



Medical Protective Representation of Complete Retirement

I, _____, hereby represent that I have / will permanently retire from the practice of medicine as of 12:01 a.m., _____.

I understand that under the terms of the policy issued to me by the Medical Protective Company ("Company"), "permanent retirement" is defined to mean that an insured has completely and permanently ceased any practice of medicine for compensation.

In consideration of this permanent retirement and having met all policy requirements, the Company will waive any and all premium charges normally associated with the extension contract.

Furthermore, I understand that by accepting this waiver of the extension contract premium, the Company has the right, at any time, to request proof of my continued permanent retirement. Additionally, should I resume any practice of medicine for compensation, I have a duty to inform the Company of that fact within 15 days of the resumption of practice and I have an obligation to pay the premium that would have been due but for the waiver of the extension contract premium. I will also be responsible to reimburse the Company for any necessary cost of collections and reasonable attorney fees.

If I fail to purchase the extension contract within 45 days following my resumption of the practice of medicine for compensation, I acknowledge the Company, in its sole discretion, may either: (1) void the extension contract which would result in my having no coverage for any claims that would otherwise have been reportable under the extension contract or (2) institute a collection action for the premium that would have been originally due for the extension contract.

I affirm that I understand all the representations listed above and all are true and correct to the best of my knowledge and belief.

Signature: _____

Insured Name:

Policy number:

Date Signed: _____

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