Texas Medical Liability Insurance Underwriting Association (JUA)

1812 Centre Creek Drive, Suite 305 • Austin, Texas 78754
(512) 452-4370

APPLICATION FOR RETIRED VOLUNTEER PHYSICIANS MEDICAL PROFESSIONAL LIABILITY LEGAL DEFENSE COVERAGE POLICY

THE POLICY PROVIDES COVERAGE FOR LEGAL DEFENSE COSTS ONLY. IT DOES NOT PROVIDE INDEMNITY COVERAGE.

To the above designated Association:
As a retired licensed physician entitled in good faith to medical professional liability legal defense coverage in Texas, the undersigned hereby makes application for such insurance in accordance with the provisions of Chapter 2203 of the Insurance Code of Texas, as amended, and the Plan of Operation of the Texas Medical Liability Insurance Underwriting Association ("ASSOCIATION") created in such Article. **THE UNDERSIGNED RECOGNIZES AND AGREES THAT IF HE OR SHE IS ISSUED A POLICY FOR LEGAL DEFENSE COVERAGE DUE TO MEDICAL (PROFESSIONAL) LIABILITY CLAIMS OR SUITS PURSUANT TO THIS APPLICATION, HE OR SHE MAY BE ASSESSED IN AN AMOUNT NOT TO EXCEED ONE HUNDRED PERCENT (100%) OF THE PREMIUM PAID FOR THIS POLICY, AND THAT IF HE OR SHE SHOULD FAIL TO PAY SUCH ASSESSMENT WHEN LEVIED AGAINST HIM OR HER, THAT THIS POLICY AND ANY OTHER POLICY INSURING THE UNDERSIGNED WHICH IS WRITTEN THROUGH THE ASSOCIATION MAY BE CANCELLED, AND THE UNEARNED PREMIUM OTHERWISE REFUNDABLE ON SUCH POLICY (OR POLICIES) MAY BE OFFSET BY THE ASSOCIATION AGAINST THE AMOUNT OF SUCH UNPAID ASSESSMENT**. The undersigned further recognizes and agrees that such insurance as is applied for herewith is subject to such rates, premium modifications, surcharges and policyholder's stabilization reserve fund charges as are now or may hereafter be filed with the Texas Department of Insurance. The undersigned further agrees that the Producer of Record herein shown acts solely as the agent of the undersigned and is not an agent of or for the ASSOCIATION or of the company assigned to issue and service such insurance.

IMPORTANT NOTES:

- **Coverage is offered only on an occurrence policy with limits of $100,000 per occurrence / $300,000 annual aggregate.**
- **Coverage applies only to the individual physician named, not to any partnership or association or other institution.**
- **Coverage applies only to incidents that occur when the physician is a retired physician licensed by the Texas Medical Board whose only practice is the provision of voluntary charity care and is providing medical services for or on behalf of a charitable organization and who does not receive compensation in excess of reimbursement of expenses incurred.**
- **If this policy is cancelled a minimum premium of $250.00 will be retained, regardless of the number of days the coverage was in force.**

1. The insurance herewith applied for has currently been tendered to and rejected by two carriers, including licensed and engaged in writing the coverage applied for in Texas or self-insurance trust created under Insurance Code Chapter 2212. These rejections must be evidenced only by valid notification from the insurer or trust. This requirement applies to each and every application, whether new or renewal. **THIS IS A MANDATORY REQUIREMENT. COVERAGE CANNOT BE BOUND WITHOUT COPIES OF THESE WRITTEN REJECTIONS.**

   Name of Rejecting Carriers: (1) _____ (2) _____

   Date of Rejections: (1) _____ (2) _____

2. a. **APPLICANT'S FULL NAME**:_____ _____
   Date of Birth

   b. Mailing Address: _____ _____ _____ _____ _____
   Street City County State Zip

3. **Future EFFECTIVE DATE Desired**: _____

4. **My Medical Professional Specialty is**: _____

5. Are you licensed, registered or certified to practice your profession in the State of Texas? ……☐ Yes ☐ No

   Medical License number_____

6. **Name and Location of Charitable Organization(s) where you will be volunteering services:**

_____

_____

7. Has any claim or suit for any alleged malpractice been brought against you within the past seven years resulting in an indemnity payment? ..... ☐ Yes ☐ No

   If yes, a resume of each such claim or suit must be submitted including date of occurrence, date reported and the indemnity payment amount.

8. **MINIMUM DEPOSIT REQUIRED:** Payment of the Minimum Deposit must be made by CASHIER'S CHECK, BANK DRAFT or POSTAL MONEY ORDER payable to the Texas Medical Liability Insurance Underwriting Association and must accompany this application. If two or more classifications apply, the deposit premium for the highest rated shall be submitted. It is agreed that the remainder of the annual premium and policyholder's stabilization reserve fund charge will be paid within (20) days after receipt of the ASSOCIATION'S billing. Failure to make this payment within such period of time will result in cancellation of any policy (or policies) bound or issued pursuant to this application. Coverage will not be bound by the ASSOCIATION prior to the receipt of the minimum deposit.
   For renewal of a JUA expiring policy the full estimated renewal premium plus the Policyholders Stabilization Reserve Fund Charge quoted must be submitted with the application.

9. A POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE will be collected, when required, on all policies. This charge was authorized by H.B. 1048 of the 65th legislature.

10. It is understood that the ASSOCIATION'S Manager may designate an Insurance Company to issue and service the policy on behalf of the ASSOCIATION. The undersigned agrees:
    a. To comply with all reasonable rules of the Servicing Company for the prevention of injuries
    b. To furnish the Servicing Company promptly with any Report of Injury
    c. To furnish all other forms and information required by the terms of the policy
    d. To maintain adequate records in order that an accurate audit may be made by the Servicing Company.
    e. To pay as due all monies for premium under such policy, including the policyholder's stabilization reserve fund charge, to the Servicing Company provided, however, that in the event of default on payment of any premiums or other charges due under any policy issued as a result of this application all premiums and other charges due and unpaid shall become payable at the office of the Texas Medical Liability Insurance Underwriting Association, Austin, Travis County, Texas, and the undersigned hereby promises and agrees to pay all such premiums at the office of the ASSOCIATION. I further agree that there are no unpaid premiums or other charges due this Association from prior insurance of the type applied for.
    f. That no insurance coverage will be considered bound until applicant has received a Binder duly executed by the Manager of the ASSOCIATION and such insurance shall become effective from the date and time specified by the ASSOCIATION Manager.

IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE APPLICANT

The foregoing statements are made by applicant as material representations of fact for the purpose of showing that he/she is in good faith entitled to insurance and securing approval of this application, and such statements are true and correct. It is understood that the underwriting data on this application may be made available to all Member Companies of the ASSOCIATION.

I authorize and consent to investigations in respect of material information bearing upon moral character, professional reputation and fitness to engage in the activities embraced by my license or authority to practice my profession, including authorization to every person or entity, public or private, to release to the ASSOCIATION any documents, records or other information bearing upon the foregoing.

Date # PROFESSIONAL LICENSE NUMBER Signature of Applicant

Telephone Number Fax Number Print Name

STATE OF TEXAS GENERAL LINE - PROPERTY AND CASUALTY LICENSED AGENT KNOWN AS PRODUCER OF RECORD

As Producer of Record, I certify that the information relating to rating and classifications as shown and all other answers and data given above, are true and correct to the best of my knowledge and belief and that I am a licensed Texas Insurance Agent.

Name of Producer of Record (Type or Print) Producer's Federal Income Tax Identification Number

Street Address Telephone Number Fax Number

City State Zip Signature of Producer of Record