Medical Professional Liability Insurance Application/Power of Attorney

Reciprocal Attorney-in-Fact, Inc. (RAF) for
the New Jersey Physicians United Reciprocal Exchange

To the Applicant

Currently, NJ PURE offers two options for medical professional liability insurance:

Claims-Made Option: The Claims-Made Option is designed to cover claims made against you during the policy period, so long as the medical incident that gives rise to the claim occurs on or after the retroactive date. There is no coverage for claims that may be made against you after cancellation or nonrenewal, unless you either purchase or otherwise qualify for a free extended reporting period endorsement under the terms stated in the policy.*

Occurrence-Evergreen Plan Option: This option includes extended reporting (or "tail") coverage and affords an unlimited period of time to report covered claims that result from medical incidents that occur while your policy with NJ PURE is in effect.*

These descriptions are intended as a general guide and do not serve to modify or supercede language contained in the insurance policy in any way. Feel free to call NJ PURE for more information or to request a specimen policy form.

The limits of insurance available under this program are:

$1,000,000 each medical incident; $3,000,000 aggregate.

This insurance applies only to claims that result from professional services provided in the state of New Jersey.

Checklist of Items Needed

- ❑ Copy of CV
- ❑ Copies of all certifications
- ❑ Copies of license
- ❑ Detailed narratives for claims
- ❑ Updated claim history reports from all carriers within the last ten years
- ❑ If question #56 is answered yes, a copy of dec page

Fold and tear along perforated line to remove stub.

General Information

1. Name of Applicant: ______________________ 2. Gender: ❑ Male ❑ Female

3. Degree: ______________________ Title (if applicable): ______________________

4. Requested Coverage: ❑ Claims-Made **OR** ❑ Occurrence-Evergreen Plan 5. Requested Effective Date: ____/____/____

6. Office Street Address: ______________________

7. City/State/Zip Code: ______________________

8. Mailing Address (if different): ______________________

9. Office Phone: (____) __________ 10. Fax:* (____) __________ 11. E-Mail: __________

12. Web Site: __________ 13. Soc. Sec. No.: ___-__-____ 14. Date of Birth: ____/____/____

15. Contact Person and Title: ______________________ 16. Phone: (____) __________

*In providing a fax number, applicant agrees to receive information from NJ PURE about its products and services via facsimile.

Professional Education and Training

	Name and Location of School and/or Hospital	Degree and/or Specialty	Completion Date (or Expected)
17. Medical School:			
18. Internship:			
19. Residency:			
20. Residency:			
21. Fellowship:			

22. If you attended a foreign medical school, are you certified by the Educational Council for Foreign Medical Graduates? ❑ Yes ❑ No

23. How many total continuing education credits (CME's) achieved in the past 3 years? __________

Please provide your Curriculum Vital (CV).

Certification

24. Have you ever been denied Board Certification? If yes, please explain on Page 9. ❑ Yes ❑ No

25. Are you Board eligible? ❑ Yes ❑ No If yes, are you in the exam process? ❑ Yes ❑ No

26. Are you Board certified by a member-board of the American Board of Medical Specialties or Osteopathic Specialties? ❑ Yes ❑ No

27. Name of Specialty Board: ______________________

28. Date Certified: ____/____/____ 29. Latest Recertification Date: ____/____/____

30. If dual or subspecialty certified, name of Specialty Board: ______________________

31. Date Certified: ____/____/____ 32. Latest Recertification Date: ____/____/____

Please provide a copy of all your Board Certificates.

Fold and tear along perforated line to remove stub.

Licensure

33. New Jersey License No.: ____________________ 34. Expiration Date: ____/____/____

35. D.E.A. Registration No.: ____________________ 36. Expiration Date: ____/____/____

37. C.D.S. No.: ____________________ 38. Expiration Date: ____/____/____

39. List all states in which you are currently licensed (or have been licensed in the past), and specify licensure status for each state.

40. Has your medical license in any state ever been suspended, revoked, denied, restricted, limited or voluntarily surrendered (or do you currently have matters on appeal or under review)? If yes, explain on Page 9. ❑ Yes ❑ No

41a. Are you currently under investigation (or have you ever been under investigation) by any state licensing board or agency? If yes, explain on Page 9. ❑ Yes ❑ No

41b. Have you ever had any disciplinary action rendered against you by any state licensing board or agency, or have any decisions been made by the Board of Medical Examiners on appeal? If yes, explain on Page 9. ❑ Yes ❑ No

Please provide copies of your current licenses.

Hospital Privileges

42. Please indicate the name and location (city and state) of each hospital where you now hold staff privileges:

43. Has any hospital ever taken action to deny, suspend, revoke, or restrict your medical staff privileges or your application or reapplication for medical staff privileges (or do you currently have matters under appeal or review)? If yes, identify hospital, date, and reasons on Page 9. ❑ Yes ❑ No

44. Have you ever resigned from a hospital staff while under investigation? If yes, identify hospital, date, and reasons on Page 9. ❑ Yes ❑ No

Coverage History

Note: You must list ALL prior carriers from the last ten years. Please list in reverse chronological order, beginning with the most recent or current carrier. If your policy type has changed (even while insured with the same carrier), you must indicate that as well. If you need additional room, please continue on Page 9.

Insurance Company Name	Specify Years Covered (Mo./Yr. to Mo./Yr.)	Policy Type(s)	Retroactive Date

45a. If your previous policy was claims-made, did you, or are you planning to, obtain an extended reporting period ("tail") endorsement? ❑ Yes ❑ No

45b. Do you wish to obtain coverage from NJ PURE for medical incidents that occur prior to your requested effective date with NJ PURE? ❑ Yes ❑ No

46. Have you ever practiced as a physician without professional liability insurance? If yes, give dates and reasons on Page 9. ❑ Yes ❑ No

47. Has your professional liability insurance ever been cancelled or nonrenewed (other than at your request) or has your application for professional liability insurance ever been declined? If yes, give dates and reasons on Page 9. ❑ Yes ❑ No

Current Practice

48a. Under what business/organization/group name do you practice? ____________________

48b. Business/organization/group type (check one): ❑ Solo unincorporated ❑ Shareholder & employee in a professional corporation ❑ Solo professional corporation ❑ Partner (in a professional partnership) ❑ Employee or contractor

48c. Would you like to list this legal entity as an additional insured on your policy which shares your limits of liability? ❑ Yes ❑ No

49. Practice Profile: Please indicate the average number per week (if applicable):

__________ Practice Hours (total hours) __________ Patient Visits (office, hospital, etc.)

__________ Surgeries (Minor) - in hospital. Any minor operation performed under local anesthesia.

__________ Surgeries (Minor) - in office or other nonhospital facility. Any minor operation performed under local anesthesia.

__________ Surgeries (Major) - in hospital or other facility. Any operation performed under general anesthesia.

50. In the past 10 years, have you ever filed for bankruptcy? ❑ Yes ❑ No

51. Do you provide any medical services over the Internet? If yes, please explain on Page 9. ❑ Yes ❑ No

52. Does your principal medical or surgical practice involve working for (or within) a correctional facility? ❑ Yes ❑ No

53a. Do you hold any positions outside of your principal medical or surgical practice (e.g., part-time in an E.R.; part-time at a correctional facility, clinic or nursing home; work at an HMO or other managed care or insurance company; work as a medical director, etc.)? ❑ Yes ❑ No

53b. If so, please list other positions and facilities. (Mail will be sent to office street address listed in "General Information" section.)

	Location	Position	Employer/Facility Name	Street	City/State/Zip	County	Phone
1.							
2.							
3.							

54. Please indicate total hours worked per week and per month at each office location (#1–3, as designated in the chart above) for the listed activities:

ACTIVITY	LOCATION #1 (from table above)	LOCATION #2 (from table above)	LOCATION #3 (from table above)
Administrative Duties	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:
Direct Patient Care (includes hospital rounds) and Record Keeping	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:
Surgeries and Assists	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:
House Calls and External Facility Visits (i.e., nursing homes)	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:
Utilization Review	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:
Teaching	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:	Hrs. Per Week: Hrs. Per Month:

55a. Are you now covered by any malpractice insurance or indemnity agreement that (in the event you are approved for coverage with NJ PURE) will provide additional or alternative coverage even after your policy with NJ PURE becomes effective? ❑ Yes ❑ No

55b. If yes, please describe or list on Page 9 the company for which you provide professional services, your title, the hours worked, and the company location. Please attach a copy of the declarations page for the position you have referenced in this question.

56. Have you ever been convicted of a crime (other than a minor traffic violation)? If yes, explain in detail on Page 9. ❑Yes ❑No

57. Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or can affect your ability to practice medicine or surgery? If yes, explain on Page 9. ❑ Yes ❑ No

58. Do you currently practice, or plan to practice, medicine or surgery outside the state of New Jersey?
If yes, explain in detail on Page 9. (Note: NJ PURE provides professional liability insurance coverage for claims that result from professional services provided in the state of New Jersey only). ❑ Yes ❑ No

59. In the past 5 years, has your principal practice been outside the state of New Jersey? If yes, explain in detail on Page 9. ❑ Yes ❑ No

Employees

60. Do you employ or contract with any physician, surgeon, nurse anesthetist, nurse-midwife, nurse-practitioner, physician's assistant, or pharmacist? ❑ Yes ❑ No

61. If yes, provide the following information for each. (Use Page 9 if you need more space.)

Name	Designation	Name of Current Insurer	Current Policy Number	Is NJ PURE Coverage Desired?*
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

*Requires a separate application.

62. Number of other employees (R.N.s, L.P.N.s, Medical Assistants, etc.): ____________

63. How many employees have left your practice in the past three years (either voluntarily or involuntarily)? ____________

Specialty Classification

64. Please check which **ONE** of the following best describes your practice:

- ❑ Administrative Medicine
- ❑ Allergy/Immunology
- ❑ Anesthesiology
- ❑ Bariatrics
- ❑ Cardiology
- ❑ Cardiovascular Surgery
- ❑ Colon & Rectal Surgery
- ❑ Dermatology
- ❑ Emergency Medicine
- ❑ Endocrinology
- ❑ Family Practice
- ❑ Family Practice/Obstetrics
- ❑ Forensic Medicine
- ❑ Gastroenterology
- ❑ General Practice
- ❑ General Surgery
- ❑ Geriatrics
- ❑ Gynecology
- ❑ Gynecology/No Major Surgery
- ❑ Hematology/Oncology
- ❑ Infectious Disease
- ❑ Internal Medicine
- ❑ Neonatology
- ❑ Nephrology
- ❑ Neurological Surgery
- ❑ Neurology
- ❑ Nuclear Medicine
- ❑ Obstetrics & Gynecology
- ❑ Ophthalmology/No Surgery
- ❑ Ophthalmology/Surgery
- ❑ Orthopedics
- ❑ Orthopedics/No Major Surgery
- ❑ Otolaryngology
- ❑ Otolaryngology/No Major Surgery
- ❑ Pain Management
- ❑ Pathology
- ❑ Pediatrics
- ❑ Physical Medicine & Rehabilitation
- ❑ Preventive/Occupational Medicine
- ❑ Psychiatry
- ❑ Public Health
- ❑ Plastic Surgery
- ❑ Pulmonary Medicine
- ❑ Radiology
- ❑ Surgical Assisting
- ❑ Thoracic Surgery
- ❑ Urology
- ❑ Urology/No Major Surgery
- ❑ Vascular
- ❑ Other (please identify):

Medical and Surgical Procedures

65. Please check off "Yes" or "No" for each of the following procedures or activities to indicate which, if any, you perform or engage in. Indicate the number you performed in the past year and also indicate below if you anticipate any significant changes for the coming year. Please provide details for any 'Yes' response on Page 9 (supplemental application form may be required).

All Specialties

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Obstetrical deliveries
❑ Yes ❑ No			Prenatal and/or postpartum care
❑ Yes ❑ No			Any procedure using any type of fiber-optic scope
❑ Yes ❑ No			Any invasive procedure (incision, excision, puncture, tap, etc.) of any organ, including the skin
❑ Yes ❑ No			Any procedure involving withdrawal by needle of bodily fluids (other than blood products), such as amniocentesis, lumbar puncture, abdominal tap, etc.
❑ Yes ❑ No			Biopsy of any type (excisional or needle)
❑ Yes ❑ No			Catheterization (other than urethral)
❑ Yes ❑ No			Cervical/vaginal smears
❑ Yes ❑ No			Hair transplants and/or restorations
❑ Yes ❑ No			Any procedure involving injection and/or diagnosis using any radiopaque contrast material
❑ Yes ❑ No			Any imaging procedure that you perform and/or results that you interpret (X-ray, mammogram)
❑ Yes ❑ No			Laser therapy or surgery; laser hair removal
❑ Yes ❑ No			Polyp removal
❑ Yes ❑ No			Dialysis therapy (hemodialysis or peritoneal dialysis)
❑ Yes ❑ No			Liposuction
❑ Yes ❑ No			Cosmetic procedures (Botox, thread lifts, mesotherapy, etc.) (If yes, you also need to complete the Cosmetic Supplemental Application.)
❑ Yes ❑ No			Diabetes management
❑ Yes ❑ No			Electrocardiography, echocardiography, cardiac stress tests or implantation of any pacemaker
❑ Yes ❑ No			Participate in clinical trials for any drug company or for any organization acting on behalf of any drug company
❑ Yes ❑ No			Assist at any major surgical procedure as first assistant (making incisions, excising or handling organs, etc.)
❑ Yes ❑ No			Assist at surgery other than as first assistant
❑ Yes ❑ No			Any procedure not typical to the specialty in which you received your residency or fellowship training
❑ Yes ❑ No			Teach, proctor or supervise medical students, residents or fellows (indicate the # of hours per week):
❑ Yes ❑ No			Teach, proctor or supervise other students (e.g. nurse-practitioners)
❑ Yes ❑ No			Do you participate in clinical care? (Where? ________________)
❑ Yes ❑ No			Do you participate in charity care? (Where? ________________)
❑ Yes ❑ No			Do you perform any on call services? (Where? ________________)
❑ Yes ❑ No			Do you perform physicals for school or work? (Where? ________________)
❑ Yes ❑ No			Do you perform drug testing? (Where? ________________)
❑ Yes ❑ No			Do you perform independent medical examinations? (Where? ________________)
❑ Yes ❑ No			Does your practice involve the use of Human Growth Hormone TX?

Obstetrics & Gynecology

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Obstetrical deliveries
❑ Yes ❑ No			Vacuum extraction/forceps
❑ Yes ❑ No			Vaginal birth after Cesarean delivery
❑ Yes ❑ No			Termination of pregnancies within the first trimester
❑ Yes ❑ No			Termination of pregnancies after the first trimester
❑ Yes ❑ No			Termination of pregnancies (or any invasive or surgical procedure) in a nonhospital setting (indicate type and number of procedures and location where performed)
❑ Yes ❑ No			Invitro fertilization, if yes, how long do you follow the patient once pregnancy is confirmed? ____
❑ Yes ❑ No			If you perform mammography (or other methods of imaging), are these reviewed by a radiologist?
❑ Yes ❑ No			Any surgical procedure outside the scope of your training in obstetrics and gynecology
❑ Yes ❑ No			If you practice primarily as a perinatologist, do you assume control of the patient's progress, including follow-up care, or do you act solely as a consultant?

Medical and Surgical Procedures

Surgery

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Breast surgery (excision of tumors, etc.)
❑ Yes ❑ No			Bariatric surgery (If yes, you also need to complete the Bariatric Supplemental Application.)
❑ Yes ❑ No			Cosmetic procedures (liposuction, abdominoplasty, rhinoplasty, breast reduction or augmentation, etc.) (If yes, you also need to complete the Cosmetic Supplemental Application.)
❑ Yes ❑ No			Any surgical procedure performed in a nonhospital setting
❑ Yes ❑ No			Any nonhospital procedure using anesthesia (other than local)
❑ Yes ❑ No			Any laparoscopic procedure (Please explain on page 9.)
❑ Yes ❑ No			Any laser procedure (Please explain on page 9.)
❑ Yes ❑ No			Vascular or peripheral vascular surgery
❑ Yes ❑ No			Transplant surgery (lung, kidney, liver, heart, etc.)
❑ Yes ❑ No			Any orthopedic procedures
❑ Yes ❑ No			Any obstetrical or gynecological procedures including, but not limited to, termination of pregnancies, etc.
❑ Yes ❑ No			Any surgical procedure or medical treatment not typical to your specialty training

Orthopedics

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Spine surgery
❑ Yes ❑ No			Microsurgical procedures
❑ Yes ❑ No			Hip replacement surgery
❑ Yes ❑ No			Any surgical procedure or medical treatment not typical to your specialty training

Weight Reduction/Control

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Weight reduction/control emphasizing/utilizing dietary means (food and/or vitamin supplements)
❑ Yes ❑ No			Weight reduction/control utilizing surgery/surgical means
❑ Yes ❑ No			Weight reduction/control via injections
❑ Yes ❑ No			Weight reduction/control utilizing drugs or through the prescription of drugs
❑ Yes ❑ No			Any surgical procedure or medical treatment not typical to your specialty training

Homeopathy

Check One	# Patients in Past Year	Expected Changes?	Procedure/Activity
❑ Yes ❑ No			Does your practice include homeopathy? (If so, please list percentage of practice devoted to homeopathy__________ %)
❑ Yes ❑ No			Do you produce, distribute, and/or recommend homeopathic products related to treatment? (Please explain on page 9.)

Claims History

THIS SECTION SHOULD NOT BE LEFT BLANK. Please list all claims that are pending, closed with payments, and closed without payments. You may attach whatever **ADDITIONAL** information you would like us to consider. Any missing information will prevent approval of your application.

66. To your knowledge and upon inquiry, are you aware of any claim, adverse outcome, incident or other circumstance (including requests for medical records) that might result in a claim or suit? ❑ Yes ❑ No

67. Enter the total number of claims made against you in the past 10 years: ________________________________

68. List each claim below. For each claim, you must complete the "Supplemental Claim Information" page before your application may be approved. Also obtain current loss history statements from each of your previous insurers and forward them to us.

Claim No.	Patient INITIALS*	Insurance Company	Date of Medical Incident	Date Reported	Date Closed	Claim Amount Paid (on your behalf)
1.						
2.						
3.						
4.						
5.						

If you had any more claims in the past 10 years, provide the requested information for each on Page 9.
*Do NOT disclose patient's name or other specifically identifying patient information.

Supplemental Claim Information

The following information is required to properly understand your prior claims experience and to process your application. Absence of any information will delay the processing of your request. Please respond to each of the questions. One form should be completed for each claim or suit. **(You may photocopy the form and attach the additional copies.)**

CLAIM NO. (from the "Claims History" section of the NJ PURE application): ____________________

1a. Gender of patient/plaintiff who filed the claim or suit: __________ 1b. The approximate age at the date of incident: __________

2. Beginning and ending date(s) of **all** treatment rendered **by you to this patient**: ____/____/____ to ____/____/____

3. **Exact date(s)** of treatment that the patient alleges you deviated from the standard of care: ____/____/____

4. Date the claim or suit was made against you: ____/____/____

5. Your diagnosis for which **you** were treating patient: ____________________

6. If you performed surgery on the patient, please indicate: ____________________

   Name of the surgical procedure: ____________________ Date of Surgery ____/____/____

7. Regardless of validity or merit, what was the specific **allegation** made against you as to your deviation?

____

____

8. Regardless of merit or validity, what **physical damages or complication(s)** did the patient claim as a result of your care or treatment?

____

____

9a. Claim or Suit? ❑ Claim ❑ Suit

9b. Claim or Suit is presently: ❑ Open ❑ Closed

10. State and county in which the claim or suit is/was filed: ____________________

11. If closed, what date was the claim or suit closed? ____/____/____

12. Amount of payment on your behalf **(ONLY on your behalf)**: $ ____________________

13. Name of insurance carrier making the payment on your behalf? ____________________

14. Was the payment made by: ❑ Settlement prior to trial ❑ During trial ❑ Jury verdict?

15. If we have further questions, would you be willing to meet with representatives of NJ PURE to discuss this case? ❑ Yes ❑ No (OR you may contact us and make an appointment to speak with our underwriting department. We may be reached at 1.877.265.7873.)

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Additional Information and Explanation

You may use this page to provide requested additional details about any item in the application to which you provided a "Yes" answer.

Question No.	Details

Please attach additional pages as necessary to complete your responses. Thank you.

NJ PURE Power of Attorney

1. The undersigned subscriber HEREBY offers to exchange reciprocal insurance contracts with other subscribers at the New Jersey Physicians United Reciprocal Exchange (NJ PURE, hereinafter called the "Exchange"), organized pursuant to N.J.S.A.17:50-1 et seq., and hereby appoints Reciprocal Attorney-in-Fact, Inc. (RAF), a New Jersey corporation, as Attorney-in-Fact, through whom to exchange reciprocal insurance contracts with others in the name of the Exchange. The location of the office of the Attorney-in-Fact for the Exchange is Princeton, New Jersey, but may be changed by the Attorney-in-Fact upon notice to the subscriber and in compliance with any requirements of the Secretary of State and the Department of Banking & Insurance.

2. Subscriber understands and agrees that the reciprocal insurance contracts to be exchanged hereunder are nonassessable as provided for in N.J.S.A. 17:50-7 and that the Exchange shall have at the time of the issuance of a reciprocal insurance contract to subscriber, and shall thereafter maintain, a surplus of at least $2 million.

3. Subscriber agrees to pay in addition to premiums, an amount equal to the subscriber's annual Claims-Made premium for the first year of membership, and an amount, as required by the Exchange, of up to 10% of the total premium for the second through the sixth year of membership, as surplus contributions, for the benefit and protection of all subscribers. Return of surplus can occur only after withdrawal from the Exchange and only with the approval of the Attorney-in-Fact and the Commissioner of Banking and Insurance. In any event, such return cannot be authorized prior to the satisfaction of the surplus requirements of the Exchange valued at the year-end valuation of assets and reserves following the settlement of claims related the policy years during which the subscriber remained a policyholder.

4. Subscriber agrees to pay Attorney-in-Fact an "organizational charge" equal to 1% of subscriber's total annual premium during each of subscriber's first two years of membership in the Exchange. Such amounts shall be used initially to pay the start-up charge of the Attorney-in-Fact for its services in forming, conducting initial solicitation, and obtaining a license for the Exchange. After the Attorney-in-Fact has received full payment of the start-up charge plus accrued interest it will credit all subsequently paid "organizational charges" to the surplus account of the Exchange for the benefit of all policyholders.

5. Subscriber authorizes Attorney-in-Fact, on subscriber's behalf, to issue, effect, modify and terminate reciprocal insurance contracts containing such terms and conditions as Attorney-in-Fact deems suitable for the purpose of exchanging with other subscribers any and all kinds of reciprocal insurance contracts for which the Exchange is authorized by law; to perform solicitation, underwriting, classification and rating of reciprocal insurance contracts; to collect monies due; to manage, invest and reinvest the funds of Exchange; to borrow money in the name of the Exchange; to give, waive or receive all notices and proofs of loss; to settle losses and claims; to effect reinsurance; to accept and authorize others to accept services of process and appear in behalf of subscriber in any suits, actions, or proceedings; to perform every lawful and appropriate act not herein specified that the subscriber or subscribers could individually or collectively perform in relation to contracts herein authorized; to enter into contracts with other corporations, individuals, or partnerships to perform one or more of the duties set forth above, such as, but not limited to, marketing and solicitation, claims handling, actuarial services, investment counseling; and to have such other powers and duties as are or may be required to properly and efficiently manage the affairs of the Exchange and to act on behalf of the subscriber.

6. Subscriber specifically authorizes the Attorney-in-Fact to act in subscriber's behalf and as the representative of subscriber in concert with all other subscribers, in any legal matter including any class actions which directly or individually involve matters of insurance or finance that have or may have, in the opinion of the Attorney-in-Fact, an adverse effect on the Exchange and constitutes an appropriate action for the benefit of the Exchange. Subscriber agrees that the costs of any such action shall be paid in full by the Exchange.

7. Subscriber authorizes Attorney-in-Fact, at its sole discretion, to return, or accrue for the benefit of each subscriber, savings realized from the exchange of contracts and the management of the Exchange and its funds and, for the purpose of apportioning savings between subscribers, Attorney-in-Fact shall divide subscribers by kinds of contracts exchanged.

8. Subscriber authorizes payment of an amount not exceeding 12.5% of total annual gross written premiums as compensation to RAF to be the Attorney-in-Fact for the subscribers of the Exchange and to perform the overall management functions necessary to effect the exchange of reciprocal insurance contracts among subscribers including the provision, at the attorney's sole cost, of officers and senior managers of the attorney, to act on behalf of the subscribers of the Exchange for functions such as marketing and solicitation, underwriting, claims handling, internal legal and financial accounting, and regulatory compliance.

9. Subscriber authorizes Attorney-in-Fact to use the remaining portion of premium deposits and investment income derived from the funds of the Exchange (a) to establish loss and unearned premium reserves; (b) to pay losses and loss adjustment expenses; (c) to pay costs required for reinsurance premiums and expenses; fees for legal, actuarial, accounting and other consulting services; investment expenses; taxes; license fees and other fees; membership fees and costs of services of rating bureaus and trade associations; costs of bonding as required; costs of independent audits and regulatory examinations; costs of assessments for the Guaranty Fund, or any other charges imposed by any regulatory or government agency of New Jersey or of the United States; for support services necessary for the functions identified in paragraph 8, and such other costs as may be necessary for the proper and efficient operation of the Exchange; and (d) together with paid-in surplus contributions, to maintain required surplus levels for the Exchange.

10. Subscriber understands and agrees that subscriber's liability incurred hereunder shall be individual and several, and shall not be joint.

11. Subscriber agrees that no officer or advisor of the Attorney-in-Fact shall be personally liable to the Exchange or its subscribers for any breach of duty owed to the Exchange or its subscribers, provided however that this provision shall not relieve an officer or advisor from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to the Exchange and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers and advisors of the Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above. Subscriber is aware and agrees that the purpose of this provision is to give to such officers and advisors the same protection afforded by statute to officers and directors of for-profit corporations, not-for-profit corporations, banks, savings and loans and insurance companies domiciled in the State of New Jersey.

12. Subscriber agrees that this Power of Attorney is expressly limited to the uses and purposes herein expressed and to no other. This Power of Attorney shall remain in full force and effect, so long as the subscriber remains a member in good standing of the Exchange, unless and until a modified form is required by the Attorney-in-Fact and executed by subscriber. The power of attorney may be terminated by subscriber, or by the Attorney-in-Fact, by the termination of all reciprocal insurance contracts of the subscriber to which this power of attorney applies, subject to the provisions of N.J.S.A. 17:50-1 et seq. and of the reciprocal insurance contracts exchanged. The subscriber's obligations under this power of attorney shall survive the termination of this power of attorney until any and all claims involving the reciprocal insurance contracts of the subscriber and any and all other matters existing between the subscriber and the Exchange, or with third parties have been settled or satisfied. This power of attorney is considered to be coupled with an interest.

Subscriber/Applicant's Statement and Signature

I hereby agree to the provisions of the foregoing Power of Attorney, which shall take effect and bind me only if and when my application is accepted and I become a subscriber of New Jersey Physicians United Reciprocal Exchange (NJ PURE).

I hereby declare that the statements on this application are true and request NJ PURE to issue the reciprocal insurance contract applied for in reliance thereon and at rates based on these facts.

I authorize the release and exchange of any information regarding my medical training, claim history, hospital privileges, professional status, and other matters related to the insurance herein applied for by or between any hospital, medical school, insurance company, agent or broker, licensing or regulatory authority or any professional association, society, or specialty board of which I am or have been a member, and NJ PURE. I agree to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

I understand that the Exchange reserves the right to reject any application that does not meet its membership and underwriting requirements, and that I may be asked to furnish additional information as necessary to determine my eligibility for coverage and my applicable premium charge. No coverage exists until the initial premium is received and a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

I acknowledge that I have been informed by NJ PURE representatives that the submission of complete and accurate application information to NJ PURE is necessary for proper underwriting and rating of my application. I further acknowledge that the completeness and accuracy of this information is of the essence for the exchange of reciprocal insurance contracts to be effective. I understand and agree that any material misrepresentation or omission by me in this application will void coverage from the inception date of the contract.

I understand that any person who files an application for insurance or a statement of claim containing any materially false information or conceals information concerning any fact material thereto, commits a fraudulent insurance act, and is subject to criminal and civil penalties.

______________________________	______________________________	____/____/____
Subscriber/Applicant (Please Print)	Signature	Date

NOTICE: All questions asked and answered on this application form are deemed to be ongoing. If any of the information should change, it is your affirmative responsibility to notify NJ PURE of the changes within 15 working days.

Addendum to NJ PURE Power of Attorney regarding Surplus Contribution

First Year Surplus Contribution to Be Paid in Two Annual Installments

This addendum need be executed only if the subscriber wishes to pay the first year's surplus contribution in two annual installments.

Applicant/Subscriber:

The applicant/subscriber agrees to pay the first year's surplus contribution, an amount equal to the subscriber's annual claims-made premium for the first year of membership (as described in paragraph 3 of the NJ PURE Power of Attorney executed by the subscriber), and further agrees to pay that amount in two annual installments.

The payment of the first year's surplus contribution will be paid as follows: 75% of the first year's surplus contribution in the first year and the remaining 25% of the first year's surplus contribution in the second year.

If, for any reason the subscriber's membership with the Exchange were terminated prior to the full payment of the first year surplus contribution, the full amount of the first year surplus contribution would be considered due at the time of termination.

Signature ______________________________

Date: ____/____/______________________________

Addendum to NJ PURE Power of Attorney

ASSIGNMENT OF ANY RETURNS

(Refund of Premium and/or Surplus Contribution and Return of Savings Realized by the Exchange, If Any)

This section should only be completed if the premium and surplus contribution is paid by someone other than the Applicant/Subscriber.

Name of Payor: ______________________________

(Employer or other person or entity to whom any refund and/or return of savings realized by NJ PURE should be made payable)

The undersigned Payor and Applicant/Subscriber acknowledge that: (i) the Payor is the person solely responsible for the payment of the premiums and the surplus contributions for the Applicant/ Subscriber's insurance policy applied for and any renewal or replacement of it, and (ii) the Applicant/Subscriber is the only named insured under such insurance policy and any renewal or replacement.

The Applicant/Subscriber hereby assigns to Payor any and all rights to receive any refund of premium and surplus contribution and any return of savings realized by NJ PURE as described in section 7 of the NJ PURE Power of Attorney, related to such insurance policy, all in accordance with the terms of the NJ PURE Power of Attorney.

The Applicant/Subscriber appoints Payor or Payor's successors or assigns as Applicant/Subscriber's attorney-in-fact for purposes of this addendum, with authority to cancel the insurance policy applied for. The Applicant/Subscriber also consents to NJ PURE providing Payor any documents or instruments concerning the insurance policy.

No other interest in the insurance policy herein applied for may be assigned without the prior written consent of NJ PURE.

This addendum will remain in effect unless both Payor and Applicant/Subscriber agree in writing to its termination and such agreement is delivered to and accepted by NJ PURE.

Applicant/Subscriber's Signature ______________________________ Date: ____/____/______

Payor's Signature ______________________________ Payor's Tax ID No. ______________________

Accepted by New Jersey Physicians United Reciprocal Exchange

By Its Attorney-in-Fact, Reciprocal Attorney-in-Fact, Inc.:

By: ______________________________ Date: ____/____/______

Reciprocal
Attorney-in-Fact, Inc.
(RAF) for
the New Jersey
Physicians United
Reciprocal Exchange

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