Preferred Physicians Medical
Risk Retention Group
A Mutual Insurance Company

ANESTHESIOLOGIST APPLICATION PROFESSIONAL LIABILITY INSURANCE

Claims-Made Policy

NOTICE

This application is provided by a risk retention group. A risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for a risk retention group.

IMPORTANT

- Please complete the application in its entirety. We are unable to offer coverage based upon an incomplete application.
- Please print or type your answers.
- Your signature is required on page 8.
- You may explain any special needs not specifically addressed in this application (e.g., part-time status) in the Remarks section on page 8, or you may attach a separate sheet.
- If you are applying for coverage as a locum tenens, please indicate so under item 6 on page 2.
- If you are applying for coverage in conjunction with a change in your employment, practice configuration or location, please complete this application to reflect the situation in your new position or location.

NOTE: If you have any questions about this application please call us. We will be happy to assist you. You may fax this application for review. If you fax an application, please mail the original with the original authorized signature on page 8 for final approval.

Clear Form

PART 1: PERSONAL INFORMATION

1. FIRST NAME | MIDDLE NAME | LAST NAME | DEGREE

2. DATE OF BIRTH (MM / DD / YYYY)

3. SOCIAL SECURITY NO.

4. DRIVER'S LICENSE #(S)

STATE _____ NUMBER _____ STATE _____ NUMBER _____

5. LIST ALL MEDICAL LICENSE NUMBERS (ACTIVE, INACTIVE, EXPIRED OR REVOKED):

STATE _____ NUMBER _____ STATE _____ NUMBER _____

STATE _____ NUMBER _____ STATE _____ NUMBER _____

STATE _____ NUMBER _____ STATE _____ NUMBER _____

6. PRACTICE STATUS (PLEASE DESCRIBE YOUR STATUS AS IT WILL BE WHEN THIS COVERAGE BECOMES EFFECTIVE):

☐ INDIVIDUAL

☐ GROUP PRACTICE MEMBER – GROUP NAME: _____ START DATE: _____ MM / DD / YYYY

☐ I AM A SHAREHOLDER OR PARTNER IN A GROUP PRACTICE CORPORATION OR PARTNERSHIP.

☐ I AM AN EMPLOYEE OF A GROUP PRACTICE IN WHICH I HAVE NO OWNERSHIP.

☐ I AM AN INDEPENDENT CONTRACTOR PRACTICING WITHIN A GROUP PRACTICE.

☐ SOLE OWNER OF A GROUP PRACTICE CORPORATION. GROUP NAME: _____

☐ LOCUM TENENS – REPLACING: _____ FROM: _____ MM / DD / YYYY TO: _____ MM / DD / YYYY

7. DO YOU PRACTICE AS A SOLO P.C. FOR TAX OR BILLING PURPOSES? ☐ YES ☐ NO

IF YES, PLEASE INDICATE:

REGISTERED AGENT _____ T.I.N. _____

8. RESIDENCE ADDRESS

STREET _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ EMAIL _____

9. IF YOU ARE MOVING, WHERE CAN WE REACH YOU PRIOR TO THE EFFECTIVE DATE OF THIS COVERAGE?

☐ SAME BUSINESS ADDRESS AS THE GROUP ☐ OTHER (LIST BELOW)

STREET _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ EMAIL _____

10. BUSINESS ADDRESS – AFTER THIS COVERAGE BECOMES EFFECTIVE, WHERE CAN WE REACH YOU?
GROUP MEMBERS MAY SKIP THIS ITEM UNLESS THEY WILL HAVE A BUSINESS ADDRESS DIFFERENT FROM THE GROUP.

STREET _____ CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ EMAIL _____

ALL APPLICANTS - COMPLETE ITEM 11 ONLY IF POLICY DOCUMENTS AND CORRESPONDENCE OR PREMIUM INVOICES SHOULD BE MAILED TO A LOCATION OTHER THAN THE BUSINESS ADDRESS

11. MAILING ADDRESS FOR:

☐ DOCUMENTS / CORRESPONDENCE _____

☐ PREMIUM INVOICES _____

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PART 2: EDUCATION / TRAINING

IF AVAILABLE, PLEASE ATTACH A CURRENT CURRICULUM VITAE.
YOU MAY SKIP ANY ITEM IN PART 2, PAGE 3, IF THE INFORMATION IS CONTAINED IN YOUR CURRENT CV.

☐ *A CURRENT CURRICULUM VITAE IS ATTACHED.*

12. PLEASE PROVIDE THE COMPLETE NAME OF YOUR MEDICAL TRAINING INSTITUTION OR FACILITY. EXPLAIN ANY GAPS UNDER REMARKS, PAGE 8.

	DATES (MM / YYYY)	TRAINING INSTITUTION AND FACILITY NAME CITY / STATE	GRADUATE YES	GRADUATE NO
MEDICAL SCHOOL				
FROM:			☐	☐
TO:				
FROM:			☐	☐
TO:				
INTERNSHIP				
FROM:				
TO:				
FROM:				
TO:				
RESIDENCY				
FROM:				
TO:				
SPECIALTY:				
FROM:				
TO:				
SPECIALTY:				
FELLOWSHIP				
FROM:				
TO:				
PROGRAM EMPHASIS:				
FROM:				
TO:				
PROGRAM EMPHASIS:				

13. BOARD CERTIFIED STATUS:

☐ BOARD CERTIFIED IN ANESTHESIOLOGY

☐ BOARD ELIGIBLE:

TRADITIONAL EXAMS COMPLETED
- ☐ PART 1 (WRITTEN EXAM)
- ☐ PART 2 (ORAL EXAM)

STAGED EXAMS COMPLETED
- ☐ BASIC EXAM
- ☐ ADVANCED EXAM
- ☐ APPLIED EXAM

SUBSPECIALTY CERTIFICATION COMPLETED:
- ☐ PAIN MANAGEMENT
- ☐ SLEEP MEDICINE
- ☐ CRITICAL CARE MEDICINE
- ☐ PEDIATRIC ANESTHESIOLOGY
- ☐ HOSPICE AND PALLIATIVE MEDICINE

NOT BOARD CERTIFIED OR BOARD ELIGIBLE

14. ARE YOU BOARD CERTIFIED IN ANY OTHER SPECIALTY?

SPECIALTY: _____ CERTIFYING BOARD: _____

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PART 3: PRACTICE DESCRIPTION

15. INDICATE WHAT TYPES OF FACILITIES WILL YOU BE PRACTICING AT WHEN THIS COVERAGE STARTS AND PERCENTAGE AT EACH FACILITY:

_____ % HOSPITAL
_____ % SPECIALTY HOSPITAL
_____ % HOSPITAL-AFFILIATED SURGERY CENTER
_____ % NON HOSPITAL SURGERY CENTER
_____ % FREESTANDING PROCEDURE CENTER
_____ % OFFICE-BASED SURGERY CENTER
_____ % FREESTANDING PAIN CLINIC
_____ % OTHER _____

PLEASE ESTIMATE YOUR PRACTICE BY THE TYPES OF CASES THAT YOU WILL BE DOING WHEN THIS COVERAGE STARTS:

_____ % GENERAL SURGERY
_____ % BARIATRIC
_____ % CARDIOVASCULAR
_____ % CHRONIC PAIN
_____ % CRITICAL CARE
_____ % EMERGENCY / TRAUMA
_____ % GASTROENTEROLOGY
_____ % NEUROSURGERY
_____ % OBSTETRICS / GYNECOLOGY
_____ % OPHTHALMOLOGY
_____ % ORAL SURGERY
_____ % ORTHOPEDIC
_____ % OTOLARYNGOLOGY
_____ % PEDIATRIC
_____ % PLASTIC SURGERY
_____ % PODIATRY
_____ % UROLOGY
_____ % OTHER _____

16. WILL YOU BE PRACTICING MEDICINE OTHER THAN ANESTHESIOLOGY / PAIN MANAGEMENT? ☐ YES ☐ NO

SPECIALTY: _____ % OF TOTAL PRACTICE: _____

17. HAVE YOU PRACTICED PREVIOUSLY IN ANY OTHER SPECIALTY? ☐ YES ☐ NO

SPECIALTY: _____ DATES: _____ (MM / YYYY) TO _____ (MM / YYYY)

18. PRACTICE INFORMATION

a. DO YOU CONDUCT YOUR PRACTICE IN ACCORDANCE WITH ASA STANDARDS FOR BASIC ANESTHETIC MONITORING? ☐ YES ☐ NO

b. DO ALL POST ANESTHESIA CARE LOCATIONS MEET ASA STANDARDS FOR POST ANESTHESIA CARE? ☐ YES ☐ NO

c. IS THE JOINT COMMISSION UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, AND WRONG PERSON SURGERY FOLLOWED AT EACH OF YOUR SURGICAL PRACTICE LOCATIONS? ☐ YES ☐ NO

d. DO YOU USE AN ANESTHESIA-SPECIFIC INFORMED CONSENT AT EACH PRACTICE LOCATION? ☐ YES ☐ NO

e. DO YOU PLACE REGIONAL BLOCKS WHILE THE PATIENT IS UNDER GENERAL ANESTHESIA? ☐ YES ☐ NO

f. DO YOU PARTICIPATE IN VBAC PROCEDURES? ☐ YES ☐ NO

g. DOES YOUR GROUP HAVE PROTOCOL IN PLACE TO PREVENT INTRAOPERATIVE FIRES? ☐ YES ☐ NO

19. a. DO YOU EMPLOY OR SUPERVISE ANY OF THE FOLLOWING PARAMEDICAL PERSONNEL? ☐ YES ☐ NO

	# EMPLOYED	# FACILITY EMPLOYS	# INDEPENDENT CONTRACTORS	NORMAL SUPERVISION RATIO
CRNAS				
PHYSICIAN ASSISTANTS / ANESTHESIA ASSISTANTS				
NURSE PRACTITIONERS				
STUDENT NURSE ANESTHETISTS				
OTHER: _____ (PLEASE SPECIFY)				

b. CHECK ALL APPLICABLE ITEMS REGARDING THE ABOVE PERSONNEL:

☐ YOU NEVER MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS
☐ YOU MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS, BUT NOT WHILE DOING CASES.
☐ YOU MAY MEDICALLY DIRECT OR SUPERVISE CRNAS, PAS OR AAS WHILE DOING CASES.
☐ CRNAS DO CASES WITHOUT SUPERVISION BY AN ANESTHESIOLOGIST.

GROUP MEMBERS APPLYING TOGETHER OR NEW MEMBERS OF AN INSURED GROUP MAY SKIP ITEM 20 BELOW:

20. LIST ALL PHYSICIANS WITH WHOM YOU SHARE CALL OR ARE YOUR EMPLOYEES (INCLUDING INDEPENDENT CONTRACTORS YOU HIRE):

NAME	SHARE CALL	EMPLOYEE	CONTRACTOR
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

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PART 4: PRACTICE LOCATIONS

21. PLEASE PROVIDE PRACTICE LOCATIONS PRIOR TO THE EFFECTIVE DATE OF THIS COVERAGE, OR ATTACH YOUR CURRENT CV. (OTHER THAN YOUR TRAINING LISTED IN PART 2 ON PAGE 3 OR CURRENT PRACTICE LOCATIONS LISTED IN ITEM 22.)

	PRACTICE DATES (MM / YYYY)	FULL FACILITY NAME CITY / STATE
FROM:		
TO:		
FROM:		
TO:		
FROM:		
TO:		
FROM:		
TO:		

22. LIST ALL PRACTICE LOCATIONS YOU WILL HAVE WHEN THIS COVERAGE BEGINS:
(PREFERRED PHYSICIANS MEDICAL WILL SEND CERTIFICATES OF INSURANCE TO EACH FACILITY LISTED, UNLESS YOU DIRECT OTHERWISE.)

FIRST PRACTICE DATE AT THIS LOCATION (MM / DD / YYYY)	% OF CASES	FULL FACILITY NAME MAILING ADDRESS CITY / COUNTY / STATE / ZIP	DON'T SEND CERTIFICATE
			☐
		☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER	
			☐
		☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER	
			☐
		☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER	
			☐
		☐ HOSPITAL ☐ NON-HOSPITAL PAIN CLINIC ☐ NON-HOSPITAL SURGERY CENTER ☐ OFFICE ☐ OTHER	

Clear Form

PART 5: SPECIAL CIRCUMSTANCES / CLAIM INFORMATION

23. SPECIAL CIRCUMSTANCES: (EXPLAIN ALL YES ANSWERS IN REMARKS, PAGE 8.)	YES	NO
a. HAVE YOU EVER BEEN INVESTIGATED, DISCIPLINED, SUSPENDED, RESTRICTED, REVOKED, DENIED RENEWAL OR HAS ANY OTHER ACTION BEEN TAKEN AGAINST YOUR NARCOTICS LICENSE OR YOUR LICENSE TO PRACTICE MEDICINE IN ANY STATE WHETHER VOLUNTARILY AGREED TO OR NOT?	☐	☐
b. HAVE YOU HAD RESTRICTIONS PLACED ON YOUR PRIVILEGES OR RESTRICTIONS PLACED ON THE TYPE OF CASES ASSIGNED TO YOU BY A HOSPITAL, OTHER HEALTHCARE FACILITY, OR PRACTICE ENTITY, OR HAVE YOU EVER BEEN INVESTIGATED FOR PATIENT CARE OR SAFETY REASONS AND FOUND NOT TO HAVE MET THE STANDARD OF CARE?	☐	☐
c. HAVE YOU VOLUNTARILY AGREED TO LIMITATIONS ON YOUR PRIVILEGES OR LIMITATIONS ON THE TYPE OF CASES ASSIGNED TO YOU BY A HOSPITAL, OTHER HEALTHCARE FACILITY, OR A PRACTICE ENTITY?	☐	☐
d. HAVE YOU EVER BEEN DISCIPLINED BY OR HAD MEMBERSHIP OR PARTICIPATION RESTRICTED BY ANY MEDICAL SOCIETY OR HEALTH INSURANCE PLAN OR ORGANIZATION INCLUDING MEDICARE AND MEDICAID PROGRAMS?	☐	☐
e. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR OR HAVE YOU EVER BEEN NAMED AS A DEFENDANT IN A CRIMINAL OR CIVIL TORT CASE OTHER THAN A MEDICAL MALPRACTICE CASE?	☐	☐
f. HAVE YOU EVER HAD; OR HAVE YOU EVER BEEN INVESTIGATED FOR; OR HAVE YOU EVER RECEIVED TREATMENT FOR AN ALCOHOL OR SUBSTANCE ABUSE PROBLEM OR BEEN CONVICTED OF AN ALCOHOL AND/OR DRUG RELATED OFFENSE?	☐	☐
g. HAVE YOU EVER HAD ANY PERSONAL HEALTH PROBLEMS WHICH MIGHT AFFECT YOUR PRACTICE OF MEDICINE; OR HAVE YOU EVER BEEN UNDER PSYCHIATRIC CARE OR TREATED FOR MENTAL ILLNESS?	☐	☐
h. DO YOU ADVERTISE TO THE PUBLIC BY RADIO OR TELEVISION BROADCAST, INTERNET, NEWSPAPER, YELLOW PAGES OR DIRECT MAIL? (PLEASE ENCLOSE COPIES OF ANY MATERIALS USED TO PROMOTE YOUR PRACTICE.)	☐	☐
i. ARE YOU ENGAGED IN ANY MEDICAL MOONLIGHTING ACTIVITY?	☐	☐

24. CLAIM INFORMATION: (EXPLAIN ALL YES ANSWERS BELOW, OR ATTACH A NARRATIVE DESCRIPTION.)	YES	NO
a. HAVE YOU EVER BEEN NOTIFIED EITHER DIRECTLY OR INDIRECTLY OF, OR ARE YOU AWARE OF YOUR INVOLVEMENT IN A MALPRACTICE CLAIM OR SUIT?	☐	☐
b. HAVE YOU BEEN OR ARE YOU CURRENTLY THE SUBJECT OF AN INVESTIGATION FOR ANY REASON BY A MEDICAL BOARD, LICENSING BOARD OR HEALTH DEPARTMENT?	☐	☐
c. ARE YOU AWARE OF ANY INCIDENTS, CIRCUMSTANCES, ADVERSE EVENTS OR SENTINEL EVENT WHICH MIGHT GIVE RISE TO A CLAIM OR SUIT AGAINST YOU?	☐	☐
d. ARE YOU AWARE OF ANY CLAIM OR SUIT, INCIDENTS, CIRCUMSTANCES, ADVERSE EVENTS OR SENTINEL EVENT INVOLVING YOU THAT HAS NOT YET BEEN REPORTED TO YOUR CURRENT INSURER, OR WHICH HAS NOT BEEN ACCEPTED FOR COVERAGE BY YOUR CURRENT INSURER?	☐	☐

THIS SECTION MUST BE COMPLETED IF QUESTION 24 A, B OR C WAS ANSWERED "YES".

DATE OF INCIDENT (MM / DD / YYYY)	ALLEGATION / INCIDENT DESCRIPTION: (PLEASE INDICATE CURRENT STATUS AND ANY PAYMENTS MADE ON YOUR BEHALF.)	REPORTED TO INSURER YES	REPORTED TO INSURER NO
		☐	☐
		☐	☐

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PART 6: COVERAGE INFORMATION

25. DESIRED EFFECTIVE DATE OF COVERAGE: _____
MM / DD / YYYY

26. LIMITS OF LIABILITY REQUESTED (CHECK ONE):
- ☐ $1,000,000 EACH CLAIM / $3,000,000 AGGREGATE PER YEAR
- ☐ $500,000 EACH CLAIM / $1,500,000 AGGREGATE PER YEAR
- ☐ $250,000 EACH CLAIM / $750,000 AGGREGATE PER YEAR
- ☐ $200,000 EACH CLAIM / $600,000 AGGREGATE PER YEAR
- ☐ OTHER: _____ EACH CLAIM / _____ AGGREGATE PER YEAR

INCLUDE MEDICAL BOARD INVESTIGATION DEFENSE EXPENSE COVERAGE? ☐ YES ☐ NO
COVERAGE LIMITS: $25,000 EACH INVESTIGATION / $75,000 AGGREGATE PER YEAR

27. DO YOU CURRENTLY HAVE A PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE POLICY? ☐ YES ☐ NO

PLEASE FORWARD A COPY OF YOUR CURRENT POLICY DECLARATION PAGE AS SOON AS POSSIBLE.

a. INFORMATION CONCERNING YOUR CURRENT POLICY AND COVERAGE. (SHOW PAST THREE (3) YEARS.)

POLICY DATES *FROM* (MM / YY)	POLICY DATES *TO* (MM / YY)	INSURER	FORM OF COVERAGE *OCCURRENCE*	FORM OF COVERAGE *CLAIMS MADE*	LIMITS OF LIABILITY *EACH CLAIM* / *AGGREGATE*
			☐	☐	/
			☐	☐	/

b. IF YOUR CURRENT PROFESSIONAL LIABILITY INSURANCE COVERAGE IS ON A CLAIMS-MADE FORM, DO YOU WISH TO PURCHASE COVERAGE FOR YOUR PRIOR ACTS FROM PREFERRED PHYSICIANS MEDICAL (IN LIEU OF PURCHASING EXTENDED REPORTING PERIOD COVERAGE, COMMONLY REFERRED TO AS A "TAIL", FROM YOUR CURRENT INSURER)? ☐ YES ☐ NO

c. IF 27(b) IS YES, WHAT IS THE "PRIOR ACTS" OR "RETROACTIVE" DATE ON YOUR CURRENT POLICY? _____
MM / DD / YYYY

PART 7: OTHER INFORMATION

28. INDICATE THE MEDICAL ASSOCIATIONS AND SOCIETIES TO WHICH YOU BELONG:

- ☐ AMERICAN SOCIETY OF ANESTHESIOLOGISTS
- ☐ STATE SOCIETY OF ANESTHESIOLOGISTS
- ☐ LOCAL SOCIETY OF ANESTHESIOLOGISTS
- ☐ AMERICAN MEDICAL ASSOCIATION
- ☐ STATE MEDICAL ASSOCIATION
- ☐ LOCAL MEDICAL ASSOCIATION
- ☐ AMERICAN OSTEOPATHIC ASSOCIATION
- ☐ STATE OSTEOPATHIC ASSOCIATION
- ☐ AMERICAN OSTEOPATHIC COLLEGE OF ANESTHESIOLOGISTS
- ☐ STATE OSTEOPATHIC COLLEGE OF ANESTHESIOLOGISTS
- ☐ INTERNATIONAL ANESTHESIA RESEARCH SOCIETY
- ☐ AMERICAN SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS
- ☐ AMERICAN SOCIETY OF REGIONAL ANESTHESIA
- ☐ SOCIETY FOR AMBULATORY ANESTHESIA
- ☐ SOCIETY OF CARDIOVASCULAR ANESTHESIOLOGISTS
- ☐ SOCIETY OF NEUROSURGICAL ANESTHESIA AND CRITICAL CARE
- ☐ SOCIETY FOR OBSTETRIC ANESTHESIA AND PERINATOLOGY
- ☐ SOCIETY FOR PEDIATRIC ANESTHESIA
- ☐ AMERICAN ACADEMY OF PAIN MANAGEMENT
- ☐ AMERICAN ACADEMY OF PAIN MEDICINE
- ☐ _____
- ☐ _____

29. LIST THREE PHYSICIANS (PREFERABLY ANESTHESIOLOGISTS, NOT ASSOCIATES) WHOM WE MAY CONTACT AS REFERENCES:

NAME	ADDRESS	PHONE

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PART 8: REMARKS

PART	ITEM	REMARKS (ATTACH ADDITIONAL PAGES IF NECESSARY)

PART 9: ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

I assign both the right to cancel my policy and the return of any unearned premium therefore to my Employer, _____

_____,

upon the termination of my relationship as an employee with my Employer. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked at any time by sending written notice, signed by the Employer and me, to Preferred Physicians Medical's home office, 11880 College Boulevard, Overland Park, Kansas 66210-2141.

INITIAL HERE _____

PART 10: AGREEMENT AND RELEASE

ALL APPLICANTS MUST SIGN THIS RELEASE

APPLICATION AGREEMENT AND RELEASE AUTHORIZATION

1. I understand that this is an application for insurance and not an insurance binder.
2. I have accurately and truthfully completed the application and have not withheld any information which is reasonably likely to influence the judgment of the Company in considering my application. I agree to notify Preferred Physicians Medical of any change in the information provided. I understand that any misrepresentation or concealment of information may void all coverage extended by Preferred Physicians Medical.
3. For the purpose of evaluating my application, I authorize Preferred Physicians Medical to obtain information about me and my practice from my past or present employer, medical associations or societies, insurance providers or consultants, health care facilities, other health care providers, licensing boards, governmental agencies and credit bureaus. I further authorize Preferred Physicians Medical to obtain information regarding civil litigation or criminal prosecution. I agree to release from liability and hold harmless Preferred Physicians Medical and any individual or organization providing information pursuant to this release.
4. If I have applied for Prior Acts Coverage, I have accurately and truthfully reported in the application any adverse outcomes, circumstances or events that could give rise to a claim, I understand that coverage for same will not be provided unless specifically accepted by Preferred Physicians Medical. I further understand that the limits of liability provided under the prior acts coverage may be no greater than my coverage under prior insurance policies.
5. If this application is accepted, I understand that Preferred Physicians Medical may be asked to provide credentialing information on my behalf to hospitals, insurance entities, credentialing programs, and governmental agencies. I agree to release from liability and hold harmless Preferred Physicians Medical in providing this information.
6. I understand that Preferred Physicians Medical is a mutual insurance company and each applicant who becomes a policyholder becomes a member of the mutual. Each member of the mutual is required to provide an irrevocable proxy authorizing the proxyholder to exercise certain voting rights related to corporate governance. This proxy will be executed along with your policy documents.

_____ _____

APPLICANT'S SIGNATURE DATE