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

Entity Professional Liability Insurance Application

Entity Information

1. Full entity name: ____________________

2. Doing business as (DBA): ____________________

3. Practice address: ____________________

4. Contact person:____________________Title: ____________________

5. Phone number:____________________Fax number:____________________E-mail Address: ____________________

6. Effective date:____________________Retroactive date:____________________Limits of liability: ____________________

7. Does this entity have current coverage? ☐ Yes ☐ No *If yes, complete #8*

8. Current carrier:____________________Current premium: ____________________

Practice Information

9. Primary specialty:____________________Percentage of practice: ____________________

10. Secondary specialty:____________________Percentage of practice: ____________________

11. Degree of surgery: ☐ No Surgery ☐ Minor Surgery ☐ Surgery

12: Number of hour entity is open per week:____________________Number of weekly patient encounters: ____________________

13. Number of healthcare professionals practicing at the entity:____________________Annual Revenue: ____________________

14. Please list all of your employed or contracted healthcare professionals (Please provide application for all providers covered under this policy):

Name:____________________Certification:____________________ Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________ Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

Name:____________________Certification:____________________Requesting coverage: ☐Yes ☐No

15. Are all the above licensed in accordance with state and federal regulations?

☐ Yes ☐No *If no, explain in Remark Section*

16. Does the entity have a medical director requesting coverage?

☐ Yes ☐No Please list name:_

17. Does the entity have a Risk Management or Risk Control program in place?

☐ Yes ☐ No

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

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

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

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

20. Does the entity provide addiction medicine services?

☐ Yes ☐ No

Practice Information (Continued)

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

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

22. Has the entity ever had professional liability insurance declined, nonrenewed, canceled, or restricted, or have you had an involuntary deductible or surcharge assessed against you?

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

23. Has the entity ever been investigated by, entered into any consent agreement with, or have an investigations currently in progress or pending by any state licensing board, board of medical examiners, DEA, or other governmental agency?

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

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

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

Remarks Section

Medical Procedures

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

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

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

_____

Total number of non-surgical procedures performed annually: _____

Total number of surgical procedures performed annually: _____

Please check all procedures that you perform:

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

Cardiology

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

Cosmetic/Plastic Surgery

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

Pain Management

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

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

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

Claim Information

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

1. Name of claimants: _____

2. Age: _____

3. Gender: ☐ Female ☐ Male

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

_____

5. Allegation: _____

_____

6. Date of Incident: _____

7. Location: _____

8. Insurance Carrier(s): _____

9. Other defendants: _____

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

☐ Closed Claim Indemnity Paid: _____ Expense Paid: _____

Date closed: _____ ☐ Settlement ☐ Judgement

11. Conditions and diagnosis at time of incident: _____

_____

_____

_____

_____

12. Dates and description of professional services rendered: _____

_____

_____

_____

_____

13. Condition of patient subsequent to professional services: _____

_____

_____

_____

_____

14. Additional Comments: _____

_____

_____

_____

_____

Disclaimer and Signature

GENERAL FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA FRAUD WARNING: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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

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

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

The person signing this Warranty further represents and warrants to the Company the following:

a. He / She is an authorized agent of the entity(ies) and/or individual(s) seeking insurance from the Company; and

b. He / She is authorized to complete this Warranty on behalf of the entity (ies) and/or individual(s) seeking insurance from the Company.

Signature: _____

Print Name: _____

Title: _____

Date: _____

Statement of No Claims, Losses, Medical Incidents

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

1. The Insured has reviewed, or has had an opportunity to review, the proposed insurance Policy from the Company. All capitalized terms referenced herein shall have the same meaning afforded to them in the Policy.

2. The Insured has conducted a diligent search and investigation as part of completing this Statement of No Claims/Losses/Medical Incidents and represents and warrants to the Company the following:

a. No Claims, Occurrences, Medical Incidents, facts, circumstances, or situations exist that have not been previously reported to the Insured's prior insurance carrier;
b. No requests for medical records have been made to any Insured, which refer to a potential lawsuit, medical malpractice action, pre-suit proceedings, or notice of intent;
c. No requests for medical records have been made to any Insured about which any Insured knew (or should have known) and could have reasonably foreseen that such request might be expected to be the basis of a Claim; and
d. No prior insurance carrier has refused or denied coverage for any Claims made against any Insured for the previous five (5) years.
e. The below questions are answered accurately:

1.) Any patient(s) who died unexpectantly?	☐ Yes	☐ No
2.) Any patient(s) who had a permanent or serious injury?	☐ Yes	☐ No
3.) Any patient(s) who had a birth injury (mother or infant)?	☐ Yes	☐ No
4.) Any patient(s) who had a retained foreign body?	☐ Yes	☐ No
5.) Any patient(s) who had major organ failure?	☐ Yes	☐ No

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

4. The person signing this Statement of No Claims/Losses/Medical Incidents further represents and warrants to the Company the following:

a. He / She is an authorized agent of the entity(ies) and/or individual(s) seeking insurance from the Company; and
b. He / She is authorized to complete this Statement of No Claims/Losses/Medical Incidents on behalf of the entity (ies) and/or individual(s) seeking insurance from the Company.

Signature:_____ Date: _____

Printed _____

Proxy

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

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

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

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

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

Signature

Signature: _____

Print Name: _____

Date: _____

Stock Subscription and Shareholder Agreement

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

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

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

Subscriber Signature

Signature: _____

Print Name: _____

Date: _____

Acceptance

Bold Risk Retention Group, Inc. hereby accepts this Stock Subscription and Shareholder Agreement.

Signature: _____