endorsement** effective date:

Insured: _____

Specialty: _____

It is further agreed that **coverage** is canceled for the prior Specialty of the above **Insured** except as to claims first reported to the Company after this **endorsement** effective date that arise from **professional services** rendered or which should have been rendered during the **policy period**.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A010 – Locum Tenens

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** is provided under this **policy** for **claims** arising from **professional services** rendered, or which should have been rendered, during the period indicated below, by the following locum tenens individual temporarily serving in the place of the following **Insured**:

Locum Tenens	Insured Replaced	From	To

Revised Total Policy Premium:

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A011 – Deletion of Locum Tenens

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** afforded under this **policy**, in connection with the following locum tenens individual, for the period listed below, is hereby cancelled flat at the request of the Insured:

Locum Tenens Insured Replaced

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A012 – Exclusion of Outside Practice

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** is excluded from this **policy** for **claims** arising out of **professional services** rendered, or which should have been rendered, in the course of the **insured's** employment by, association with or contract with the facility, organization or individual listed below. The Company will neither defend nor indemnify for such **claims**.

This **endorsement** applies to:

Revised Total Policy Premium:

Countersigned _____

A handwritten signature in blue ink that reads "Eugenie Shea".

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A013 – Exclusion of Procedure

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** is excluded under this **policy** for **claims** arising from the **insured's** performance of the procedures listed below. The Company will neither defend nor indemnify the **insured** for **claims** arising from the performance of such procedures: This **endorsement** applies to:

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A014 – Medical Director Coverage - Limited

Effective Date:

Endorsement Number:

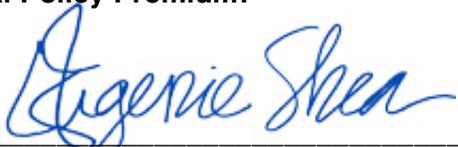
Policy Number:

In consideration of the **premium** charged it is understood and agreed that **coverage** under this **policy** includes **coverage** for **claims** arising from **professional services** rendered or which should have been rendered in the **insured's** capacity as medical director for the following facility(ies):

<u>Insured's Name</u>	<u>Facility</u>	<u>Effective</u>	<u>Retroactive</u>	<u>Cancellation</u>
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This **endorsement** applies to:

Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A015 – Limitation of Coverage to Specific Employment

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** is excluded under this **policy** for **claims** arising from **professional services** rendered, or which should have been rendered, except for **claims** arising from **professional services** in connection with employment by, or association with, the following:

Revised Total Policy Premium:

Countersigned



AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A016 – Suspension of Insurance

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** under this **policy** is placed on Suspension of Insurance for the following **Insured**:

Insured's Name: _____

The Company will defend and indemnify this **insured** for **claims** first reported to the Company during the Suspension of Insurance period, but only if such **claims** arise from **professional services** rendered, or which should have been rendered, by this **insured** prior to this **endorsement effective date** and subsequent to the **insured's retroactive date**.

The Company will neither defend nor indemnify this **insured** for **claims** arising from **professional services** rendered or which should have been rendered on or after this **endorsement effective date**.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A017 – Deletion of Suspension of Insurance

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **Endorsement #** _____, Suspension of Insurance, is deleted for the following **Insured:**

Insured's Name: _____

Nevertheless, the Company will neither defend nor indemnify this **insured** for **claims** arising from **professional services** rendered or which should have been rendered during the suspension of insurance period stated below:

From: _____ 12:01am **To:** _____ 12:01am

Revised Total Policy Premium:

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A018 – Deductible Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that the following deductible is added to the following **Insured**:

<u>Insured's Name:</u>	<u>Deductible Amount:</u>			<u>Deductible Type:</u>
	Per Claim	Annual	Aggregate	

Deductible Definition: The deductible applies to **claim expenses** and **indemnity** of all **claims**. Each **insured** listed above is responsible for payment of the deductible as expenses are incurred by the Company. The deductible obligation amount is first applied to **claim expenses** and **indemnity** up to the maximum amount of the deductible obligation before any **claim expenses** or **indemnity** is paid by the Company.

Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A019 – Cancellation Endorsement

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **Endorsement #** _____ issued to _____ is hereby canceled.

The terms of exclusion, if any, of the above **endorsement** will still govern your **coverage** at the time a **claim** is first reported to the Company, if the exclusion was in effect at the time you rendered or failed to render **professional services** from which such **claim** arises.

Revised Total Policy Premium:

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A020 – Inclusion of Procedures

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **policy** includes **coverage** for **claims** arising from the **insured's** performance of the procedures listed below:

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A021 – Former Insured Coverage

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that any former **insured's** coverage under previous policies held by the **Insured** named on the **Declarations Page** shall be covered under this **policy**, but this **coverage** shall apply only to **claims** resulting from rendering or failing to render professional services when insurance was in force on behalf of such former insured and reported during the **policy** period or any annual renewal thereof. **Coverage** is provided only to the extent that such former insured would have been **covered** under this current **policy**.

Name	Specialty	Effective Date	Retroactive Date	Cancellation Date
------	-----------	----------------	------------------	-------------------

Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A023 – Slot Coverage Endorsement

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** provided under this **policy** for group practices may be available, at the Company's discretion, on a slot basis, rather than on an individual physician basis, as follows:

- 1) Identified below are the individuals and practice settings covered under this **endorsement**. **Coverage** will be provided on a shared limits basis for **insureds** moving through any one slot. Multiple slots may be purchased; however, one slot may represent no more than one full-time equivalent, or approximately forty work hours per week, on average. Multiple slots will be identified by unique slot position numbers.
- 2) The applicable manual rate will be determined by the classification and **retroactive date** of the slot. An Extended Reporting **Endorsement** may be purchased for the slot based on the applicable **retroactive date**, classification and **limit of liability**.
- 3) The **insured**, as stated on the **Declarations Page**, shall have the right to cancel **coverage** under this **endorsement**, upon giving prior written notice to the Company, for **insured** physicians or **non physician healthcare providers**, designated below, as of the date such individuals leave the **insured's** practice.
- 4) The **insured**, as stated on the **Declarations Page**, shall have the right to designate replacements for such **insured** physicians or **non-physician healthcare providers**, if they
 - a. make application to the Company ; and
 - b. are approved for **coverage** by the Company.
- 5) **Premium** shall be calculated from the dates on which **coverage** began for the **insured** physicians or **non physician healthcare providers** who occupy the slot.
- 6) While this slot coverage is open, the Company will cover **insured's** designated below, for **claims** arising from **professional services** which were rendered or should have been rendered by such **insureds**, during the periods designated below.
- 7) If an Extended Reporting **Endorsement** is purchased within 30 days after cancellation of a slot, the Company shall cover **insureds** designated below for **claims** arising from **professional services** which were rendered or should have been rendered by such **insureds** during the periods designated below.



A023 – Slot Coverage Endorsement, cont'd

Effective Date:

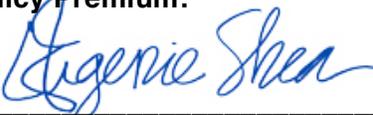
Endorsement Number:

Policy Number:

- 8) If an Extended Reporting **Endorsement** is not purchased within 30 days of the cancellation date of a slot, all **coverage** will have ceased as of the cancellation date of the slot. The Company has no obligation to offer the Extended Reporting **Endorsement** to other than the **insured**, as shown on the **Declarations Page**.

Slot Position Number	Name	Retroactive Date	Start Date	Term Date	Class	Practice Setting
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Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A024 – Cancel Additional Insured Slot Position

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that **coverage** is canceled under this **policy** for the following **Additional Insured:**

Slot Position	Number	Name:	Specialty

Subject to payment of **premium**, this slot shall remain open until such time as a replacement is designated by the **Insured**, and endorsed into the slot position by the Company, by issuing a **Declarations Page** or **endorsement** listing the replacement.

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A025 – Extended Reporting Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the payment of **premium**, the Company agrees to provide to the **insured**, captioned below, **coverage** for **claims** reported after cancellation of the **coverage** shown below, which are based on incidents that occurred on or after the **retroactive date** below and prior to the cancellation date of **coverage**. The **coverage** provided by this **endorsement** is the same as the **coverage** provided in the **policy**, and is subject to all terms, conditions, exclusions, and limitations of the **coverage** and liability of the **policy**. This Reporting Endorsement does not extend the original policy period. Upon issuance of this endorsement, the premium charge is considered fully earned.

It is further agreed that the **limits of liability** listed below represent the maximum amount the Company will pay for all **claims** reported during the Extended Reporting Period. This **endorsement** may not be cancelled by the Company except for non-payment of premium.

Insured:	Retroactive	Effective	Cancellation	Limits of Liability:		
	Date:	Date:	Date:	Per Claim	Annual	Aggregate

Reporting Period: _____.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A026 – Insured Entity Shared Limit Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement** adds/deletes the following entity as **insured** under this **policy**:

Name:	Address:	Effective Date:	Retroactive Date:	Cancellation Date:	Premium:
<hr/>					

The Company will pay all sums for **claims** for which the **insured** as an entity listed above becomes legally obligated to pay as **damages** because of **medical incidents** rendered or which should have been rendered by its physician and surgeon **insureds**, employees as **insureds** or **protected persons**. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**.

In consideration of the fact that the **insured** entity, listed above, has been included as an **insured** at no additional **premium** charge, the **insured** entity shall not have its own **limit of liability**, but shall share in the **limits of liability** of the **insured** physicians. Any **damages** paid on behalf of the **insured** entity (whether by reason of a **claim** or **suit** against (1) the **insured** entity, (2) any covered employee or person covered by **endorsement** to the **policy** or (3) any **insured** physician on account of liability arising by reason of his status as a member, partner, officer, director or shareholder of the **insured** entity) shall be applied against the **limits of liability** applicable to the **insured** physicians, in such order and manner as the Company deems appropriate.



A026 – Insured Entity Shared Limit Endorsement, cont'd

Effective Date:

Endorsement Number:

Policy Number:

If **damages** are awarded, or a settlement is made with the Company's consent, against the **insured** entity and one or more **insured** physicians, the total **limits of liability** available to the **insured** entity and such **insured** physicians shall not exceed the **limits of liability** then available under the **policy** to such **insured** physicians. If **damages** are awarded, or a settlement is made with the Company's consent, against the **insured** entity, but not against any **insured** physicians, the **limit of liability** available to the **insured** entity shall equal the lowest of the **limits of liability** then available under the policy to all **insured** physicians.

Revised Total Policy Premium:

A handwritten signature in blue ink that reads "Eugenie Shea". The signature is written in a cursive style and is positioned above a horizontal line.

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A027 – Insured Entity Separate Limit Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement** adds/deletes the following entity as **insured** under this **policy**:

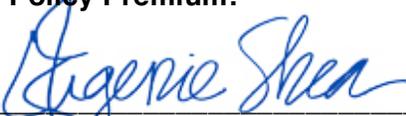
Name:	Address:	Effective Date:	Retroactive Date:	Cancellation Date:	Limit of Liability:	Premium:
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The Company will pay all sums for **claims** for which the **insured** as an entity listed above becomes legally obligated to pay as **damages** because of **medical incidents** rendered or which should have been rendered by its physician and surgeon **insureds**, employees as **insureds** or **protected persons**. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**.

The Insuring Agreement, Coverage B and Coverage C, and Conditions 1 and 2 are hereby amended to reflect separate **limits of liability** for the **insured** named above.

The **insured** named above will share **limits of liability** only with **insured non-physician healthcare providers**, unless such providers are afforded separate **limits of liability** by **endorsement**, and with **insured protected persons**. The **insured** named above will not share **limits of liability** with **insured** physicians and surgeons or with **insured** employed physicians.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A028 – Schedule of Physicians Endorsement

Effective Date:
Endorsement Number:
Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement adds/deletes** the following physician and surgeons as **insureds** under this **policy**:

Insured's Premium Specialty Effective Date: Retroactive Date: Limits of Liability:
Name: _____

The Company will pay, on behalf of the **insured**, either individually or as a solo professional association, all sums for **claims** for which the **insured** becomes legally obligated to pay as **damages** because of **medical incidents** rendered, or which should have been rendered, by the **insured**, or anyone for whose **professional services**, acts or omissions the **insured** is legally responsible under Coverage D. These **medical incidents** must have occurred subsequent to the **retroactive date** and be reported in writing to the Company during the **policy period**.

Unless stated otherwise by **endorsement**, the **limits of liability** stated above are shared with all **insured** entities under Coverages A and B and all **non physician healthcare providers** or **protected persons** under Coverage D, regardless of the number of persons or entities covered.

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A029 – Non-Physician Healthcare Providers Endorsement (Separate Limits of Liability)

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **endorsement adds/deletes** the following **non-physician healthcare providers** as **insureds** under this **policy**. These persons are provided individual **coverage** and separate **limits of liability**.

Insured's Premium Name	Specialty	Effective Date:	Retroactive Date:	Term Date	Limit of Liability:
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The Insuring Agreement, Coverage B, Coverage C and Coverage D, and Conditions 1, 2 and 4 are hereby amended to reflect separate **limits of liability** for the **insureds** named above.

The **insureds** named above will not share **limits of liability** with any other **insureds** under this **policy**.

Professional services must have been rendered while in the course and scope of employment and under the supervision of the physician or surgeon **insured**.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A030 – Lower Limits of Liability for Prior Acts

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, the **limits of liability** shown on the **Declarations Page** and applicable **endorsement(s)** are amended in accordance with the **policy** insuring agreements, conditions, definitions and exclusions, as follows:

Insured: _____

For all **claims** arising from **medical incidents** that take place entirely on or after _____ and before _____, the Per **Claim limit of liability** is _____, subject to an Aggregate **limit of liability** of _____.

For all **claims** arising from **medical incidents** that take place entirely on or after _____ and before the termination of this **policy**, the Per **Claim limit of liability** is _____, subject to an Aggregate **limit of liability** of _____.

However, the maximum amount payable for all **damages** combined because of all **claims** reported during this **policy period** is _____.

No **coverage** shall apply if the Company or any other insurer has or had a policy in effect, which would otherwise provide coverage for liability arising from medical incidents for which a claim was or should have been reported to the insuring company under such previous policy before the effective date of this **endorsement**.

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A031 – Change of Sole Agent Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged, it is understood and agreed that this **policy**, including its insuring agreements, conditions, definitions and exclusions, has been changed as follows:

_____ has been designated as the Sole Agent to act on behalf of all **insureds** under this **policy**:

The Company will require the written consent of the Sole Agent named above to make or conclude any offer of settlement or offer of judgment. Consent will not be unreasonably withheld by the Sole Agent. The Company is not required to pursue appeal of any judgment or **suit**. The Company will have the right but not the obligation to appeal.

Further, the Sole Agent named above will act on behalf of all **insureds** under this **policy** in the giving and receiving of notices including cancellation, and is responsible for accepting **endorsements**, paying **premiums** and receiving return **premiums**.

Signature of **Insured** named on the **Declarations Page** of this **policy**

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A032 – Exclusion of Services to Obstetrical Patients

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged for this **policy**, it is hereby understood and agreed, subject to all terms, conditions and exclusions of this **policy**, the following is added to **"EXCLUSIONS - NO DEFENSE OR INDEMNIFICATION"**:

The Company will not provide **coverage** for liability, defend or indemnify any **insured**, or any employee acting within the course and scope of employment of any **insured**, for the following:

The rendering of, or failure to render obstetrical medical treatment to an expectant mother or to her fetus or child during the second and/or third trimesters of pregnancy and/or during labor and/or delivery. **Coverage** for obstetrical medical treatment is provided during the first trimester of pregnancy provided the patient is referred to an obstetrician once the pregnancy is diagnosed.

However, this **endorsement** does not exclude **coverage** for emergency deliveries or emergency gynecological services performed solely as a result of a call from a hospital when the **insured** is on emergency room call as a condition of the hospital's granting such **insured** staff privileges.

This **endorsement** is accepted by the undersigned **Insured**:

_____ Date

_____ Signature

Revised Total Policy Premium:

Countersigned _____

Eugenie Shea
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A033 – Liability Exclusion – Public Health Officer

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged for this **policy**, it is hereby understood and agreed, subject to all terms, conditions and exclusions of this **policy**, the following is added to **"EXCLUSIONS - NO DEFENSE OR INDEMNIFICATION"**:

The Company will not provide **coverage** for liability, defend or indemnify any **insured**, or any employee acting within the course and scope of employment of any **insured**, for the following:

Any liability arising out of any administrative or other service, act or omission rendered as a Public Health Officer.

Date

Signature

Revised Total Policy Premium:

Countersigned _____

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A034 – Amend Limits of Liability – Prospective Only

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged for this **policy**, it is understood and agreed, subject to all terms, conditions and exclusions of this **policy**, that the **limits of liability** shown on the **Declarations Page** or subsequent **endorsement** are amended as follows:

Insured's name, as shown on the Declaration's Page: _____

Limits of Liability:

		Medical Board	
<u>Per Claim:</u>	<u>Annual Aggregate</u>	<u>Defense-per claim:</u>	<u>Annual Aggregate:</u>

It is further understood and agreed the amended **limits of liability** referenced above will apply prospectively and not retroactively. In other words, such amended limits will apply only to **claims** arising from **medical incidents** occurring on or after the **effective date** of this **endorsement**.

_____	_____
Date	Signature

Revised Total Policy Premium:

Countersigned 
 AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A035 – Excluded Persons or Entities

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged for this **policy**, it is hereby understood and agreed, subject to all terms, conditions and exclusions of this **policy**, the following is added to **"EXCLUSIONS - NO DEFENSE OR INDEMNIFICATION"**:

The Company will not provide **coverage** for liability, defend or indemnify any **insured**, or any employee acting within the course and scope of employment of any **insured**, for the following:

Any liability arising out of any professional services, or other services, acts or omissions rendered by the following individuals or entities, or by anyone acting on their behalf:

Further, the Company will not provide **coverage** for any vicarious liability of any **insured** with respect to the individuals or entities named above, nor will **coverage** be provided by the Company for liability arising from any **insured's** recruitment, credentialing, quality assurance activities, training, supervision, or any other activities regarding any person or entities listed above.

Revised Total Policy Premium:

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A036 – Coverage for Charitable Services

Effective Date:

Endorsement Number:

Policy Number:

In consideration of the **premium** charged for this **policy**, it is hereby understood and agreed, subject to all terms, conditions and exclusions of this **policy**, the "**POLICY TERRITORY LIMITATION OF COVERAGE**" section in the **Policy CONDITIONS** is deleted and replaced with the following:

The **coverage** afforded under this **policy** for **damages** as a result of **professional services** rendered, or which should have been rendered, is limited to the State(s) reflected on the **Declarations Page**, or subsequent **endorsement** delineating professional premises.

In addition, with respect to charity work, the covered Territory is worldwide, but only if:

- a) the **professional services** were performed without compensation, or the expectation of compensation;
- b) the **professional services** were performed outside the United States, its territories or possessions, Puerto Rico or Canada;
- c) except in a medical emergency, the **patient** is not a citizen of the United States; and
- d) the **claim** is made and litigated within the United States.

Revised Total Policy Premium:

A handwritten signature in blue ink that reads "Eugenie Shea".

Countersigned _____

AUTHORIZED REPRESENTATIVE

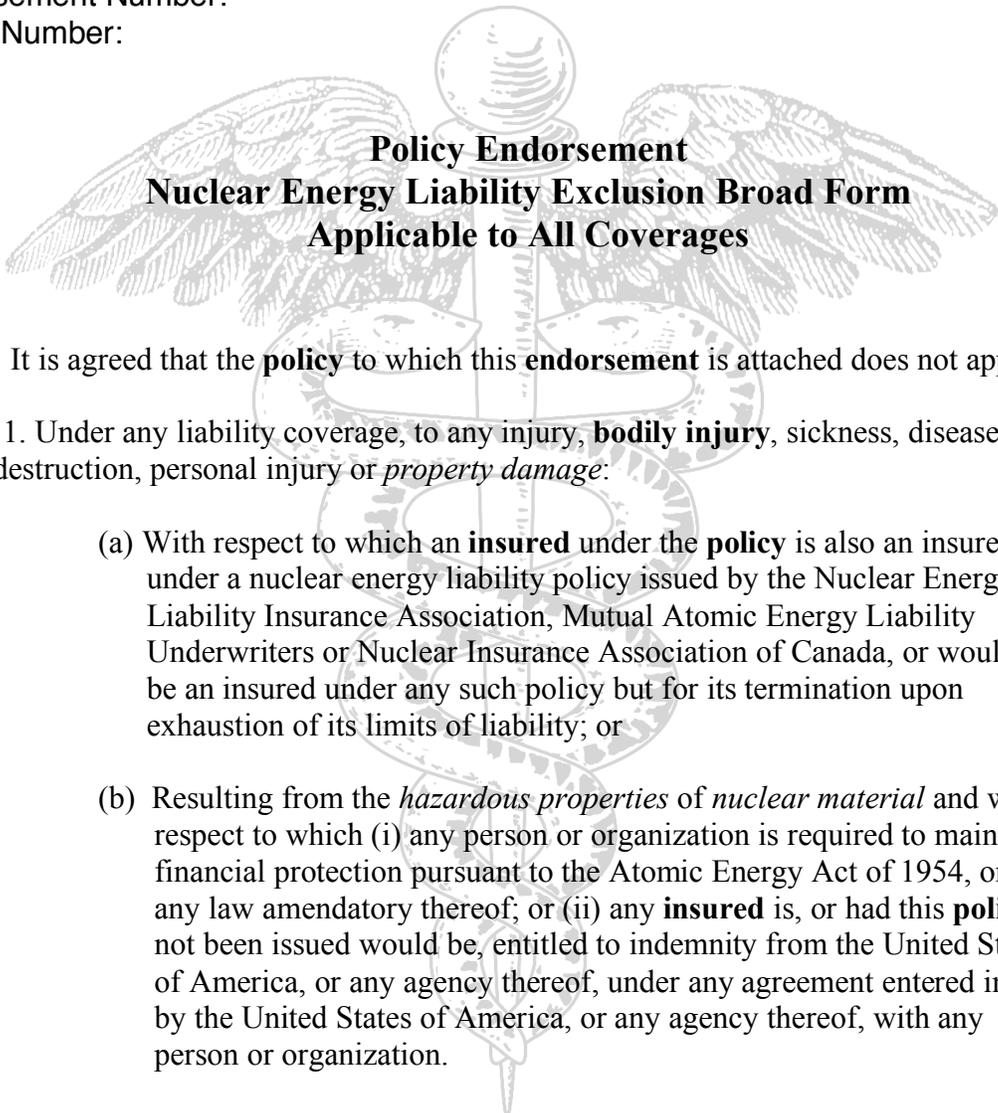
Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supercedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.

A041

Effective Date:

Endorsement Number:

Policy Number:

A large, faint watermark of a caduceus (a staff with two snakes entwined around it and wings at the top) is centered in the background of the page.

Policy Endorsement
Nuclear Energy Liability Exclusion Broad Form
Applicable to All Coverages

It is agreed that the **policy** to which this **endorsement** is attached does not apply:

1. Under any liability coverage, to any injury, **bodily injury**, sickness, disease, death, destruction, personal injury or *property damage*:
 - (a) With respect to which an **insured** under the **policy** is also an insured under a nuclear energy liability policy issued by the Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an insured under any such policy but for its termination upon exhaustion of its limits of liability; or
 - (b) Resulting from the *hazardous properties of nuclear material* and with respect to which (i) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof; or (ii) any **insured** is, or had this **policy** not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under any agreement entered into by the United States of America, or any agency thereof, with any person or organization.
2. Under any Supplemental Payments provision relating to immediate medical or surgical relief or first aid, to expenses incurred with respect to **bodily injury**, sickness, disease, death, destruction, personal injury or *property damage* resulting from *hazardous properties of nuclear material* and arising out of the

operation of a *nuclear facility* by any person or organization.

3. Under any liability coverage, to any injury, **bodily injury**, sickness, disease, death, destruction, personal injury or *property damage* resulting from the *hazardous properties of nuclear material*, if:
 - (a) The *nuclear material*: (i) is at any *nuclear facility* owned by, or operated by or on behalf of any **insured**; or (ii) has been discharged or dispersed therefrom;
 - (b) The *nuclear material* is contained in *spent fuel* or *waste* at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of any **insured**; or:
 - (c) The **bodily injury** or *property damage* arises out of the furnishing by any **insured** of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any *nuclear facility*; but if such facility is located within the United States of America, its territories or possessions or Canada, this exclusion (c) applies only to *property damage* to such *nuclear facility* and any property thereat.

As used in this **endorsement**:

1. "*Hazardous properties*" include radioactive, toxic or explosive properties.
2. "*Nuclear facility*" means:
 - (a) Any *nuclear reactor*;
 - (b) Any equipment or device designed or used for: (i) separating the isotopes of uranium or plutonium; (ii) processing or utilizing *spent fuel*; or (iii) handling, processing or packaging *waste*;
 - (c) Any equipment or device used for the processing, fabricating or alloying of *special nuclear material* if at any time the total amount of such material in the custody of any **insured** at the premises where such equipment or device is located consists of or contains more than

25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235; or,

(d) Any structure, basin, excavation, premises, or place prepared or used for the storage or disposal of *waste*,

and includes the site on which any of the foregoing is located, all operations conducted on such site and all premises used for such operations.

3. "*Nuclear material*" means *source material*, *special nuclear material* or *by-product material*.
4. "*Nuclear reactor*" means any apparatus designed or used to sustain nuclear fission in a self-supporting chain reaction or to contain a critical mass of fissionable material.
5. "*Property damage*" includes all forms of radioactive contamination of property.
6. "*Source material*", "*special nuclear material*", and "*by-product material*" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof.
7. "*Spent fuel*" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a *nuclear reactor*.
8. "*Waste*" means any waste material: (a) containing *by-product material*; and (b) resulting from the operation by any person or organization of any *nuclear facility*.

Under no circumstances does this endorsement add coverage for liability of any insured: (a) relating to any premises where such insured practices all or part of his or her medical profession; or (b) covered under a general liability, worker's compensation, automobile or fire insurance, or insurable under such a policy.

A large, stylized, hand-drawn signature in blue ink that reads "Eugenie Shea". The signature is written in a cursive, flowing style. Behind the signature, there is a faint, light gray illustration of a caduceus, which is a staff with two snakes entwined around it and wings at the top.

Countersigned

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.

A042 – Amend Reporting of Medical Incident

Effective Date:
Endorsement Number:
Policy Number:

It is understood and agreed that the following is added to the **Policy** under **INSURED’S DUTIES IN THE EVENT OF CLAIMS:**

Notification by the **Insured** to the Company of a **medical incident** does not have to occur within thirty (30) working days of the incident. However, notification by the **Insured** to the Company of a **medical incident** must occur as soon as practicable and within the **Policy Period**.

Revised Total Policy Premium: Not Applicable

Countersigned



AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.

A043 – Amend Retroactive Date Endorsement

Effective Date:
Endorsement Number:
Policy Number:

It is understood and agreed that the Retroactive Date listed on the Declarations Page or subsequent endorsement(s) is hereby amended to read as follows:

Insured:
Previous Retroactive Date:
New Retro Active Date:
Effective Date of Change:
Premium:

Revised Total Policy Premium:

All other terms and conditions of the policy remain the same.

Countersigned



AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.

A044 – Delete Insured Endorsement

Effective Date:
Endorsement Number:
Policy Number:

In consideration of the return premium, if any, the insured name below is hereby deleted from the policy referenced above:

Insured's Name:
Cancellation Date:
Return Premium:

Revised Total Policy Premium:

All other terms, conditions, and exclusions of the policy remain unchanged

Countersigned



AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.

A045 – Amend Policy Territory Limitation of Coverage

Effective Date:
Endorsement Number:
Policy Number:

It is understood and agreed that the following is added to the **Policy** under **POLICY TERRITORY LIMITATION OF COVERAGE:**

The coverage afforded under this policy will cover a medical incident in the United States of America, it's territories and possessions, Puerto Rico or Canada provided a claim is made and suit is brought in the United States of America, it's territories and possession, Puerto Rico or Canada.

Revised Total Policy Premium:

Countersigned



AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A046 – Cancel Policy Endorsement

Effective Date of Cancellation:

Endorsement Number:

Policy Number:

In consideration of the return premium of \$ _____, the above captioned policy is hereby cancelled effective 12:01 a.m. on _____.

All other terms, conditions and exclusions of the policy remain unchanged.

A handwritten signature in blue ink that reads "Eugenie Shea".

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the cancellation date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A049 – Vicarious Liability Coverage for Entity

Effective Date:

Endorsement Number:

Policy Number:

Insured Named on Declarations Page:

In consideration of the **premium** charged for this **policy**, it is hereby understood and agreed, subject to all terms, conditions and exclusions of this **policy**, the following is added to Coverage B: Medical Corporation, Partnership, Association, Limited Liability Partnership or Entity:

The Company will provide vicarious liability **coverage** for the entity named above, with respect to any liability arising out of any professional services, or other services, acts or omissions rendered by the following individuals or entities:

However, such individuals or entities named immediately above must have primary medical professional liability insurance in force and applicable to any such liability arising out of any professional services, or other services, acts or omissions so rendered. Additionally, limits of liability of such insurance must be equal to or greater than the limits of liability on this policy afforded to the Medicus insured entity named above.

Revised Total Policy Premium:

Countersigned 
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A058 – Definition of Limits of Liability Amendatory Endorsement

Effective Date:

Endorsement Number:

Policy Number:

It is understood and agreed that this **endorsement** deletes the definition of **Limits of Liability** on page 6 of the captioned **policy** and replaces with the following:

"LIMITS OF LIABILITY: Means the maximum amount of **indemnity** payments the Company agrees to pay per **claim** and for all **claims** under the **policy**. In the case of **Coverage E**, it is the maximum amount of **defense costs** the Company agrees to pay for Medical Board Defense. **Coverage E limits of liability** are in addition to the limits defined below:

1. **Per Claim:** The **limit of liability** stated “per **claim**”, as appears on the **Declarations Page** or by **endorsement**, is the limit of the Company’s liability for all **bodily injury** or **damage** arising out of, or in connection with, the same or related **medical incident** or **claim**.
2. **Aggregate:** Subject to the Per Claim **limit of liability**, the total limit of the Company’s liability for all bodily injury or damages under this policy shall not exceed the **limit of liability** stated as “aggregate” as appears on the Declarations Page or by **endorsement**. All **medical incidents** for which **claims** are made during the policy period are included.

Revised Total Policy Premium:

Countersigned 

AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the effective date shown above, this endorsement, when countersigned, becomes part of the above numbered policy issued by the Company designated in the Declarations, and supersedes and controls anything in the policy contrary hereto but is otherwise subject to the Declarations, Issuing Agreements, Exclusions and Conditions thereof.



A060– Arkansas Amendatory Endorsement

Effective Date:

Endorsement Number:

Policy Number:

In compliance with the insurance laws and regulations of the State of Arkansas, the following changes are made to the **Insured's Policy**:

- I. On Page 5 of the **Policy**, the following sentence is added in its entirety to the definition "**DAMAGES** ":

Punitive **Damages** are **Damages** that may be imposed to punish a wrongdoer and to deter others from similar conduct.

- II. The following paragraph is added in its entirety to the section of the **Policy** entitled "**PREMIUMS**" on Page 12:

If the company revises its rates or rules and the revision results in a **Premium** increase equal to or greater than 25% for the **Insured** on any renewal **Policy** issued for a term of 12 months or less, the Company will mail or deliver to the **Insured's** agent not less than 60 days prior to the **Effective Date** of renewal and the Insured not less than 30 days prior to the **Effective Date** of renewal notice specifically stating the Company's intention to increase the **Premium**.

- III. The section "CANCELLATION AND NON RENEWAL" on page 12 of the **Policy** is removed in its entirety and replaced by the following:

Cancellation

Either the **Insured** or the Company may cancel a **Policy**.

The **Insured** may cancel a **Policy** at any time by:

- (1) Returning the **Policy** to us or any of our authorized representatives, indicating the **Effective Date** of cancellation; or
- (2) Providing a written notice to us, stating when the cancellation is to be effective.

The Company must receive the **Policy** or written notice of cancellation before the cancellation **Effective Date**.

Within the first sixty days of a **Policy**, the Company may cancel it at any time and for any reason. The Company will mail notice of cancellation at least twenty days prior to the cancellation **Effective Date**.



If the **Policy** has been in effect for 61 days or more, it may be canceled for any of the following reasons:

- (1) Nonpayment;
- (2) Fraud or material misrepresentation made by or with the knowledge of the **Insured** in obtaining the **Policy**, continuing the **Policy**, or in presenting a **Claim** under the **Policy**;
- (3) Any **Insured** violates the terms and conditions of this **Policy**;
- (4) The occurrence of a material change in the risk which substantially increases any hazard insured against after **Policy** issuance;
- (5) Violation of code or laws that substantially increases any hazard insured against under the **Policy**.
- (6) A material violation of a material provision of the **Policy**.

The Company shall mail notice of cancellation to the **Insured** at least 20 days prior to the **Effective Date** of cancellation. However, if the reason for cancellation is non-payment of **Premium**, the Company shall mail notice of cancellation and the reason for cancellation at least 10 days prior to the **Effective Date**.

All cancellation notices shall state the reason for cancellation, the **Effective Date** of cancellation, and will be mailed to the **Insured** at the last mailing address known to us.

If the Company cancels the **Policy**, the refund will be pro-rata. If the **Insured** cancels, the refund may be less than pro-rata. The cancellation will be effective even if we have not made or offered a refund. In the event that an **Insured** does cancel the **Policy**, the minimum retained **Premium** shall be \$500 each for every **Insured** covered by the **Policy**.

Non-Renewals and Conditional Renewals

Except in the case of nonpayment of **Premium**, the Company shall renew a **Policy** unless a written notice of nonrenewal is mailed at least sixty days prior to the (1) **expiration date** of the **Policy**; or (2) anniversary date of a **Policy** for a term longer than 1 year and not having a fixed **expiration date**.

The company may non-renew this **Policy** by mailing written notice to the **Insured**, at the last known address, at least sixty days before the **expiration date**. Proof of mailing will be sufficient proof of notice.



IV. The following section is added in its entirety to the **Policy**:

Extended Reporting **Endorsement**

The Company will provide at no additional charge an automatic sixty-day extended reporting **Endorsement** upon cancellation or termination of the **Policy** by either the Company or the **Insured**.

At the expiration of the automatic sixty-day extended reporting period, the Company will offer an extended reporting period **Endorsement**. The availability of and **Premium** for an extended reporting period **Endorsement** will be disclosed upon notice of termination of a **Claims-made Policy**.

V. The following section is added in its entirety to the **Policy**:

No part of the Company's **Policy**, application, or supporting documents shall be construed to imply any sort of condition, provision, or agreement which directly or indirectly deprives the **Insured** of the right to trial by jury on any question of fact arising under the **Policy** or contract.

Countersigned _____
AUTHORIZED REPRESENTATIVE

Effective not prior to time applied for, on the **Effective Date** shown above, this **Endorsement**, when countersigned, becomes part of the above numbered **Policy** issued by the Company designated in the **Declarations Page**, and supersedes and controls anything in the **Policy** contrary hereto but is otherwise subject to the **Declarations Page**, Issuing Agreements, Exclusions and Conditions thereof.



Physicians and Surgeons Liability Insurance – Certificate of Coverage

INSURED NAMED ON DECLARATIONS PAGE:

ADDRESS:

TYPE OF COVERAGE: Claims Made - Professional Liability

POLICY NUMBER:

CARRIER: Medicus Insurance Company

POLICY PERIOD:

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This certificate is not an insurance policy and does not amend, extend or alter the coverage afforded by the policy referenced herein. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by policy described herein is subject to all the terms, exclusions and conditions of such policy. The policy referenced herein is a Physicians and Surgeons Liability Insurance Policy. It covers professional liability only.

<u>Name</u>	<u>Limit of Liability</u>	<u>Specialty</u>	<u>Retro Date</u>
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Physicians and Surgeons Liability Insurance – Certificate of Coverage

Should the above described policy be cancelled, or the terms or conditions changed, Medicus Insurance Company is under no obligation or liability of any kind to notify the Certificate Holder.

CERTIFICATE HOLDER:

Authorized Representative

Date Document Produced:

SERFF Tracking Number: MEIC-125877924 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-110508-IF FORM
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Form Filing/AR-110508-IF Form

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MEIC-125877924 State: Arkansas
Filing Company: Medicus Insurance Company State Tracking Number: #? \$?
Company Tracking Number: AR-110508-IF FORM
TOI: 11.1 Medical Malpractice - Claims Made Only Sub-TOI: 11.1000 Med Mal Sub-TOI Combinations
Product Name: Medical Professional Liability Insurance
Project Name/Number: Initial Form Filing/AR-110508-IF Form

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty **Review Status:** Approved 11/13/2008

Comments:

Attachment:

AR Transmittal.pdf

Satisfied -Name: Self Certification **Review Status:** Approved 11/13/2008

Comments:

Attachment:

Form certification.pdf

Property & Casualty Transmittal Document

<p>1. Reserved for Insurance Dept. Use Only</p>	<p>2. Insurance Department Use only</p> <p>a. Date the filing is received:</p> <p>b. Analyst:</p> <p>c. Disposition:</p> <p>d. Date of disposition of the filing:</p> <p>e. Effective date of filing:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">New Business</td> <td style="width: 50%;"></td> </tr> <tr> <td>Renewal Business</td> <td></td> </tr> </table> <p>f. State Filing #:</p> <p>g. SERFF Filing #:</p> <p>h. Subject Codes</p>	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #			
Medicus Insurance Holdings, Inc.				
4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Medicus Insurance Company	Texas	12754	20-5623491	2886

5. Company Tracking Number	AR-110508-IF FORM
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Paula Battistelli Medicus Insurance Company 8500 Shoal Creek Blvd Bldg 3, Suite 200 Austin, TX 78757	Regulatory Compliance Coordinator	512-879-5128	877-686-0558	pbattistelli@medicusins.com
7.	Signature of authorized filer		<i>Paula Battistelli</i>		
8.	Please print name of authorized filer		Paula Battistelli		

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	11.000 – Medical Malpractice Insurance
10. Sub-Type of Insurance (Sub-TOI)	11.000 – Physicians & Surgeons Medical Liability
11. State Specific Product code(s) (if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	Deductible Credits for Physicians & Surgeons
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: On approval Renewal: On approval
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1. This filing transmittal is part of Company Tracking #		AR-110508-IF Form			
2. This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)					
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Certificate of Insurance	NA 10/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
02	Declarations Page	002 11/02/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
03	Application	MD-App 09/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
04	Policy	001 1/25/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
05	Additional Professional Office Locations	A001 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
06	Amend Professional Office Location	A002 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
07	Amend Policy Date	A003 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
08	Amend Limits of Liability	A004 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
09	Amend Insured Name on Declarations Page	A005 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
10	Additional Insured	A006 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
11	Non-Physician Healthcare Providers (Shared Limits of Liability)	A007 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
12	Change of Rate	A008 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
13	Change of Specialty	A009 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
14	Locum Tenens	A010 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
15	Deletion of Locum Tenens	A011 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA

16	Exclusion of Outside Practice	A012 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
17	Exclusion of Procedure	A013 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
18	Medical Director Coverage-Limited	A014 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
19	Limited Coverage to Specific Employment	A015 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
20	Suspension of Insurance	A016 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
21	Deletion of Suspension of Insurance	A017 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
22	Deductible Endorsement	A018 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
23	Cancellation Endorsement	A019 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
24	Inclusion of Procedures	A020 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
25	Former Insured Coverage	A021 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
26	Slot Coverage	A023 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
27	Cancel Additional Insured Slot Position	A024 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
28	Extended Reporting Endorsement	A025 05/2007	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
29	Insured Entity Shared Limit	A026 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
30	Insured Entity Separate Limit	A027 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
31	Schedule of Physicians	A028 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
32	Non-Physician Healthcare Providers Endorsement (Separate Limits of Liability)	A029 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
33	Lower Limits of Liability for Prior Acts	A030 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
34	Change of Sole Agent	A031 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement	NA	NA

			<input type="checkbox"/> Withdrawn		
35	Exclusion of Services to Obstetrical Patients	A032 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
36	Liability Exclusion- Public Health Officer	A033 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
37	Amend Limits of Liability	A034 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
38	Excluded Persons or Entitites	A035 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
39	Coverage for Charitable Services	A036 10/22/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
40	Nuclear Energy Liability Exclusion	A041 10/24/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
41	Amend Reporting of Medical Incident	A042 2006	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
42	Amend Retroactive Date	A043 2006	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
43	Delete Insured	A044 2006	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
44	Amend Policy Territory Limitation of Coverage	A045 2006	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
45	Cancel Policy	A046 03/01/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
46	Vicarious Liability Coverage for Entity	A049 06/06/07	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
47	Definition of Limits of Liability Endorsement	A058 05/20/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA
48	Arkansas Amendatory Endorsement	AR A060 10/08	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	NA	NA

PC FFS-1

