THE DOCTORS COMPANY

CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE EXPRESS APPLICATION

For Healthcare Facility Physicians

AGENT INFORMATION

Agent name: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Website: _____

J11152B 7/17

APPLICATION INSTRUCTIONS AND CHECKLIST

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process your application promptly and efficiently.

- Please complete this form electronically or print your responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply to you, please write "N/A."
- The Medical Procedures questionnaire must be completed. If the procedures you perform are not mentioned in the questionnaire, please list them in the Remarks section.
- If you wish to explain any of your answers, please use the Remarks section. If you need additional space, please continue your answers on a separate page and attach it to the application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important that you provide complete and detailed claims information, including current carrier loss runs.

Required Attachments
Please include a current copy of each of the following documents with the application:

☐ Your loss runs from all insurance carriers that insured you for the past six years (if applicable).

Except to the extent as may otherwise be provided in the policy and its endorsements, the coverage of a claims-made policy is limited generally to liability for only those claims that are first reported in writing to the Company while the policy is inforce.

Insurance coverage is subject to underwriting approval and payment of the premium. No coverage exists until the premium is received and a binder or coverage summary, together with any endorsements that may apply, has been issued to the first named insured.

If you need additional forms or have any questions about the application, please contact your broker/agent, or call The Doctors Company at (800) 421-2368. To complete an electronic version of this application, please visit www.thedoctors.com/facilityphysician-apply.

IDENTIFYING INFORMATION

THE FOLLOWING SECTION MUST BE COMPLETED BY THE HEALTHCARE FACILITY PHYSICIAN

1. Name of healthcare facility: Westminster Free Clinic

   Healthcare facility address: 1000 E Janss Rd Thousand Oaks CA 91360 or 1800 S C Street, Oxnard, CA 93033

   City: _____ State: _____ Zip: _____

   The Doctors Company healthcare facility policy number (if available): HCF0931550

2. Physician's full legal name: _____

3. Home address: _____

4. City: _____ State: _____ Zip: _____

5. Home phone number: _____ Fax number: _____

6. E-mail address: _____

7. Date of birth: _____ 8. Social security number: _____

9. Requested effective date (coverage start date): _____

   Requested retroactive date (prior acts date): _____

10. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier?

    ☐ Yes ☐ No *If yes, please provide proof of tail coverage. If no, please explain in the Remarks section.*

11. Medical specialty: _____

12. Are you American Board Certified in your specialty? ☐ Yes ☐ No Board eligible? ☐ Yes ☐ No

13. If so, please provide name of of American Specialty Board: _____

14. Are you licensed by the state in which you now practice? ☐ Yes ☐ No Are you licensed in other states? ☐ Yes ☐ No

15. Federal DEA number: _____

16. Medical license number: _____ State: _____ Expiration date: _____

    ☐ Permanent ☐ Temporary

17. Number of hours worked per week at healthcare facility: <10 HOURS

    Total hours worked at ALL healthcare facility locations, if more than one (1): _____

18. Your work at the healthcare facility is performed as: ☐ Independent contractor ☐ Salaried employee ☒ Volunteer

19. If you are not a resident or full-time physician at this facility, describe the balance of your medical practice.

    Volunteer -- N/A

COVERAGE INFORMATION

20. Has a professional liability claim been made, filed, or threatened against you in the last six (6) years? ☐ Yes ☐ No

    If yes, please complete the attached Claim Information form for each claim/incident.

21. Do you know of any incident that might provide a basis for any claim or suit to be brought against you or the healthcare facility? ☐ Yes ☐ No

    If yes, please provide details in the Remarks section for each case.

22. Are you insured under any other policy? ☐ Yes ☐ No

    If yes, please provide the name of your carrier: _____

23. Will your own policy provide coverage to you for services you render on behalf of this healthcare facility? ☐ Yes ☐ No

24. Has any medical professional liability insurer canceled coverage, declined coverage, refused renewal, or renewed your coverage under restrictive conditions? ☐ Yes ☐ No

    If yes, please provide details in the Remarks section for each case.

25. Have you ever been investigated by any Department of Professional Regulations, State Board of Medical Examiners and/or Board of Dental Examiners, the State Licensing Authority, Narcotics Bureau, or other state or federal governmental agency? ☐ Yes ☐ No

    If yes, please provide details in the Remarks section for each case.

26. Have you ever been indicted, pled guilty to, or been convicted of any crime other than minor traffic violations? ☐ Yes ☐ No

    If yes, please provide details in the Remarks section for each case.

27. Please describe the specific professional services you will be rendering on behalf of this healthcare facility.

    _____

MEDICAL EDUCATION

28. a. Medical School: See CV- please attach City: _____ State: _____

    Country: CV, do not fill out Year Graduated: _____ Degree: _____

    If you are a foreign medical graduate, did you complete your Educational Counsel for Foreign Medical Graduates Certificate (ECFMG)? ☐ Yes ☐ No

    If yes, please attach a copy of your certificate.

    b. Internship

    Hospital: _____ City: _____ State: _____ From _____ *mm/yyyy* To _____ *mm/yyyy*

    c. Residency

    Hospital: _____ City: _____ State: _____ From _____ *mm/yyyy* To _____ *mm/yyyy*

    Specialty: _____

    d. Fellowship in _____ Subspecialty: _____

    Hospital: _____ City: _____ State: _____ From _____ *mm/yyyy* To _____ *mm/yyyy*

PRACTICE INFORMATION

PRACTICE INFORMATION (use a separate sheet if necessary)

29. I have practiced at the following locations during the past ten (10) years (not including training).

a. Name of practice: _____ From: _____ To: _____
mm/yyyy *mm/yyyy*

Type of practice (e.g., Medical Group, HMO): _____ City: _____ State: _____

b. Name of practice: _____ From: _____ To: _____
mm/yyyy *mm/yyyy*

Type of practice (e.g., Medical Group, HMO): _____ City: _____ State: _____

30. List hospitals to which you are applying for staff privileges or are currently a staff member, and the percentage of patient admissions for each hospital during the last twelve (12) months, including consultations.

_____ Hospital	_____ %	_____ Hospital	_____ %
_____ Hospital	_____ %	_____ Hospital	_____ %

MEDICAL PROCEDURES

Do you perform any procedures for which you did not receive training in your residency or that are outside the customary scope of practice of your specialty?

☐ Yes ☐ No *If yes, please list the procedures:* N/A--This whole page

Do you perform bariatric surgery? ☐ Yes ☐ No

Do you operate on the spine? ☐ Yes ☐ No

Do you perform deliveries? ☐ Yes ☐ No *If yes, how many deliveries do you perform per year?* _____

In a hospital: _____ *In a birthing center:* _____ *In a patient's home:* _____

Do you perform in vitro fertilization (IVF)? ☐ Yes ☐ No

Please indicate if you or any of your staff perform the following procedures:	**Physician**	**Non-Physician Licensed Staff**	**Non-Licensed Staff**
Botox Injection	☐	☐	☐
Chemical Peel	☐	☐	☐
Cosmetic Tattooing	☐	☐	☐
Laser Hair Removal	☐	☐	☐
Laser Wrinkle Removal	☐	☐	☐
Microdermabrasion	☐	☐	☐
Sclerotherapy (Specify procedure _____)	☐	☐	☐
Other Cosmetic Procedures	☐	☐	☐

Please check all procedures that you perform:

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

CARDIOLOGY

- ☐ Cardiac Catheterization
- ☐ Coronary Angiography
- ☐ Coronary Angioplasty/Stents

COSMETIC PROCEDURES

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

OPHTHALMOLOGY

- ☐ Medical Treatment Only
- ☐ All Surgical Procedures
- ☐ Limited Surgical Procedures—limited to minor surgical procedures, including:
  - • Assisting in Surgery
  - • Laser Trabeculoplasty
  - • Laser Iridotomy
  - • Laser Punctal Closure
  - • Laser Iridoplasty
  - • Laser Ablation
  - • Laser Capsulotomy

PAIN MANAGEMENT

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

NOTE: If there are procedures that are not listed above that you perform, please provide us with a detailed list in the Remarks section or in a separate attachment.

CLAIM INFORMATION

Please list each claim, incident or suit for alleged malpractice brought against the physician in the past six (6) years. Sufficient information must be provided to evaluate the medical aspects of the case specifically relating to the physician's involvement.

1. Name of patient: _____

2. Age: _____ 3. Gender: ☐ Male ☐ Female

4. Relationship to patient (e.g., attending surgeon, consultant, primary surgeon, assistant surgeon):

_____

5. Allegation(s): _____

6. Date of incident *(MM/DD/YYYY)*: _____ 7. Location: _____

8. Insurance carrier(s): _____

9. Other defendants: _____

10. Present status: ☐ Open claim Indemnity and expenses reserved: _____
☐ Closed claim Loss of: $_____ Expenses paid: $_____
Date closed: _____ ☐ Settlement ☐ Judgment

11. Conditions and diagnosis at time of incident:

_____

_____

_____

_____

_____

12. Dates and description of professional services rendered:

_____

_____

_____

_____

_____

13. Condition of patient subsequent to professional services (and dates of follow-up visits, if known):

_____

_____

_____

_____

_____

REMARKS SECTION

AGREEMENTS

AGREEMENT: I do hereby affirm the truth of all statements and answers, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for insurance. I have also made a reasonable inquiry, where appropriate, to ensure the responses herein are as complete and accurate as possible. I understand that any erroneous information or material misrepresentation may cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that no coverage will be bound by the company until such time as I have signed the application and returned the original to the company with the required payment.

AGREEMENT: I understand that in order to underwrite the requested insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for furnishing such information.

AGREEMENT: I agree that this application shall be deemed appended to and a part of, any policy of insurance issued to me based on this application.

AGREEMENT: I further agree that my signature of this application shall be deemed to be a concurrent execution of the attached Subscriber Agreement and Power of Attorney.

SIGNATURE REQUIRED:

X _____ _____

Applicant Signature | Date

NOTICES

INSURANCE FRAUD WARNING

ALABAMA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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

COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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 policyholder 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.

DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA
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 of the third degree.

IDAHO
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

KANSAS
Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

KENTUCKY
Any person who knowingly and with intent to defraud any insurance company or other 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.

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

NOTICES (CONTINUED)

MAINE
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND
Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

MISSOURI
An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

NEW JERSEY
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO
Any person who, with intent to defraud or knowing that he 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.

OKLAHOMA
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. The absence of such a statement shall not constitute a defense in any prosecution.

OREGON
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RHODE ISLAND
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

WASHINGTON
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SUBSCRIBER AGREEMENT AND POWER OF ATTORNEY

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, the Subscriber agrees to the below-stated terms and conditions.

1. The undersigned subscribes for membership in The Doctors Company and agrees with The Doctors Company and with other Subscribers, through their Attorney-in-Fact, The Doctors Management Company ("the Attorney"), to exchange with all other Subscribers contracts of liability insurance, or reinsurance, in a form and containing terms and conditions as are approved by The Doctors Company Board of Governors.

2. Subscriber designates and appoints the Attorney to be his or her true and lawful agent and Attorney-in-Fact to act in his or her name, place, and stead and in the name of The Doctors Company , to exchange contracts of insurance and to do all things that the Subscribers might or could do severally or jointly with regard to the operation and management of The Doctors Company and the business of interinsurance. Subscriber adopts and approves the Management Agreement between The Doctors Company and the Attorney, as it may be amended from time to time, and of any successor Management Agreement as it also may be amended.

3. Subscriber delegates to the Board of Governors of The Doctors Company authority to negotiate all the terms and conditions of the Management Agreement between The Doctors Company and the Attorney on behalf of the Subscriber, including, but not limited to, the compensation to be paid to the Attorney by the Subscriber or The Doctors Company .

4. Subscriber further delegates to the Board of Governors of The Doctors Company all necessary and proper powers to conduct, manage, and control the affairs and business of The Doctors Company , subject to those retained by law or through the Rules and Regulations of The Doctors Company , or as they may be further amended at the Annual Meeting of Subscribers.

5. The Board of Governors is made up of public and professional members elected by a majority of Subscribers present or represented by proxy at the Annual Meeting of Subscribers. Governors generally serve four-year terms. Each year, Governors with expiring terms will stand for election.

6. Subscribership begins with the commencement of the policy period of the liability insurance policy issued by The Doctors Company and ends upon cancellation or other termination of that policy. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements. After termination of subscription, Subscriber shall have no further rights to participate in any distribution of savings to Subscribers or in any distribution of assets upon dissolution of The Doctors Company .

7. The Board of Governors may appoint any individual, partnership, or corporation to become successor to the Attorney with all of the powers and duties stated in this Agreement. All references to "Attorney" shall then be deemed to include such successor Attorney-in-Fact.

8. The principal offices of The Doctors Company and the Attorney shall be maintained at Napa, California, or at such other place approved by the Board of Governors.

9. The Agreement can be signed by each Subscriber separately with the same effect as if the signatures of all Subscribers were on one and the same instrument, and signature of the Application to which this Agreement is attached shall constitute signature of this Agreement. This Agreement shall continue in full force and effect until revoked by the written request of Subscriber who has signed this document. This Agreement shall be governed by and interpreted according to the laws of the State of California. All Subscriber Agreements shall be binding upon all Subscribers, and the provision of each shall not materially differ. Wherever the word "Subscriber" is used, it refers to all members of The Doctors Company , including the Subscriber who has signed this document.

N/A --This whole page

PROXY

I appoint the members of the Board of Governors, and each of them, agents and attorneys with powers of substitution in each of them my lawful proxy to vote and act for me and in my name at all annual, regular, and special meetings of the Subscribers of The Doctors Company.

This proxy is solicited on behalf of the management of The Doctors Company and will empower the holders to vote on the Subscriber's behalf for the election of members of the Board of Governors 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 for five years from the date stated below.

You may revoke this proxy by giving The Doctors Company written notice of your revocation at least 10 days before the date of any annual, regular, or special meeting at which such 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 (OPTIONAL):

X _____ _____

Signature Date

Type or print name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

INSURANCE APPLICANT BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into by and between The Doctors Company, including all of its subsidiaries, hereinafter referred to as "we," and "you" in conjunction with the policy of insurance we have entered into with you. This agreement supersedes and replaces any prior Business Associate Agreement ("BAA").

We are committed to comply with the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and as modified by the HITECH provisions of the American Recovery and Reinvestment Act of 2009 and related rules and as may be modified subsequently (the "Privacy Regulations"). Under the Privacy Regulations, you are a "covered entity," and as required by 45 C.F.R. Section 164.502(e) and 45 C.F.R. Section 164.504(e), we acknowledge that we, in certain instances, may be your "business associate." We must use and disclose information that identifies an individual; relates to health, health treatment, or healthcare payment; and is maintained in any form (e.g., electronic, paper, oral) ("Protected Health Information" or "PHI") in our performance of services under this Policy, and we agree to abide by the assurances, terms, and conditions contained herein in the performance of our obligations.

This document sets forth the terms, conditions, and obligations pursuant to which Protected Health Information that is provided, created, or received by us from you or on your behalf, will be handled.

We agree as follows:

A. Permitted Uses and Disclosures of Protected Health Information.

Pursuant to this Agreement, we provide services ("Services") for your operations that may involve the use and disclosure of Protected Health Information as defined by the Privacy Regulations. These Services may include, among others, quality assessment; quality improvement; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of healthcare practitioners and providers; credentialing, conducting, or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, we may make any uses of Protected Health Information necessary to perform our obligations under this Agreement. All other uses not authorized by this Agreement are prohibited. Moreover, we may disclose Protected Health Information for the purposes authorized by this Agreement: (i) to our employees, subcontractors, and agents, in accordance with Section D(5) below; (ii) as directed by you in writing; or (iii) as otherwise permitted by the terms of this Agreement. Additionally, unless otherwise limited herein, we are permitted to make the following uses and disclosures:

B. Our Obligations and Activities.

We may use and disclose the Protected Health Information in our possession to third parties for the purpose of our proper management and administration, such as obtaining reinsurance, or to fulfill any of our present or future legal responsibilities, such as complying with insurance regulator requests, provided that (i) the disclosures are required by law; or (ii) we have received from the third party written assurances regarding its confidential handling of such Protected Health Information as required under 45 C.F.R. Section 164.504(e)(4) and where necessary received a BAA.

C. In addition to using the Protected Health Information to perform the services set forth above, we may:

(1) Aggregate the Protected Health Information in our possession with the Protected Health Information of other covered entities that we have in our possession through our capacity as a business associate to said other covered entities, provided that the purpose of such aggregation is to provide you with data analyses relating to your healthcare operations. Under no circumstances may we disclose Protected Health Information of one covered entity as defined by 45 C.F.R. Parts 160 and 164 to another covered entity absent your express written authorization; and

(2) De-identify any and all Protected Health Information provided that the de-identification conforms to the requirements of 45 C.F.R. Section 164.514(b), and further provided that you are sent the documentation required by 45 C.F.R. Section 164.15(b), which shall be in the form of a written assurance from us. Pursuant to 45 C.F.R. 164.502(d)(2), de-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement.

D. With regard to our use and/or disclosure of Protected Health Information, we agree to do the following:

(1) Use and/or disclose the Protected Health Information only as permitted or required by this Agreement or as otherwise required by law and then only to the minimum necessary extent to accomplish the intended purpose of the use;

(2) Report to your designated Privacy Officer, in writing, any use and/or disclosure of the Protected Health Information that is not permitted or required by this Agreement of which we become aware as soon as practical and within ten (10) business days of our discovery of such unauthorized use and/or disclosure. Where practical and possible, we will take steps to mitigate the harmful effect of any unpermitted disclosure of PHI;

(3) Use commercially reasonable efforts to maintain the security of the Protected Health Information and take appropriate physical, administrative, and technical safeguards to prevent unauthorized use and/or disclosure of such Protected Health Information;

(4) Require all of our subcontractors and agents that undertake to perform the services that we perform under this Agreement and that receive, use, or have access to Protected Health Information under this Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use and/or disclosure of Protected Health Information that apply to us pursuant to this Agreement;

(5) Unless prohibited by attorney-client and other applicable legal privileges or unless it would violate our contractual and other legal obligation to you, make available all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to the Secretary of the United States Department of Health and Human Services for purposes of determining your compliance with the Privacy Regulations;

(6) Upon prior written request, make available during normal business hours at our offices all records, books, agreements, policies, and procedures relating to the use and/or disclosure of Protected Health Information to you within five (5) business days for purposes of enabling you to determine our compliance under the terms of this Agreement;

(7) We shall honor any request from you for information to assist in responding to an individual's request for an accounting of disclosures of Protected Health Information to us. However, should you be asked for an accounting of the disclosures of an individual's Protected Health Information in accordance with 45 C.F.R. Section 164.528, such accounting should not include any disclosures to us which are to carry out your healthcare operations. See 45 C.F.R. Section 164.528(a)(1)(i);

(8) Upon termination of this Policy, the protections of this Agreement will remain in force and we shall make no further uses and disclosures of Protected Health Information except for the proper management and administration of our business or as required by law;

(9) In those instances when you would be required to honor an individual's request for access and/or amendment of Protected Health Information disclosed to us, we will assist you to comply with your duties under 45 C.F.R. Sections 154.524 and 164.526. However, usually you will not be required to honor such requests because Protected Health Information in our possession is not part of a designated record set as that term is defined by 45 C.F.R. 164.501; and/or because the information is exempt from access and amendment under 45 C.F.R. Sections 164.524(a) and 164.526(a)(2); and/or because access would violate your superseding contractual and other legal rights; and/or because any amendment could be tampering with evidence in a civil or administrative matter;

(10) You may terminate this Agreement by canceling this Policy if we violate a material term of this Agreement;

(11) You agree that we may modify this Agreement as required to comply with applicable laws or regulations.

In witness whereof, The Doctors Company has caused this Agreement to be signed by its Chairman at its Home Office.

Richard E. Anderson, MD
Chairman of the Board of Governors

THE DOCTORS COMPANY
medical malpractice insurance

TO: The Doctors Company
Underwriting Department

REQUEST TO ADD HEALTHCARE PROFESSIONAL

Note: If a question does not apply, simply enter "N/A."

RE: **Additional Coverage for Policy #** HCF0931550

Please add _____ to the policy of Westminster Free Clinic,
Healthcare Professional Name — Group Name

effective _____.
Date

This healthcare professional will be working:

☒ 0–10 hours per week ☐ 11–20 hours per week ☐ 21–25 hour per week ☐ 26+ hour per week

1. Please place N/A in slot # N/A.
2. This healthcare professional will:
   - ☐ Have separate limits—please complete and return an application for coverage.
   - ☐ Share limits—if sharing limits please attach a CV and provide the following information:

N/A	N/A	N/A
Date of Birth	Social Security Number	Medical License Number(s)

3. Please provide Prior Acts Coverage: ☐ Yes ☒ No
   If yes, Retroactive Date requested: _____
4. Does this healthcare professional have any history of alcohol, narcotics, or any other substance abuse?
   ☐ Yes ☐ No
   (If yes, please include a letter from your treating physician or institution outlining the dates of treatment, results of treatment, current status, and any agreement you have made with any recovery organization.)
5. Has/is this healthcare professional's license(s) been revoked, suspended, or restricted in any way?
   ☐ Yes ☐ No
   (If yes, please provide details in the Remarks section and include supporting documents.)

I understand that coverage is not automatic and **no coverage will be inforce** prior to written underwriting approval.

_____ _____
Signature — Date

_____
Print Name

NAPA, CALIFORNIA
MAILING ADDRESS PO Box 2900, Napa, CA 94558 | **LOCAL ADDRESS** 185 Greenwood Road, Napa, CA 94558
P 800.421.2368 . 707.226.0100 | thedoctors.com

REMARKS SECTION

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PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name_____

Signature: _____**Date**: _____

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

_____

_____

_____

Modification to the wording or format of the Practitioner Credentialing Application will invalidate the application.