



# Texas Medical Liability Insurance Underwriting Association (JUA)

1812 Centre Creek Drive, Suite 305 Austin, TX 78754  
512-452-4370 www.tmliaa.com

## APPLICATION FOR MEDICAL (PROFESSIONAL) LIABILITY INSURANCE PHYSICIANS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

To the above designated Association:

As a licensed physician or other non-institutional health care provider entitled in good faith to medical liability insurance 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 or JUA) created in such Article. THE UNDERSIGNED RECOGNIZES AND AGREES THAT IF HE OR SHE IS ISSUED A POLICY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE 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.

1. The insurance herewith applied for must show CURRENT rejections by two authorized insurance companies licensed and engaged in writing in Texas the same coverage being applied for. The below applicant must show inability to obtain substantially equivalent coverage and rates from two authorized insurers. These mandatory rejections are required to be evidenced only by copies of valid notifications provided from authorized insurers. This requirement applies to every application, whether applying for new or renewal coverage. **THIS IS A MANDATORY REQUIREMENT. QUOTES CANNOT BE PROVIDED AND COVERAGE CANNOT BE BOUND WITHOUT COPIES OF MANDATORY 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

c. Practice Physical Address: \_\_\_\_\_  
City County State Zip

d. Attach a copy of any additional locations where you practice other than the primary office location provided under 2-c.

e. Email address for insured: \_\_\_\_\_

f. Email address for office manager: \_\_\_\_\_

g. Provide the name of all facilities at which you currently have staff membership or clinical privileges. Attach a copy of your clinical privileges approved at each facility. Attach an addendum if additional space is needed. **THIS IS A MANDATORY REQUIREMENT. QUOTES CANNOT BE PROVIDED AND COVERAGE CANNOT BE BOUND WITHOUT THIS INFORMATION.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Do you provide direct patient care at nursing homes and assisted living facilities? .....  Yes  No

If yes, provide the names and locations of nursing homes or assisted living facilities at which you provide direct patient care. Include copies of letters from each nursing home and assisted living facility showing approved privileges to admit and treat patients.

Do you provide medical director duties at any of the nursing homes or assisted living facilities at which you provide direct patient care? .....  Yes  No

Is coverage for your Medical Director duties at nursing homes or assisted living facilities handled by the nursing home or assisted living facility? .....  Yes  No

**THIS IS A MANDATORY REQUIREMENT. QUOTES CANNOT BE PROVIDED AND COVERAGE CANNOT BE BOUND WITHOUT THIS INFORMATION.**

4. Check the type of coverage applying for:

Occurrence

Claims-Made

If Claims-Made is requested, check one of the following:

First Year

Prior Acts Coverage

If Prior Acts Coverage is requested, complete form JUA-82 and attach a copy of your current/most recent declaration's page.

Request retro coverage date for prior acts: \_\_\_\_\_

5. Request future coverage effective date: \_\_\_\_\_

6. My Primary Texas Licensed Medical Professional Specialty is: \_\_\_\_\_

My Secondary Texas Licensed Medical Professional Specialty is: \_\_\_\_\_

You must check "✓" all areas which are included in your medical practice or profession even if performed infrequently.

SPECIALTY OR PROCEDURE	✓	CLASS CODE	SPECIALTY OR PROCEDURE	✓	CLASS CODE
Acupuncture		80437	Gynecology - No Surgery		80244
Aerospace Medicine		80230	Hematology/Oncology - Minor Surgery		80278
Allergy		80254	Hematology/Oncology - No Surgery		80245
Anesthesiology		80151	Hypnosis		80232
Angiography		80422	Infectious Diseases - Minor Surgery		80279
Arteriography		80422	Infectious Diseases - No Surgery		80246
Bronchoesophagology		80101	Intensive Care Medicine		80283
Cardiovascular Disease - Minor Surgery		80281	Internal Medicine - Minor Surgery		80284
Cardiovascular Disease - No Surgery		80255	Internal Medicine - No Surgery		80257
Catheterization		80422	Laparoscopy		80440
Colonoscopy		80443	Laryngology - Minor Surgery		80285
Dentistry * - Excluding Oral Surgery or Operative Work		80211	Laryngology - No Surgery		80258
Dentistry * - Including Oral Surgery or Operative Work		80210	Lasers		80425
Dermatology - Minor Surgery		80282	Legal Medicine		80240
Dermatology - No Surgery		80256	Lymphangiography		80434
Diabetes - Minor Surgery		80271	Myelography		80428
Diabetes - No Surgery		80237	Needle Biopsy - Lung or Prostate		80446
Discograms		80428	Neoplastic Diseases - Minor Surgery		80286
Emergency Medicine - Including Major Surgery		80157	Neoplastic Diseases - No Surgery		80259
Emergency Medicine - No Major Surgery		80102	Nephrology - Minor Surgery		80287
Endocrinology - Minor Surgery		80272	Nephrology - No Surgery		80260
Endocrinology - No Surgery		80238	Neurology - Minor Surgery		80288
ERCP		80443	Neurology - No Surgery		80261
Family or General Practice - Minor Surgery		80421	Nuclear Medicine		80262
Family or General Practice - No Surgery		80420	Nurse (Certified) Midwife - Births		80962
Forensic Medicine		80240	Nurse (Certified) Midwife - No Births		80963
Gastroenterology - Minor Surgery		80274	Nurse (CRNA)		80960
Gastroenterology - No Surgery		80241	Nurse (Registered)		80998
General Preventive Medicine		80231	Nurse (Registered) - Xray Therapists		80714
Geriatrics - Minor Surgery		80276	Nurse (Registered) Practitioner		80998P
Geriatrics - No Surgery		80243	Nutrition		80248
Gynecology - Minor Surgery		80277	Occupational Medicine		80233

SPECIALTY OR PROCEDURE	✓	CLASS CODE	SPECIALTY OR PROCEDURE	✓	CLASS CODE
Ophthalmology - Minor Surgery		80289	Surgery - Cardiac		80141
Ophthalmology - No Surgery		80263	Surgery - Cardiovascular		80150
Otology - Minor Surgery		80290	Surgery - Colon and Rectal		80115
Otology - No Surgery		80264	Surgery - Endocrinology		80103
Otorhinolaryngology - Minor Surgery		80291	Surgery - Family or General Practice not Primarily Engaged in Major Surgery		80117
Otorhinolaryngology - No Surgery		80265	Surgery - Gastroenterology		80104
Pathology - Minor Surgery		80292	Surgery - General		80143
Pathology - No Surgery		80266	Surgery - Geriatrics		80105
Pediatrics - Minor Surgery		80293	Surgery - Gynecology		80167
Pediatrics - No Surgery		80267	Surgery - Hand		80169
Perfusionist		P80151	Surgery - Head and Neck		80170
Phlebography		80434	Surgery - Laryngology		80106
Physiatry		80235	Surgery - Maxillofacial		80155
Physical Medicine & Rehabilitation		80235	Surgery - Neoplastic		80107
Pneumoencephalography		80428	Surgery - Nephrology		80108
Podiatry - No Surgery		80993	Surgery - Neurology		80152
Podiatry - Surgery		80993S	Surgery - Obstetrics		80168
Psychiatry		80249	Surgery - Obstetrics Gynecology		80153
Psychoanalysis		80250	Surgery - Ophthalmology		80114
Psychosomatic Medicine		80251	Surgery - Orthopedic		80154
Public Health		80236	Surgery - Otolaryngology		80158
Pulmonary Disease		80269	Surgery - Otorhinolaryngology		80159
Radiation Therapy		80425	Surgery - Plastic		80156
Radiology - Minor Surgery		80280	Surgery - Plastic Otorhinolaryngology		80155
Radiology - No Surgery		80253	Surgery - Rhinology		80160
Radiopaque Dye Injections		80449	Surgery - Thoracic		80144
Rheumatology		80252	Surgery - Traumatic		80171
Rhinology - Minor Surgery		80270	Surgery - Urological		80145
Rhinology - No Surgery		80247	Surgery - Vascular		80146
Shock Therapy		80431	Therapeutic Abortion		80437
Surgery - Abdominal		80166	Weight Control - As a Specialty		80437
Surgery - Bariatric		80166B	* Dentistry procedures that require any cutting and suturing shall be considered oral surgery or operative dentistry.		

7. Do you perform any procedures not customary to your specialty? (If yes, list below) .....  Yes  No

8. Check the Limits of Liability applying for:

- |  |  |
|--|--|
| <input type="checkbox"/> \$ 100,000 / \$ 300,000 | <input type="checkbox"/> \$ 300,000 / \$ 900,000     |
| <input type="checkbox"/> \$ 200,000 / \$ 600,000 | <input type="checkbox"/> \$ 500,000 / \$ 1,500,000   |
| <input type="checkbox"/> \$ 250,000 / \$ 750,000 | <input type="checkbox"/> \$ 1,000,000 / \$ 3,000,000 |

9. Do you perform any one or more of the following procedures?
- a. Minor\*\* surgery other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia .....  Yes  No
  - b. Assisting in major\*\* surgical procedures on your own patients .....  Yes  No
  - c. Assisting in major surgical procedures on other than your own patients .....  Yes  No
  - d. Major surgery (includes procedures done under general, spinal or caudal anesthesia).....  Yes  No
  - e. Normal deliveries of newborns .....  Yes  No
  - f. Percutaneous biopsy for diagnostic study of organs or structures other than skin or superficial fascia .....  Yes  No
  - g. Weight control surgery or procedures. Describe procedures.....  Yes  No
  - h. Prenatal care .....  Yes  No

\*\*Tonsillectomies, Adenoidectomies and Cesarean Sections are considered to be major surgical procedures.

i. Administer Anesthesia

1. General Anesthesia

-To your own patients? .....  Yes  No

-Is general anesthesia administered in your office? .....  Yes  No

If yes, provide who administers general anesthesia in your office and explain relationship with your practice:

\_\_\_\_\_  
\_\_\_\_\_

-Do healthcare providers who administers general anesthesia in your office carry current required liability insurance? Submit copies of evidence of current liability insurance  Yes  No

This is a mandatory requirement. Noncompliance renders you ineligible for coverage.

-Is general anesthesia administered in a hospital or surgicenters? .....  Yes  No

If yes, provide who administers and explain relationship:

\_\_\_\_\_  
\_\_\_\_\_

- 2. Spinal .....  Yes  No
- 3. Caudal .....  Yes  No
- 4. Acupuncture .....  Yes  No

j. Treat by intravenous or intramuscular sedation .....  Yes  No

-Is treatment administered in your office? .....  Yes  No

If yes, provide who administers intravenous or intramuscular sedation and explain relationship with your practice:

\_\_\_\_\_  
\_\_\_\_\_

-Do healthcare providers who administers intravenous or intramuscular sedation in your office carry current required liability insurance? Submit copies of evidence of current liability insurance.  Yes  No

This is a mandatory requirement. Noncompliance renders you ineligible for coverage.

-Is treatment administered in a hospital or surgicenters? .....  Yes  No

If yes, provide who administers and explain relationship:

\_\_\_\_\_  
\_\_\_\_\_

- k. Catheterization-arterial, cardiac or diagnostic-other than (1) the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, (2) urethral catheterization or (3) umbilical cord catheterization for diagnostic purposes or for monitory blood gases in newborns receiving oxygen .....  Yes  No
- l. Needle biopsy (Please explain, i.e. lung, liver, kidney, breast, etc.) .....  Yes  No
- m. Pneumatic or mechanical esophageal dilatation (not with bougie or olive) .....  Yes  No
- n. Radiopaque Dye-injections into blood vessels, lymphatics, sinus tracts or fistulae .....  Yes  No
- o. Lumbar epidural steroid injections .....  Yes  No
- p. Cervical epidural steroid injections .....  Yes  No
- q. Selective nerve root blocks .....  Yes  No
- r. Sacroiliac joint injections .....  Yes  No

- s. Lumbar facet injections .....  Yes  No
- t. Cervical facet injections .....  Yes  No
- u. Selective occipital nerve blocks .....  Yes  No
- v. Trigger point injections .....  Yes  No
- w. Joint Injections .....  Yes  No
- x. Sympathetic nerve blocks .....  Yes  No
- y. Spinal taps/Lumbar punctures.....  Yes  No
- z. Closed reductions .....  Yes  No
- aa. Paracentesis .....  Yes  No
- bb. Thoracentesis .....  Yes  No
- cc. Circumcisions .....  Yes  No
- dd. Chemotherapy.....  Yes  No

If yes, explain how it is administered:

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ee. Botox Injections for:

- 1. Muscle relaxant.....  Yes  No
- 2. Anti-wrinkle or other cosmetic purposes.....  Yes  No
- 3. Migraines.....  Yes  No
- 4. Abnormal sweating.....  Yes  No
- 5. Other .....  Yes  No

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6. Describe training and qualifications of all persons administering Botox in connection with your practice:

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7. If administered in any setting other than in your medical office at which other professional services are rendered, explain in detail:

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8. Attach a copy of the informed consent agreement patients are required to review and sign prior to treatment with Botox.

- ff. Wound Care .....  Yes  No  
If yes, attach a list of procedures performed.

- gg. Neonatology.....  Yes  No

- hh. Telemedicine.....  Yes  No

If yes, provide location(s) \_\_\_\_\_

- ii. Cosmetic/Aesthetic Procedures.....  Yes  No  
If yes, attach a list of procedures performed.

- jj. Pain Management Procedures.....  Yes  No  
If yes, attach a list of procedures performed.

- kk. Cardioversion (chemical or electrical) .....  Yes  No

- ll. Arterial Lines/Arterial Punctures .....  Yes  No

- 10. Are you engaged in emergency practice? If yes, where? .....  Yes  No

11. Are you a member of an emergency room team? .....  Yes  No

12. Do you render emergency room care other than as a requirement for staff privileges? .....  Yes  No

If yes, provide location(s) \_\_\_\_\_

13. Do you carry separate medical professional liability insurance for emergency room care? .....  Yes  No  
If yes, provide a copy of evidence of current emergency room coverage.

14. Do you perform procedures in an ICU/CCU/NICU unit? (other than to maintain staff privileges) .....  Yes  No

14. Are you in active U.S. Military Service? .....  Yes  No

15. a. Medical, Dental or Nursing School: \_\_\_\_\_ Country: \_\_\_\_\_ Degree: \_\_\_\_\_ Year: \_\_\_\_\_

b. Served internship at: \_\_\_\_\_ Country: \_\_\_\_\_ Year: \_\_\_\_\_

c. Served residency at: \_\_\_\_\_ Country: \_\_\_\_\_ Year: \_\_\_\_\_

d. Are you Board Certified  Yes  No Specialty \_\_\_\_\_ Year: \_\_\_\_\_

e. Are you Board Eligible  Yes  No Specialty \_\_\_\_\_ Year: \_\_\_\_\_

f. Are you a foreign medical or dental school graduate? .....  Yes  No

If yes, provide: Year \_\_\_\_\_ Name of certifying school or organization \_\_\_\_\_

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

17. Are you currently or have previously been licensed, registered or certified to practice outside of the State of Texas?.....  Yes  No

If so, provide the State and license number: \_\_\_\_\_

18. Has your license, authority or privileges ever been revoked, cancelled or suspended? .....  Yes  No  
If yes, submit a copy of the details issued by the state licensing board.

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

We require a complete copy of a current self-query from the National Practitioner Data Bank or a current valued loss run from the prior carrier(s) covering at least the last eight years. Loss information must not be older than 90 days prior to the date of completion of this application. THIS IS A MANDATORY REQUIREMENT. QUOTES CANNOT BE PROVIDED AND COVERAGE CANNOT BE BOUND WITHOUT THIS INFORMATION.

20. Are you a partner/stockholder/owner in any of the following?

a. Medical Partnership .....  Yes  No

b. Professional Association .....  Yes  No

c. Corporation .....  Yes  No

d. Facility or Institution .....  Yes  No

If yes, provide the complete name of organization and list of all members:

Name of organization: \_\_\_\_\_

Name of Member Doctors	Specialty	Insurer	Limits
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

e. Do you request Coverage for your Partnership, Professional Association, Corporation, Facility or Institution? .....  Yes  No

If yes, attach a copy of the Partnership Agreement, Articles of Association or Incorporation or Certificate of Formation filed with and certified by the State of Texas for medical/dental services only.

f. If coverage is requested for your Partnership/Professional Association/Corporation, Facility or Institution do you prefer a separate policy with separate limits of liability at an additional charge of 20%? .....  Yes  No

21. Do you or your Partnership/Professional Association/Corporation, Facility or Institution employ or contract with any of the following for medical professional services:

a. Licensed physicians, surgeons, podiatrists, dentists, pharmacists, optometrists, chiropractors or perfusionists? .....  Yes  No

**If yes, list below and submit evidence that each carries individual medical professional liability insurance with limits of at least \$100,000. each occurrence, \$300,000. aggregate per annum. SELF INSURED PROGRAMS ARE NOT ACCEPTABLE. THIS IS A MANDATORY REQUIREMENT. NONCOMPLIANCE RENDERS YOU INELIGIBLE FOR COVERAGE.**

Name	Specialty	Performs IV/IM Sedation?	Performs General Anesthesia?	Performs Invasive Procedures?	Performs Shock Therapy?	Performs Minor Surgery?	Performs Major Surgery?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No					
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No					
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No					

b. Physician's or surgeon's assistants? .....  Yes  No If Yes, how many? \_\_\_\_\_

c. Licensed or certified technicians?

1. Radium, diagnostic, x-ray, laboratory, pathological or other? .....  Yes  No If Yes, how many? \_\_\_\_\_

2. Radiation therapy? .....  Yes  No If Yes, how many? \_\_\_\_\_

3. Certified Registered Nurse Anesthetists? .....  Yes  No If Yes, how many? \_\_\_\_\_

4. Certified Nurse Midwife – Births? .....  Yes  No If Yes, how many? \_\_\_\_\_

5. Certified Nurse Midwife – No Births .....  Yes  No If Yes, how many? \_\_\_\_\_

6. Nurse (Registered) Practitioner? .....  Yes  No If Yes, how many? \_\_\_\_\_

22. Do you or your Partnership/Professional Association/Corporation, Facility or Institution actively share space with another provider?

If yes, provide each name and their specialty: \_\_\_\_\_  Yes  No

23. Are you employed or contracted by another physician, surgeon, dentist, podiatrists, pharmacists, optometrists, chiropractor or perfusionist?

If yes, provide each name and their specialty: \_\_\_\_\_  Yes  No

24. Provide current and previous medical professional liability insurance carrier(s) for the past 8 years:

Name of Company	Policy No.	Period of Coverage	Premium

25. Expiration date of your current or last policy and attach a copy of the Declaration page: \_\_\_\_\_.

26. Have you ever been uninsured or have had gap(s) in medical professional liability insurance coverage?  Yes  No  
If yes, provide dates you were uninsured and explain below.

\_\_\_\_\_

\_\_\_\_\_

27. In addition to the rejecting companies submitted with this application, have any previous insurers cancelled or refused to renew Medical Professional Liability Insurance coverage?  Yes  No

If yes, provide a copy of the details of the action and provide a copy of cancellation/non-renewal issued by the insurer.

If not available, provide details: \_\_\_\_\_

28. 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 on or before the requested future effective date. When 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 (if any) will be paid within twenty (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 quoted plus the Policyholders Stabilization Reserve Fund Charge (if any) must be submitted with the application.

29. Is the total premium for this policy being financed by a premium finance company?.....  Yes  No

If yes, provide a complete copy of the signed premium finance agreement with the appropriate check in the amount of the total premium. The finance agreement must be issued only in the name of the licensed applicant applying for coverage. The use of financing does not change any payment requirements stated above or in any renewal.

**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 as a rejected risk and securing approval of this application, and such statements are true and correct.

- a. To comply with all reasonable rules and recommendations for the prevention of injuries, which may include participation in an On-site Practice Review by a Risk Management/Loss Control Services Professional.
- b. To promptly furnish the Texas Medical Liability Insurance Underwriting Association a 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 Association.
- e. I understand that the Association may designate an Insurance Company to issue and service the policy on behalf of the Association. The undersigned agrees to comply with all reasonable rules of the Servicing Company for the prevention of injuries, to furnish the servicing Company promptly with any Report of Injury, to furnish all other forms and information required by the terms of the policy, and to maintain adequate records in order that an accurate audit may be made by the Servicing Carrier.
- f. To pay as due all monies for premium or claim related charges under such policy, including the stabilization reserve fund charge, to the Association by the required date. In the event of default on payment of any premium or claim related charges under such policy, including the stabilization reserve fund charge owed to the Association, coverage cannot be bound or policy can be canceled. It is further agreed that there are no unpaid premiums or charges due this Association from prior insurance of the type applied for.
- g. The information provided in this application is for Underwriting purposes only and does not constitute notice to the Texas Medical Liability Insurance Underwriting Association under any policy of a claim or potential claim.
- h. I understand that insurance is subject to review and approval. I understand that no insurance will be afforded until this application is accepted by the Texas Medical Liability Insurance Underwriting Association (JUA).
- i. No insurance coverage will be considered bound until applicant has received a Binder executed by the Executive Director of the Association and such insurance shall become effective from the date and time specified by the Association's Executive Director.
- j. The applicant authorizes and consents to investigations in respect of material information bearing upon reputation and fitness to engage in the activities embraced by the applicant's license, 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.
- k. 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 Texas Medical Liability Insurance Underwriting Association also known as the JUA.
- l. It is understood that the underwriting data on this risk may be made available to all Member Companies of the Association.
- m. Policyholder's Stabilization Reserve Fund Charge will be collected, when approved by the JUA Board of Directors.
- n. The undersigned recognizes and agrees that if a policy of medical professional liability insurance pursuant to this application is issued, the undersigned may be assessed in an amount not to exceed 100% of the premium paid for this policy, and that if the undersigned should fail to pay such assessment when levied against it, 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 and policyholder's stabilization reserve fund charges as may hereafter be approved by the Texas Department of Insurance.

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 License Number  
(Medical, Dental, Other) Signature of Applicant

\_\_\_\_\_ \_\_\_\_\_  
Telephone Number Fax Number Print Name

**STATE OF TEXAS LOCAL RECORDING AGENT KNOWN AS PRODUCER OF RECORD**

As Producer of Record, I certify that the information relating to rating including estimated premium basis as shown and all other answers and data given above are true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Texas Insurance Agency License Number

\_\_\_\_\_  
Print Name of Producer of Record

\_\_\_\_\_  
Producer's Federal Income Tax Identification Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Telephone Number Fax Number

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Signature of Producer of Record

Name of agency contact person: \_\_\_\_\_  
Print name

\_\_\_\_\_  
Email Address