EXHIBIT 2B_470580977.PDF

Exhibit 2B Reserve Study Description:

1. The actuarial methodologies used in the reserve report include paid and reported loss development as well as paid and reported Bornhuetter-Ferguson method for the large segments of its business. Reserves are evaluated at June 30th and December 31st each year.
2. PPIC has not had significant adverse development in the net carried reserves based on the 20% standard of surplus underlying PPIC's December 31, 2008 Actuarial Opinion Summary
3. PPIC's coverage year medical malpractice net loss ratios closely follow the industry. Several of PPIC's direct limit statistics are unusual relative to the industry because PPIC fronts a significant volume of business for its owners.

Exhibit 2B Surplus Study Description:

1. Surplus for PPIC as of 12/31/08 as reported in the annual statement is considered by management as adequate. This would be reinforced by the strong leverage ratios for PPIC calculated as of 12/31/08.
2. Surplus has grown significantly over the past several years. Significant additions to surplus from PPIC shareholders have contributed approximately $24 million to the $81 million growth in surplus since 2003. The remaining growth of $57 million in surplus is due to net income earned by the company and the change in unrealized gains on the equity holdings of PPIC.

Company Defined Items:

1. The information in the report is provided by county and not by territory. There have been no changes to the way the data has been grouped in the past ten years.
2. No reserving changes have been implemented in the last 10 years that would affect our Illinois claims.
3. A claim is closed when it is assigned a closed date.
4. Corporation policies are designated by the policy type "CC". These are policies written to provide coverage for corporations or professional associations owned by a physician or physician group. Typically these corporations take the form of a Partnership, Limited Liability Company or PA.
5. Base Class – PPIC uses class 1 as the base class for rating. This class consists of internal medicine physicians – no surgery. Base Territory – PPIC uses territory 1 as the base class for rating. This territory consists of the following counties – Cook, Will, Madison and St. Clair. There have been no changes to the base class and territory in the past 10 years.
6. There are no adjustments specifically made to tail exposures. PPIC charges a percentage of the mature class premium to determine the tail cost. See the tail factors listed below in 7.

7. Tail Factors:
   Year 1 – .823
   Year 2 – 1.334
   Year 3 – 1.543
   Year 4 – 1.633
   Year 5 - 1.633
8. Expenses: General Expense – 10% - consists of cost of running company (Underwriting Expenses) and include salaries, rent, travel etc.
9. Other Expense Factors:
   Death Disability and Retirement load – 4%
   Offset for investment income - .829
   Taxes, license and fee's – 2.5%
   Profit – 5%
   ULAE load – 4%
10. PPIC writes physician professional liability insurance in several states, requiring an allocation of unpaid losses as of a year end to each state with business. In the allocation of IBNR, the company utilized the expected losses by state less any direct paid losses to allocate the year end unpaid. Based upon the case reserves there were adjustments made to this allocation to eliminate negative IBNR reserves. Once the unpaid by state was derived, actual case reserves were subtracted to determine the IBNR. For the allocation by year, PPIC utilized the earned premium for an allocation basis.

RECONCILLIATION BY LYNNETTE MATZA, CHIEF FINANCIAL OFFICER AND BRYAN YOUNG, ACTUARY – attached

Rate Filing and Actuarial Support - attached

Person Responsible for filing this report:

Denise A. Hill, JD, CPCU
SVP- Chief Compliance Officer
800-441-7742 ext 3209
dhill@ppicins.com

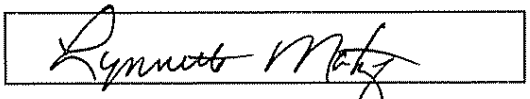
The data utilized to prepare the Illinois data submission was derived from the data base and/or excel spreadsheets that were utilized in the preparation of the 12/31/08 annual statement.

In order to determine that the information contained in the data submission is accurate, reasonable and reconciles to the annual statement, the following steps were taken:

The direct premiums earned and written premiums for the period 2000-2008 were compared in total to the premiums as reported on the state page for the state of Illinois for the years noted with no variances; the direct case and IBNR unpaid were totaled for losses and DCC and compared to the unpaid amounts as of 12/31/08 on the state page for the state of Illinois with no variance; the sum of cumulative loss payments and case reserves as of 12/31/08 were compared to the excel spreadsheets by state utilized for the preparation of the annul statement state pages and schedule p with no exception.

The earned premiums by year and IBNR as submitted were derived from the excel spreadsheets by state that were also utilized for the preparation of the annual statement state pages and schedule p with no exception.

I hereby certify the data filed in this submission is accurate and reasonably reconciles with the annual statement for Preferred Professional Insurance Company for the year ended December 31, 2008.



Lynnette Matza, Chief Financial Officer

TOWERS
PERRIN

March 31, 2009

Ms. Lynnette Matza
Senior Vice President Finance
Preferred Professional Insurance Company
11605 Miracle Hills Drive
Suite 200
Omaha, Nebraska 68154-4467

Dear Ms. Matza:

This letter is written to confirm our review of the pertinent data included in PPIC's medical malpractice filing provided in response to requirements under Title 50 Chapter I, Subchapter VV, Part 4303 Insurance Data Reporting Requirements. Based on our review, we believe the data reasonably reconciles with the most recently filed annual statutory financial statement. This letter may be provided as an attachment to PPIC's filing.

Please call if you should have questions.

Sincerely,

TOWERS PERRIN

Bryan G. Young, FCAS, MAAA

BGY:p

Attachments

Direct Dial: 404-365-1635

One Alliance Center, 3500 Lenox Road, Suite 900, Atlanta, GA 30326-4238 tel 404.365.1600 fax 404.365.1660 www.towersperrin.com

MAR.31.2009 2:52PM TILLINGHAST PS ATL NO.109 P.2

Development of Paid losses from PRISM report state sort

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			0	0	200,000	200,000	200,000	200,000	200,000
2003				0	0	40,000	40,000	40,000	40,000
2004					0	0	0	0	0
2005						0	0	0	0
2006							0	0	0
2007								0	0
2008									0
	0	0	0	0	200,000	240,000	240,000	240,000	240,000

Development of Paid losses and DCC from PRISM report state sort

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			3,767	29,868	234,640	234,640	234,640	234,640	234,640
2003				7,596	26,818	104,751	104,751	104,751	104,751
2004					7,078	27,758	36,262	36,262	36,262
2005						12,315	28,864	31,587	33,988
2006							0	0	0
2007								4,668	37,166
2008									14,631
	0	0	3,767	37,464	268,536	379,464	404,517	411,908	461,438

Development of Case losses from PRISM report state sort

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			100,000	400,000	0	0	0	0	0
2003				200,000	200,000	0	0	0	0
2004					0	0	0	0	0
2005						0	50,000	50,000	0
2006							0	0	0
2007								250,000	300,000
2008									1,500,000
	0	0	100,000	600,000	200,000	0	50,000	300,000	1,800,000

Development of Case losses and DCC from PRISM report state sort

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			126,233	400,132	0	0	0	0	0
2003				217,404	213,182	0	0	0	0
2004					37,922	83,178	0	0	0
2005						16,201	72,111	69,388	0
2006							0	0	0
2007								356,580	355,644
2008									1,729,181
	0	0	126,233	617,536	251,104	99,379	72,111	425,968	2,084,825

Expected from year end actuarial from 08dlbyst

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			30,105	48,771	51,539	58,361	53,543	48,743	41,430
2003				198,039	210,387	228,737	223,370	200,696	168,112
2004					656,870	769,642	716,419	636,910	514,675
2005						1,004,267	918,737	806,264	681,350
2006							1,400,744	1,215,402	1,084,709
2007								1,177,613	1,078,169
2008									1,515,953
	0	0	30,105	246,810	918,796	2,061,007	3,312,813	4,085,628	5,084,398

Development of IBNR Losses

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		17,465	0	0	0	0	0	0	0
2002			-69,004	-293,866	23,731	16,248	13,645	9,375	0
2003				230,968	-103,129	63,680	56,923	38,602	0
2004					302,452	214,268	182,570	122,503	20,423
2005						279,588	184,129	105,077	24,608
2006							356,962	233,771	53,412
2007								-23,498	17,770
2008									-141,465
	0	17,465	-69,004	-62,898	223,054	573,784	794,229	485,830	-25,252
Losses IBNR	0								

Development of IBNR ALAE

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		6,429	0	0	0	0	0	0	0
2002			-14,769	39,123	8,777	6,009	5,047	3,468	5,349
2003				141,995	22,647	23,553	21,054	14,277	21,704
2004					73,944	-3,928	67,526	45,310	66,446
2005						87,208	64,485	37,969	87,965
2006							132,027	86,463	140,040
2007								-22,805	83,551
2008									-33,466
	0	6,429	-14,769	181,118	105,368	112,843	290,138	164,682	371,588
ALAE IBNR	0								

Development of IBNR Loss & ALAE - IBNR

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		23,894	0	0	0	0	0	0	0
2002			-83,773	-254,743	32,508	22,257	18,691	12,843	5,349
2003				372,963	-80,481	87,233	77,977	52,879	21,704
2004					376,395	210,340	250,096	167,813	86,869
2005						366,796	248,613	143,046	112,573
2006							488,989	320,234	193,452
2007								-46,303	101,321
2008									-174,931
	0	23,894	-83,773	118,220	328,422	686,627	1,084,367	650,512	346,336

Development of IBNR ULAE

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	-	-	-	-	-	-	-	-	-
2001		-	-	-	-	-	-	-	-
2002			560	1,681	376	283	245	169	211
2003				6,828	1,537	1,108	1,023	695	857
2004					4,798	3,728	3,282	2,205	2,623
2005						4,865	4,209	2,791	3,472
2006							6,417	4,207	5,528
2007								4,076	5,494
2008									7,725
	-	-	560	8,509	6,711	9,984	15,177	14,142	25,910
ULAE unpaid	-	388	560	8,509	6,711	9,984	15,177	14,142	25,910

Development of Paid, Case & IBNR losses and DCC- ILDC

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		23,894	0	0	0	0	0	0	0
2002			46,227	175,257	267,148	256,897	253,331	247,483	239,989
2003				597,963	159,519	191,984	182,728	157,630	126,455
2004					421,395	321,276	286,358	204,075	123,131
2005						395,312	349,588	244,021	146,561
2006							488,989	320,234	193,452
2007								314,945	494,131
2008									1,568,881
	0	23,894	46,227	773,220	848,062	1,165,470	1,560,995	1,488,388	2,892,599

Total Unpaid from 08dirinc

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Loss	0	17,465	30,996	537,102	423,054	573,784	844,229	785,830	1,774,747
ALAE	0	6,429	11,464	198,654	156,472	212,222	312,249	290,650	656,413
ULAE	0	388	560	8,509	6,711	9,984	15,177	14,142	25,910
	0	24,282	43,020	744,265	586,237	795,990	1,171,655	1,090,622	2,457,070

Total Paid from 1208dirinc

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Loss	0	0	0	0	200,000	40,000	0	0	0
ALAE	0	0	3,767	33,697	31,073	70,927	25,054	7,391	49,530
ULAE	0	0	1,494	1,898	3,945	3,607	962	6,288	9,452
	0	0	5,261	35,595	235,018	114,534	26,016	13,679	58,982

Claims opened during year

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			2	0	0	0	0	0	0
2003				1	0	0	0	0	0
2004					2	0	0	0	0
2005						2	0	0	0
2006							0	0	0
2007								6	1
2008									5
	0	0	2	1	2	2	0	6	6

Claims open

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			2	2	0	0	0	0	0
2003				1	1	0	0	0	0
2004					2	2	0	0	0
2005						1	1	1	0
2006							0	0	0
2007								4	3
2008									5
	0	0	2	3	3	3	1	5	8

Claims Closed During Year

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			0	0	2	0	0	0	0
2003				0	0	1	0	0	0
2004					0	0	2	0	0
2005						1	0	0	1
2006							0	0	0
2007								2	2
2008									0
	0	0	0	0	2	2	2	2	3

Allocation of ULAE Paid

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			1,494	949	1,127	-	-	-	-
2003				949	564	515	-	-	-
2004					2,254	1,031	641	-	-
2005						2,061	321	484	556
2006							-	-	-
2007								5,804	3,336
2008									5,560
	-	-	1,494	1,898	3,945	3,607	962	6,288	9,452

Claims closed with loss payment

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			0	0	2	2	2	2	2
2003				0	0	1	1	1	1
2004					0	0	2	2	2
2005						1	1	1	2
2006							0	0	0
2007								1	3
2008									0
	0	0	0	0	2	4	6	7	10

Claims Reported

	2000	2001	2002	2003	2004	2005	2006	2007	2008
2000	0	0	0	0	0	0	0	0	0
2001		0	0	0	0	0	0	0	0
2002			2	2	2	2	2	2	2
2003				1	1	1	1	1	1
2004					2	2	2	2	2
2005						2	2	2	2
2006							0	0	0
2007								6	7
2008									5
	0	0	2	3	5	7	7	13	19

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DIVISION OF INSURANCE
STATE OF ILLINOIS/IDFPR
FILED
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SPRINGFIELD, ILLINOIS

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OCT 2 3 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

October 22, 2007

Ms. Gayle Neuman
Insurance Analyst
Property & Casualty Division
Illinois Division of Insurance
215 West Main Street
~~Frankfort, Kentucky~~ 40601
Springfield, IL

RE: Preferred Professional Insurance Company
NAIC #: 36234
Physicians & Surgeons Rate and Rule Filing
PPIC Filing #: IL-PS-07-06

Preferred Professional Insurance Company
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dear Ms. Neuman:

This letter and the enclosed material are being submitted on behalf of Preferred Professional Insurance Company (PPIC) to be effective October 23, 2007. PPIC is filing a rate decrease of 10% for its physicians and surgeons medical malpractice rates in ~~Kentucky~~ Illinois. Also, in this filing is a relativity change for employed physicians of 0.85. This relativity change is included in the actuarial support included in this filing.

I have included in this filing the an Actuarial Support Letter, Property & Casualty Submittal Document, Form RF-3, Certifications, and a complete rule manual including the employee relativity rule change. I have made a side by side comparison of the rule change as well.

If you should have any questions or require additional information you may contact me at (800) 441-7742, Ext. 248 or at the following email address: eseaman@ppicins.com. Thank you for your consideration of our filing.

Sincerely,

Emalee Seaman

Emalee Seaman
Corporate Compliance Paralegal

Enclosures

Dedicated to enhancing Catholic health care by being a unique insurance resource for health care providers.

Effective March 1, 2007

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

RECEIVED
OCT 23 2007
IDFPR (MPC)
DIVISION OF INSURANCE
SPRINGFIELD

3.	Group Name	Group NAIC #

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Preferred Professional Insurance Company	NE	36234	47-0580977	N/A

5.	Company Tracking Number	IL-PS-07-06

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Emalee Seaman 11605 Miracle Hills Drive, Suite 200 Omaha, NE 68154	Corporate Compliance Paralegal	800-441-7742, Ext. 248	402-392-2673	eseaman@ppicins.com

7.	Signature of authorized filer	Emalee Seaman
8.	Please print name of authorized filer	Emalee Seaman

Filing information (see General Instructions for descriptions of these fields)

9.	Type of Insurance (TOI)	11.1 Med Mal-Claims Made Only
10.	Sub-Type of Insurance (Sub-TOI)	**11.1023 Physicians and Surgeons**
11.	State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12.	Company Program Title (Marketing title)	**Physicians and Surgeons Professional Liability**
13.	Filing Type	☐ Rate/Loss Cost ☐ Rules ☒ Rates/Rules ☐ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	Effective Date(s) Requested	New: October 23, 2007 Renewal: October 23, 2007

Property & Casualty Transmittal Document---

15.	**Reference Filing?**	☐ Yes ☒ No
16.	**Reference Organization** (if applicable)	N/A
17.	**Reference Organization # & Title**	N/A
18.	**Company's Date of Filing**	October 22, 2007
19.	**Status of filing in domicile**	☒ Not Filed ☐ Pending ☐ Authorized ☐ Disapproved

20.	**This filing transmittal is part of Company Tracking #**	IL-PS-07-06

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Preferred Professional Insurance Company (PPIC) is filing a rate decrease of 10% for its physicians and surgeons medical malpractice rates in the state of Illinois. Also, contemplated in this filing is a relativity change for employed physicians of 0.85. The relativity change is included in the acturial support included in this filing.

PPIC is submitting this filing under the use and file provision for rate decreases. PPIC plans to implement these changes with an effective date of October 23, 2007 for new and renewal business.

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: N/A
Amount: **N/A**

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	IL-PS-07-06

2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	N/A

☐ Rate Increase ☒ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	Use & File

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
Preferred Professional Insurance Company	-10%	-14.7%	-$156,338	44	1,563,379	N/A	N/A

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a.	**Overall percentage rate indication (when applicable)**		
5b.	**Overall percentage rate impact for this filing**		
5c.	**Effect of Rate Filing – Written premium change for this program**		
5d.	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	+25%
7.	**Effective Date of last rate revision**	1/1/2004
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	Use & File

9.	**Rule # or Page # Submitted for Review**	**Replacement or Withdrawn?**	**Previous state filing number, if required by state**
01		☐ New ☐ Replacement ☐ Withdrawn	
02		☐ New ☐ Replacement ☐ Withdrawn	
03		☐ New ☐ Replacement ☐ Withdrawn	

CERTIFICATION

Pursuant to Section 215, ILCS 5/155.18 of the Illinois Insurance Code, I, Denise A. Hill,, VP, Corporate Compliance Officer, General Counsel, of Preferred Professional Insurance Company (PPIC), do hereby certify that the Physicians and Surgeons claims Made rates being filed for the State of Illinois are based on sound actuarial principles and are not inconsistent with Preferred Professional Insurance Company's experience.

In Witness Whereof, I have hereunto set my hand this **22nd** *of* **October** *, 20* **07** .

Denise A. Hill
VP, Corporate Compliance Officer, General Counsel
Preferred Professional Insurance Company

STATE OF **Nebraska**
COUNTY OF **Douglas**

On this **22nd** *day of* **October** *, 20* **07** *, Denise A. Hill appeared before me, a Notary Public, and being duly sworn, says that he has read the foregoing statement, and that the statement is true to his best knowledge.*

Notary Public
Notary Signature

GENERAL NOTARY - State of Nebraska
DANA HENDERSON
My Comm. Exp. July 17, 2011

NOTARY SEAL

My Commission Expires: 7-17-11

CERTIFICATION

Pursuant to Section 215, ILCS 5/155.18 of the Illinois Insurance Code, I, Bryan G. Young, FCAS, MAAA, Towers Perrin Tillinghast, do hereby certify that the Physicians and Surgeons claims Made rates being filed for the State of Illinois are based on sound actuarial principles and are not inconsistent with Preferred Professional Insurance Company's experience.

In Witness Whereof, I have hereunto set my hand this 19th *of* October, *20* **07**.

Bryan G. Young, FCAS, MAAA
Actuarial Consultant
Towers Perrin Tillinghast

STATE OF GEORGIA
COUNTY OF COBB

On this 19TH *day of* OCTOBER, *20* **07**, *Bryan Young appeared before me, a Notary Public, and being duly sworn, says that he has read the foregoing statement, and that the statement is true to his best knowledge.*

Notary Public
Notary Signature

Notary Public, Cobb County, Georgia
My Commission Expires March 30, 2010

NOTARY SEAL

My Commission Expires: _____

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DIVISION OF INSURANCE
SPRINGFIELD

Form (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 10/22/07 | -1-08

	(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1.	Automobile Liability		
	Private Passenger		
	Commercial		
2.	Automobile Physical Damage		
	Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Professional Liability (Line of Insurance)	1,563,379-Medical Malpractice	-10.0

Does filing only apply to certain territory (territories) or certain classes? If so, specify:
No.

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
This filing is an overall decrease of 10% to physicians and surgeons claims made rates.

* Adjusted to reflect all prior rate changes.
** Change in Company's premium level which will result from application of new rates.

Preferred Professional Insuarnce Company
Name of Company

Denise A. Hill, VP, Corporate Compliance Officer
Official - Title

03/27/2008 02:46 PM D27C6_31492

Emalee K. Seaman

From: Emalee K. Seaman
Sent: Wednesday, November 14, 2007 12:07 PM
To: 'Neuman, Gayle'
Subject: RE: Preferred Professional Ins Co - Filing #IL-PS-07-06
Attachments: Final Rule Manual.pdf

Ms. Neuman:
We apologize for the confusion of the page numbers. We have revised the page numbers from the 11/1/07 filing and I am attaching a complete manual with all the changes that have been made. Please let me know if there is anything else we need to do to receive approval of our rate and rule filing.
Thank you,
Emalee Seaman
Corporate Compliance Paralegal
Preferred Professional Insurance Company
11605 Miracle Hills Drive, Suite 200
Omaha, Nebraska 68154
Tel. (402) 392-1566 Ext. 248
Fax (402)392-2673

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, November 14, 2007 9:48 AM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

At this time, you have addressed all the issues. However, I have one last basic question about page numbering. When I requested information on territory definitions and additional liability limits on 11/1/07, you provided pages numbered 45 and 46. Pages 45 and 46 that were received with the filing on 10/23/07 seem to contain information required in the filing. It seems you have possibly reused the same page numbers. Please advise at your earliest convenience.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

THIS MESSAGE IS INTENDED FOR THE SOLE USE OF THE ADDRESSEE AND MAY BE CONFIDENTIAL, PRIVILEGED AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAWS. IF YOU RECEIVE THIS MESSAGE IN ERROR, PLEASE DESTROY IT AND NOTIFY US BY SENDING AN E-MAIL TO: Gayle.Neuman@illinois.gov

The link between coverage and caring

PPIC
UNDERWRITING GUIDELINES

As amended on 11/2/07 effective 1-1-2008

THESE ARE GUIDELINES ONLY. PPIC's general underwriting principles and criteria are described in the following pages. However, in no sense is this intended to be a totally comprehensive list of every consideration that may be used in arriving at any particular underwriting decision.

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These guidelines may be affected by individual state requirements. Refer to the specific state filing manual or state mandated endorsement for details.

SUBJECT: COMPANY MISSION	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-01	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

COMPANY MISSION

The vision for the combined organization is to support the Catholic Health Ministry of its owners and other Catholic Healthcare providers by providing a wide array of insurance products and related services at a fair market price to its owners and to insureds who maintain a relationship with Catholic Healthcare Providers. The organization will make available a complete portfolio of insurance products and services, including a full range of primary and excess liability coverages for physicians, hospitals and other healthcare providers, Workers' Compensation and related coverages, fronting programs, and Third Party Administration services such as Claims and Risk Management.

SUBJECT: UNDERWRITING PHILOSOPHY	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-02	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The basis of PPIC underwriting functions is economic. All underwriting decisions are in response to PPIC's determination of the potential for profit or loss.

B. All risks that meet eligibility requirements will be considered for acceptance on a fair, equitable, and consistent basis. PPIC is not obligated to provide coverage to any health care provider.

C. PPIC will perform all underwriting functions using professional standards designed to avoid criticism of the company, its employees, or owners.

D. All information obtained by PPIC will be held in confidence and used for underwriting purposes only. Any request for information from our underwriting files will be honored only with the written permission of the insured health care provider.

SUBJECT: RESPONSIBILITIES	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-03	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. PPIC Board of Directors. The ultimate responsibility to PPIC policyholders for the manner and quality of underwriting as performed on behalf of PPIC rests with the PPIC Board of Directors.

B. PPIC Underwriting Committee. The Board of Directors has delegated to its Underwriting Committee the responsibility for the development of the Company's underwriting philosophy, guidelines, and procedures, subject to Board approval. The Committee will also act as an appeal board for those health care providers wishing to appeal adverse decisions.

C. Management of PPIC. The President and Underwriting staff of PPIC have the responsibility to refine procedures and implement the underwriting guidelines as developed by the Underwriting Committee and approved by the Board of Directors.

SUBJECT: SOURCES OF INFORMATION	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-04	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A) Any or all of the following potential sources of information may be used in determining the acceptability of a physician:

1. Application
2. Applicant or Insured
3. PPIC Claims Department
4. PPIC Risk Management Department
5. Prior Insurers
6. State Department of Licensing and Regulation
7. Other Physicians
8. Hospitals, Hospital Administrators
9. Peer Review and Credentialing Data
10. Any Appropriate Medical Societies
11. Newspapers, Magazines, Radio, Television

B) The National Practitioner Data Bank may not be accessed.

SUBJECT: RISK MANAGEMENT	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-05	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

1) Refer to Risk Management for program details.
2) The Risk Management program is an option available to full time health care providers to earn a discount on their premium. A premium discount is available to health care providers who participate.
3) The premium discount is separate from the individual risk modification shown on guideline UW-25.
4) The premium discount given is based on a calendar year from January 1st to December 31st. The discount is applied to the renewal policy of the insured. If the insured does not renew with PPIC, no discount is allowed.
5) As renewal policies are processed before the risk management discount is known, the discount will be applied to the 2nd quarterly billing, due April 1st. At the April 1st billing, 50% of the discount will be credited, with 25% of the discount applied at the July 1st and the October 1st installment.
6) For those insureds who pay annually, a refund will be sent by April 1st.
7) The premium discount is applied to the extended reporting period premium in the event of cancellation.
8) Risk management discounts do not affect state funds, except for Nebraska. See Underwriting for details on Nebraska.

SUBJECT: INSURED QUALIFICATIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-06	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Must hold unrestricted license to practice in the applicable jurisdiction.
B. Must have an appropriate percentage of his/her practice with the sponsoring hospital. Must do enough "work" at a member institution to take advantage of and participate in Risk Management/Quality Assurance program.
C. Must be Board Certified*, or in the certification process in his/her field or practice or demonstrate equivalents competency if performing surgical specialties, anesthesiology, emergency medicine, or other recognized specialties.
D. Must not perform procedures for which he/she has not been adequately trained, or practice beyond current abilities.
E. Must cooperate with PPIC and have cooperated with previous professional liability carriers in the handling of claims.
F. Should not have a history of mental illness, or physician disability (such as alcohol or drug abuse), without proof the problem no longer exists.
G. Should not have been cancelled or non-renewed by his/her current carrier. (Not applicable if carrier withdrew from market).
H. Should have current insurance coverage.
I. Must not have been the subject of any reprimand, suspension, or any other disciplinary actions by any hospital, medical society, or specialty society that would cause PPIC to question the applicant's medical competence or medical judgment.
J. Should have membership in appropriate medical societies.
K. Should not create an unnecessary exposure to PPIC because of unusual or experimental procedures.
L. Must obtain appropriate informed consent for care or procedures performed.
M. Must keep and maintain adequate and legible medical records for all patients.
N. Must not employ abusive or otherwise inappropriate bill collecting procedures.
O. Must not have an unusually large number of dissatisfied patients, as evidenced by a frequency or lawsuits regardless of the merit of the lawsuit.
P. Must adhere to the Ethical and Religious Directives for Catholic Health Facilities at member facilities.

SUBJECT: INSURED QUALIFICATIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-06	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

Q. Should not perform or participate in:

1. Office cosmetic surgery
2. Weight control by use of drugs
3. Weight control by use of surgical operations
4. Convulsive shock therapy
5. Injection of silicones
6. Sex change surgery

Refer all requests for exception to Vice President of Underwriting.

* See Guideline #UW-33 regarding emergency medicine health care providers.

SUBJECT: NEW BUSINESS AND RENEWAL SUBMISSIONS	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-07	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. No coverage may be bound or issued until approved by the Underwriting Department of PPIC at its home office in Omaha, Nebraska.

B. A fully completed application, signed by the applicant, must be submitted before any underwriting decision will be made.

C. If approved by PPIC, coverage will be bound on the date following postmark or the effective date shown on the application, whichever is later, if a deposit premium of $500 or policy premium, whichever is less accompanies the application.

D. Prior acts coverage may be provided in accordance with the policy terms. See guideline UW-21

E. If no deposit premium is paid, coverage may not be bound until the premium (deposit or quarterly) is received by PPIC. This provision may be waived if applicant is joining an existing PPIC insured group.

F. Renewal questionnaires will be sent to the insured 60 days before policy expiration. It **must** be completed, signed and returned before a renewal policy will be issued.

SUBJECT: PREMIUM PAYMENTS	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-08	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. Premium may be paid annually or quarterly, with no interest or installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-09	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. An extended reporting period of unlimited duration will be offered when a policy is cancelled or nonrenewed for any reason, including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

G. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at the time the coverage is purchased.

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-10	
EFFECTIVE DATE: 07/01/99	REVISION DATE: 07/01/99

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be canceled. The premium is fully earned upon receipt.

D. The extended reporting period coverage may also be purchased by an individual health care provider while the policy is still in effect if the individual health care provider has properly withdrawn his/her coverage from the policy or the individual health care provider is filling a "slot" and the "slot" is closed during the policy period.

E. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled for 6 months and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC and attaining the age of 55.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – PARTNERSHIP, LIMITED LIABILITY COMPANY, CORPORATION	
LINE OF COVERAGE: ALL LINES – CLAIMS MADE	
GUIDELINE NUMBER: UW-11	
EFFECTIVE DATE: 07/01/99	REVISION DATE: 07/01/99

A. Should an individual named insured terminate association with a partnership or corporation, extended reporting period coverage can be provided to the partnership or corporation if the following criteria is met:
   1) The partnership or corporation is insured with PPIC.
   2) The individual named insured has purchased extended reporting period coverage on their individual policy or has purchased prior acts coverage with the new carrier (proof of coverage is required). Each individual named insured who terminated their association with the partnership or corporation has purchased extended reporting period coverage.
   3) Each individual named insured who terminated their association with the partnership or corporation has purchased extended reporting period coverage.

B. If all members of an entity purchase tail coverage, the entity shall then be entitled to purchase tail coverage.

SUBJECT: POLICY PERIOD	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-12	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. All health care provider policies are issued for a period of one year or less and have a common renewal date of January 1st.
B. All new policies will be pro-rated to expire on January 1st.
C. All rate increases will take effect on January 1st for renewal policies.
D. All "step increases" will take effect on the original anniversary date of the policy, with the premium spread equally over the year. (Pro rate "step" (x) plus "step" (x+1)).

EXAMPLE:

Effective date of coverage = 5/1/1989
Effective date of policy = 5/1/1989
Expiration date of policy = 1/1/1990

Annual premium = $12,000 (step x)
Renewal premium = $18,000 (step (x+1))

5/1/1989 to 1/1/1990

Policy premium = $12,000 x .671 (prorate) = $8,052

1/1/1990 to 1/1/1991

$12,000 x (.329) = $3,948 + $18,000 x (.671) = $12,078

Policy premium = $ 3,948 (step x)
+ $12,078 (step (x+1))
$16,026

SUBJECT: CALCULATION OF PREMIUM & MINIMUM PREMIUM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-13	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The initial premium shall be determined on the basis of the health care provider's specialty being practiced at policy inception. All premiums are subject to audit, and premium may be adjusted based on the audit.

B. The premium on policies written for a period of less than one year shall be computed on a prorata basis.

C. Subject to the calculation of premium procedures described above, no health care provider professional liability policy will be issued for a premium charge of less than $100.

D. Additional or return premium of $25.00 or less will be waived. Return premium will be allowed when requested by the insured.

E. Policy changes requiring additional premium will be computed on a prorata basis. The rules and rates in effect at the time of the change will be used to calculate any additional premium.

F. Policy changes (excluding cancellation) requiring return premium will be computed on a prorata basis. The original rates used to calculate the policy premium will be used to compute the return premium.

G. If an extended reporting period endorsement is issued, it is subject to a separate $100 minimum premium.

SUBJECT: CANCELLATION – NONRENEWAL	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-14	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The earned premium will be determined on a short rate basis (.90 of the prorata unearned premium) for the period the policy was in force if the insured cancels.
B. The earned premium will be determined on a prorata for the period the policy was in force if the company cancels.
C. If the insured cancels on the same date as a quarterly premium installment due date and the insured is current in all payments due PPIC, the earned premium will be the same as the premium due up to that quarterly installment date.
D. The earned premium calculated will be subject to the Minimum Premium rule.
E. Extended reporting endorsements may not be canceled, and the premium is fully earned when received.
F. If the company cancels, notice will be sent in accordance with state requirements.

SUBJECT: LIMITS OF LIABILITY	
LINE OF COVERAGE: ALL LINES – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-15	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Manual rates provide the basis limit of liability indicated on the rate page. The limits apply separately to each covered person. When an organization is also covered, the limits may apply separately to that organization (for additional premium) or that organization may share the limits with the insured (at no increase in premium). This may not be applicable in "State Fund" states. See Underwriting Department for details.

B. All health care providers in the same organization must be written with equal limits of liability. The Vice President of Underwriting must approve any exception.

C. The only limits of liability available to a health care provider are those filed and approved in the state applicable to the exposure of the health care provider.

D. PPIC is unable to offer prior acts coverage or extended reporting period coverage at higher limits than those going forward. If the limits going forward are lower and acceptable to the insured for the prior acts coverage, a signed statement is required from the insured indicating their agreement to the limits of liability.

E. State fund states must carry a minimum level of limits of liability. For higher limits, refer to underwriting.

F. State fund states may have exceptions applicable to the Partnership, Limited Liability Company, Association or corporation professional liability coverage. Refer to Underwriting Department for details.

SUBJECT: PARTNERSHIP, LIMITED LIABILITY COMPANY, ASSOCIATION, OR CORPORATION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-16	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. All health care providers who are partners, shareholders, officers, directors, or employees must be individually insured with PPIC. If the corporate entity is a group practice, all health care providers must transfer to PPIC at the renewal of their policy. Limits of liability for the partnership, Limited Liability Company, association or corporation must be equal to those carried by the health care providers.

B. An additional charge of 10% of the "per person" rate for each individual member (including employed) shall apply for all the classifications. The limit of liability provided is separate from the health care providers.

C. A medical corporation, limited liability company or association consisting of a single physician may be included as an additional insured under the sole shareholder physician's individual policy. The limits of liability are shared between the health care provider and the corporation, limited liability company or association. There is no additional premium for the shared limit. This may not be allowed in state fund states, refer to Underwriting Department.

SUBJECT: PREMIUM ADJUSTMENT FOR RISK CHANGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-17	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. Health Care Providers changing their practice to a lower rated classification or rating territory continue to have an exposure to loss from their previous practice. To recognize this exposure change, the following procedure will be used and a one time premium adjustment will apply:
   1. Determine current reporting endorsement premium from previous classification/rating territory $_____
   2. Subtract current reporting endorsement premium from new classification/rating territory $_____
   3. Difference will be premium adjustment $_____

B. The premium adjustment will be in addition to the premium for the new classification/rating territory. The insured original retroactive date will be maintained. Upon termination of the current policy or its renewal, the reporting endorsement premium applicable to the new classification/territory will apply.

C. Charge does not apply for a change in class if:
   1. Both the previous class and current class are the same class, or
   2. The specialty change occurred more than 5 years ago while insured under a claims made coverage (except for physicians having an obstetrical exposure, then a charge will apply).
   3. The specialty change occurred while the doctor was insured under an occurrence policy.

D. Additional exposure for which coverage is provided on or after the effective date of a policy shall be written on the basis of the rates and rules in effect at the time the coverage is provided.

E. If the previous carrier has made a charge for the higher rated exposure, PPIC will still make a charge unless a certificate of insurance is obtained (and approved by PPIC) that the previous carrier is providing extended reporting period coverage on the higher rated exposure.

SUBJECT: LIMITS OF LIABILITY REDUCTION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-18	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. When limits of liability are reduced on a policy of PPIC, extended reporting period coverage will be offered. If purchased, the previous limits will apply to incidents that occurred before the effective date of the change endorsement, subject to all other terms of the policy.

B. Limits of liability may not be increased for an extended reporting period endorsement. The limits shown on the last full term policy will be the only limits offered on the extended reporting period endorsement.

SUBJECT: PHYSICIANS AGE 70 OR OLDER	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-19	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. Insured physicians wishing to continue practicing medicine following their 70th birthday will be required to have a complete physical examination done by an unrelated physician.

B. A family member or a physician in the same clinic as the insured physician may not do the examination.

C. The examination must indicate the insured physician is in good physical and mental health. Any negative result will be referred to the Underwriting Committee Chairperson for review and determination if coverage may be continued.

D. The cost of the examination will be the responsibility of the insured physician.

SUBJECT: PHYSICIANS LEAVING SPONSORING HOSPITAL	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-20	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. If for any reason, other than death, disability, or retirement, a physician does not maintain an appropriate presence, or is no longer on staff of a sponsoring institution, the physician will lose eligibility to obtain coverage from PPIC.

B. The physician will be notified as soon as possible of nonrenewal or cancellation. PPIC will cooperate with the physician to allow a reasonable time for the physician to find replacement coverage.

C. Extended reporting period coverage will be offered in accordance with the policy provision.

D. State insurance laws will govern the use of this guideline.

SUBJECT: RETROACTIVE DATE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-21	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Once the retroactive date is established, it will not be advanced without the written consent of the insured. If advanced, "tail" coverage will be offered for the prior period.

B. Requests for a retroactive date prior to the first effective date will require underwriting approval. All known or pending claims will be excluded from the coverage offered.

C. Rates will be adjusted to the appropriate "year" in the claims made interim adjustments, or to the "mature" rate.

D. Health Care Providers who have moved from different rating territories, or who have changed their practice, and the requested retroactive date will include the exposure of their previous territory or previous higher rated practice, require the approval of the Underwriting Department. See guideline UW-17 for premium charge.
   1. If accepted by PPIC, a higher premium charge will be made.
   2. If PPIC is not a licensed carrier in the prior state, prior acts coverage is unavailable.
   3. If the prior state is a very high rated state, prior acts coverage is unavailable.
   4. If the health care provider spent 10 years or more in a different state, prior acts coverage is unavailable.

SUBJECT: CLASSIFICATION PROCEDURE/OTHER STATE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-22	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Classification assignment for rating purposes shall be made on the basis of medical specialty and performance or nonperformance of medical procedures.

B. The initial basis of classification assignment shall be the physician's highest rated specialty, from which more than 9% of his/her practice is derived. (example – a general surgeon (class 5) does 25% vascular surgery (class 6), rate as class 6.)

C. Any surgeon who assists in surgery only (100% of their practice) shall be rated 80445 – Surgeon/Assisting Only (Class 4). This does not apply to neurosurgery.

D. The rates as shown in this manual contemplate the exposure as being derived from professional practice within the state. For those who derive part of their income from outside the state, the territory to be used for rating purposes shall be a "blend" of the rates for each territory using the following guidelines:

1.	9% or less	No change to the rating.
2.	10 – 50%	Use the percentage of the higher rated state(s) premium in relation to the lower rated state(s) times the percentage of practice in the higher rated state times the base state rates. (Example: Iowa rates are 20% higher than Nebraska. A NE physician derives 15% of his income from IA. .20 x .15 = .03 x the NE rates for the IA exposure
3.	51% or Greater	Rated at the highest rated territory.

4. If the physician practices in more than 2 states, refer to underwriting.

SUBJECT: NEWLY PRACTICING AND PART TIME PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-23	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Newly practicing physicians. Physicians who have been in practice for less than 12 months following completion of medical training or retraining for a new medical specialty practice shall receive a premium discount. (Physician just leaving full time military practice shall be included.)
   1. Newly practicing going into "solo" practice – 50%
   2. Newly practicing going into "group" – 25%

B. Part time. Physicians whose clinical medical practice time does not exceed an average of 25 hours per week shall receive a premium discount:
   1. Less than 10 hours a week – 35% discount
   2. Less than 25 hours a week – 25% discount

SUBJECT: RESTRICTION AND/OR SUSPENSION OF COVERAGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-24	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Suspended coverage. Premiums will be prorated for physicians who are temporarily in a voluntary inactive practice status for more than 3 months. This could include:
   1. Pregnancy
   2. Military duties
   3. Missionary work outside the United States.

   The policy will be endorsed to exclude any medical incident occurring during the time of suspension.

B. Restrictions of coverage or increased rate. Policies may be issued with special restrictions or at increased premium if:
   1. the insured agrees;
   2. the policy could not be written otherwise;
   3. and in admitted states, a consent to rate filing is approved by the state regulators.

   In state fund states, this may not be allowed, refer to underwriting.

SUBJECT: INDIVIDUAL RISK MODIFICATION	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-25	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. An adjustment to the premium (maximum of +/- 25%) developed at inception may be allowed, based on:
   1. Unusual or difficult procedures/characteristics;
   2. Failure to comply with reasonable Risk Management recommendations (negative only);
   3. Prior claim history (viewed as a function of the effectiveness of loss control);
   4. Cooperation with sponsoring hospital;
   5. Collection procedures.

B. The risk management program is in addition to the credits shown above.

C. An adjustment to the premium (maximum of –20%) developed at inception may be allowed for a group of health care providers employed by a health care facility. The health care facility must be owned by one of PPIC's owners. If a group has qualified for this adjustment and the health care facility discontinues employing the group, the adjustment may continue for 3 years after the employment ends.

D. The adjustment to the premium available is dependent on individual state approval.

SUBJECT: VICARIOUS LIABILITY	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-26	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The rate for employed or full time contract physicians or surgeons shall be 10% of the rate applicable for the employed physician or surgeon.

SUBJECT: HEALTH MAINTENANCE ORGANIZATIONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-27	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Coverage for the vicarious liability of PPOs or HMOs arising out of professional services performed by contracting physicians shall be $0.20 per person enrolled. Code as 80999. Must be approved by Underwriting Department.

SUBJECT: CONTRACTUAL LIABILITY	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-28	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. The policy provides no coverage for contractual liability

B. Any contract must contain at minimum a mutual hold-harmless agreement. The health care provider cannot hold the PPO/HMO harmless for the PPO's/HMO's acts.

C. Coverage for liability of others assumed under contract by insured physicians and surgeons shall be submitted for rating. Code as 80999. Must be approved by the Underwriting Department.

SUBJECT: LOCUM TENENS COVERAGE	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-29	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Coverage for locum tenens physicians may be provided by adding the locum tenen physician to the insured physician's policy. Coverage should not normally be provided for a period exceeding 45 days.

B. If the locum tenen physician shares the limit of liability with the named insured, no additional premium will be charged. Code as 80179.

C. See Endorsement #PP-133 for terms and conditions.

D. An application must be completed and approved prior to implementing coverage. At each policy renewal a renewal questionnaire must be completed. PPIC may require updated information at any time if the locum tenen continues to work for the insured health care provider.

SUBJECT: DEPARTMENT HEADS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-30	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

A. Completed application is required. Rate according to the following schedule:

Time involved in Patient Contact	**Department Heads with Limited Clinical Duties** % applied to Physician or Surgeon Rate
Less than 25%	50%
25% to 30%	55%
30% to 35%	60%
35% to 40%	65%
40% to 45%	70%
Over 45%	75%

SUBJECT: ORAL SURGEONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-31	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Any dentist engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia.

B. Rate as a Class 5, but code as 80210.

SUBJECT: EMERGENCY ROOM PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-32	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. A physician specializing in the practice of emergency medicine must meet the following criteria:
   1. Have Board Certification in emergency medicine, or
   2. Have Board Certification in a primary care specialty (family practice or internal medicine) and have completed a course in ACLS, ATLS, and either PALS or APLS.

SUBJECT: RATES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-33	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. Rates apply on an individual insured basis and are available in the applicable state rate filing manual.

B. For risks not found in the Manual, or procedures or techniques not otherwise identified, defined, or classified, submit for rating.

C. Rates are for an annual period of time.

SUBJECT: DEDUCTIBLES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-34	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. The following credits apply for the deductible indicated. To determine deductible premium, apply the following percentage to the 100/300 premium and deduct the result from the increased limit premium.

Deductible Applies to Indemnity Only

Deductible	Credit Physician	Credit Surgeon
$5,000/$15,000	5%	5%
$10,000/$30,000	10%	10%
$25,000/$75,000	20%	18%
$50,000/$150,000	35%	35.5%
$100,000/$300,000	57.5%	58.5%

Deductible Applies to both Indemnity and Loss Adjustment Expense

Deductible	Credit Physician	Credit Surgeon
$25,000/$75,000	35%	34%
$50,000/$150,000	50%	49%
$100,000/$300,000	72.5%	72.5%

B. On group policies the total amount an insured may pay for a deductible may be capped. Pricing will vary depending on experience, the number of health care providers, and the cap selected. Refer to underwriting.

SUBJECT: CLINICS	
LINE OF COVERAGE: HEALTH CARE PROVIDER	
GUIDELINE NUMBER: UW-35	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. PPIC must insure all physicians in the clinic.

B. The clinic cannot provide overnight patient stays and must meet all company requirements.

C. Limits equal to the limits provided for the physician are available to the clinic, on a separate policy (use form CP-101). All physicians utilizing the clinic must carry limits equal to or greater than the limits available to the clinic and proof of coverage.

D. To determine the rating for the clinic, (A) use 10% of the total physicians premium divided by the total number of patients expected in the clinic that year, (b) add 1.4% of a class 1 fully mature physician rate at the limits purchased to allow for employees, and (c) multiply the sum by 100. The total is the rate per 100 outpatient visits.

EXAMPLE:

Total premium of all physicians in clinic: $35,000 x 10% = $3,500
Total number of patient visits expected: 10,000

Physician charge per patient = $3,500 10,000 = $.35
$.35 x 100 = $35.00 per 100 visits

PLUS

Class 1 physician mature rate (at policy limits): $5,000
Employee Charge = 1.4% x 5,000 = $70.00 per 100 visits

CLINIC CHARGE PER 100 VISITS =

$35.0 + $70.00 = $105.00 per 100 visits
10,000 visits = 100 x $105.00 = $10,500

E. Long term treatment clinic (i.e. dialysis, etc.) are rated per 100 outpatient visits:
1. California: 3% of Class 1 rate
2. All other states 1% of Class 1 rate

SUBJECT: CLINICS (Continued)	
LINE OF COVERAGE: HEALTH CARE PROVIDER	
GUIDELINE NUMBER: UW-35	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

F. Reporting form endorsement is available. If all professionals of the clinic purchase tail coverage, the clinic shall then be entitled to purchase tail coverage by giving the Company written notice within 30 days of its intent to purchase, and paying the appropriate premium. If all health care providers do not purchase tail coverage, the clinic is not eligible for tail coverage.

G. If no prior acts is provided to the clinic or to any health care provider in the clinic, the extended reporting period premium may be waived. The account would be written at fully mature rates at the inception of the program with PPIC. Any new health care providers added to the clinic in the future will not have prior acts provided. The clinic must develop $250,000 in annual premium and be approved by the Underwriting Department prior to offering this option to an account.

SUBJECT: ACCELERATED REPORTING	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-36	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. A free tail may be provided for those who would not otherwise qualify because they have less than 5 years to work before retirement. This situation occasionally occurs when a group of physicians is considering PPIC and certain members fall into the description described above. The following criteria must be met:
   1. The insured anticipates retirement from his or her profession in less than 5 years,
   2. The insured has attained age 55, and
   3. The insured has a claims-made coverage with the company in a group practice.

   The total number of insureds, within a group practice, that may qualify for the Accelerated Reporting Endorsement may not exceed a ratio of 1 in 5.

B. Extended reporting period coverage would be provided to the corporate entity also.

C. Refer to Underwriting for prior approval.

SUBJECT: RETIRED VOLUNTEER PHYSICIANS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-37	
EFFECTIVE DATE: 07/01/92	REVISION DATE: 07/01/99

A. This program is available in Nebraska, Colorado, and Texas only.

B. This program is for former physician policyholders of PPIC that are retired and have valid reporting endorsements. These physicians must work without remuneration. No coverage will be provided for any obstetrical, prenatal, invasive or surgical procedures of any type.

C. Coverage may be written on an individual basis only.

D. The physicians should have a valid, current medical license.

E. The maximum allowable number of hours worked per week is 20.

F. Rates apply on a per person basis and appear below. The rates apply regardless of policy term and regardless of the number of years the retroactive date precedes the policy expiration date.

Senior Volunteer Physician – No Surgery	All Number of Years
80579	$100.00

1) No premium discounts are allowable under this program.
2) No pro rata factors apply to this program.
3) A policy writing minimum premium applies to this program.

G. Partnership coverage and employee coverage is not available under this program.

H. The physicians must sign the supplemental application verifying they are doing no obstetrical, prenatal, invasive or surgical procedures.

I. These policies are not eligible for retrospective premium returns.

J. No premium payment plan is available.

K. The limits of liability are $100,000 each medical incident and $200,000 annual aggregate. Limits of liability may not be increased or decreased under this program. (200,000/600,000 in Nebraska only.)

L. Locum tenens provisions do not apply to this program.

M. Employees as additional insured coverage is not permitted under this program.

N. The reporting endorsement will be issued at no charge under this program. The physician must be retiring completely from this program.

SUBJECT: PAYROLL EMPLOYEES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-38	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. Shared Limits of Liability for Payroll Employees:

1. Coverage is provided at no charge to the insured physician for his/her liability for the supervision or the acts of payroll employees.
2. Payroll employees are additional insureds under the policy (except physicians, surgeons, certified registered nurse anesthetists, physician or surgical assistants, nurse midwives, podiatrists, and dentists).
3. The excluded payroll employees shown in 2. above may be added for an additional charge. Refer to B below.
4. Payroll employees as additional insureds have coverage restricted to professional acts done as an employee of our insured. There is no coverage for any independent work of the payroll employee insured.
5. Payroll employees will be added to a corporation policy. If the insured is a sole proprietor, the employees may be added to the sole proprietor's policy.
6. Limits of liability are always shared with the corporation, or physician. For separate limits see B. below.
7. Volunteers will be considered as a payroll employee provided that they are not excluded in 2. above.
8. No additional premium is charged.
9. The extended reporting period for the policy to which the payroll employee is attached governs the tail coverage for all payroll employees.

B. Separate Limits of Liability for Payroll Employees and Excluded Payroll Employees

1. Coverage is provided at no charge to the insured physician for his/her liability for the supervision or the acts of all employees.
2. Payroll employees will be endorsed as an additional insured under the policy
3. Payroll employees as additional insureds have coverage restricted to professional acts done as an employee of our insured. There is no coverage for any independent work of the payroll employee insured.

SUBJECT: PAYROLL EMPLOYEES (Continued)	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-38	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

4. Payroll employees will be added to a corporation policy. If the insured is a sole proprietor, the payroll employees may be added to the sole proprietor's policy.
5. A separate limit of liability will be provided to each payroll employee in which a premium is collected.
6. The premium is determined as follows:
   a. Determine the at limits rates for a class 1 physician, at the same "claims made" step as the physician the payroll employee does the majority of their work for.
   b. Based on the specialty of the employee, determine the correct code number and rate percentage. The code # and rate percentage are shown on the following page.
   c. Multiply the percentage determined by the rate.
7. Minimum premium to add a payroll employee is $100 per employee.
8. The para-professional employee shall have the option to purchase extended reporting period coverage for the policy to which the coverage is attached.

Code	Specialty Description	% of Class 1 Rates filed on State Rate Pages
	Dentists	Refer to Underwriting
	Nurse:	
87907	Anesthetist	
	a. Supervised by Surgeon	1.50
	b. Supervised by Anesthesiologists	.75
87908	c. Unsupervised	2.00
87910	Midwife	1.75
	Physician	As shown in Classification Table
	Employed Physician	0.85 of practicing specialty as shown in the Classification Table
87920	Physician Assistant	.25
87921	Podiatrist (surgery)	2.50
87922	Podiatrist (no surgery)	1.75
	Surgeon	As shown in Classification Table
87924	Surgical Assistant	.60
87998	All Other	Refer to Underwriting

- If more than two CRNA's are supervised by one anesthesiologist, refer to Underwriting for rating.

MISCELLANEOUS PROFESSIONALS – PER EMPLOYEE

Description	**Class Code**	**Relativity**
Health Sciences – Physicist/Biologist	90101	0.15
Chiropractor	80410	0.60
Chiropractor – Employed	80411	0.25
Chiropractor – Assistant	90304	0.25
Laboratory Services – Supervisor/Director	90401	0.075
Laboratory Services – Medical Technician	80711	0.05
Laboratory Services – X-ray Technician	80713	0.05
Laboratory Services – EEG/EKG/Ultrasound Tech.	90405	0.075
Dietician or Nutritionist	87903	0.075
Midwife Assistant	91402	0.50
Nursing Services – Nurse	80998	0.025
Nursing Services – Aide/Homemaker	91504	0.02
Nursing Services – Student Nurse Anesthetist	91509	0.40
Nursing Services – RN Anesthetist	91510	1.30
Occupational Therapist	91601	0.60
Occupational Therapist – Assistant	91602	0.35
Optician	87916	0.075

Optometrist	80994	0.075
Optometrist – Employed	80944	0.025
Optometry-Assistant/Technician	91802	0.15
Opthamalogic Technician	87926	0.10
Orthotics/Prosthetist – Fitting Only	91901	0.50
Prosthetist	87927	0.75
Pharmacist	59112	0.10
Pharmacist Assistant	92002	0.075
Physical Therapist – Owner	80995	0.15
Physician Therapy-Assistant/Aide/Technician	92102	0.05
Physical Therapist – Employed	92103	0.075
Physician Extender – Nurse Practitioner	92201	0.40
Physician Extender-Phys/Surg/Anesth. Assistant	92202	0.50
Physician Extender – Perfusionist	92203	1.25
Psychologist	92401	0.35
Respiratory Therapist	92601	0.50
Respiratory Therapist – Aide/Assistant/Tech	92602	0.35
Social Worker	87905	0.10
Health Services NOC – Paramedic/EMT	93105	0.25
Health Services NOC – Medical Office Assistant	93106	0.035
Health Services NOC – Operating Room Technician	93107	0.075
Dentist – Hygienist	93201	0.10
Dentist – NOC	93202	0.60
Dentistry – Oral Surgeon	80210	Class 5
Dental Anesthesia	93211	2.00
Dentistry – Orthodontist	93212	0.60
Dentistry – Pedodontist	93213	0.60
Dentistry – Periodontist	93214	0.60
Dentistry – Prosthodontist	93215	0.60
Dentistry – Endodontist	93216	0.60
Dentistry – Oral Pathologist	93217	0.60
Dentistry – Public Health	93218	0.60
Dentistry – AAOMS Member	93219	1.50
Dentistry – Other than Oral Surgeons	93220	1.50
X-Ray Therapy	80714	0.025
Chiropodist	80993	0.075
Chiropodist – Employed	80943	0.025
OR Technician	87914	0.35
Scrub Nurse	87912	0.35

SUBJECT: SLOT-RATED GROUP PROGRAM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-39	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

A. These rating programs are available to those facilities that tend to have a constant number of Full Time Equivalencies (FTE's), with high health care provider turnover.

B. Prior to a slot-rated program being bound, the insured must sign a written agreement indicating the entity will purchase tail coverage from PPIC or obtain prior acts coverage from another carrier. If prior acts coverage is obtained, the new carrier must hold PPIC harmless for certificates of insurance regarding tail coverage that were issued to prior occupants of the slot.

C. The policy provides coverage for all previously terminated and all current health care providers who are scheduled. Only if the program or a slot is terminated will a reporting endorsement be required to cover all past and present individuals.

D. "Slots" (or positions) will be used to determine the exposure base. A "slot" is based on an average of a 50 hour work week for one or more part-time health care providers. Slots may be based on full time equivalent of 50 hours (FTE) if more than one health care provider fills the "slot" during a work week. (A health care provider working full time occupies a "slot" regardless of the number of hours worked.)

E. If .50 or less of a slot is the hours contemplated, round the slot down. If .51 or more of a slot is the hours contemplated, round the slot up. A minimum of one slot is required if any health care provider is working in a particular specialty.

F. Rating for the claims made process will reflect the retroactive date of the slot.

G. RESIDENTS AND INTERNS: Rating for the claims made process will reflect the retroactive date of the program or of the new slot.

H. If a slot remains empty for an extended period of time (90+ days), it will be closed and tail coverage must be purchased. The first slot opened is the first slot closed for rating purposes.

I. PPIC will not offer prior acts coverage on a slot-rated program.

SUBJECT: NON-SLOT RATED GROUP PROGRAM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-40	
EFFECTIVE DATE: 07/01/99	REVISION DATE: 07/01/99

A. A group of health care providers may be placed on a MP-101 policy without using slot rating. This is the equivalent of one health care provider to one slot.

B. If a health care provider discontinues coverage with PPIC, the health care provider must either purchase tail coverage or obtain prior acts coverage from the new carrier.

C. Prior acts coverage is available upon review and acceptance of a completed application.

D. Payroll employees are not included in this policy. If coverage is desired for payroll employees, a separate corporate policy must be issued. Use guideline UW-37.

SUBJECT: CLASSIFICATION TABLE
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-41
EFFECTIVE DATE: 07/01/92 | **REVISION DATE: 07/01/99**

Classification	No Surgery	Minor Surgery	Major Surgery
Aerospace Medicine	(1) 80230	-	-
Allergy	(1a) 80254	-	-
Anesthesiology This classification applies to all general practitioners or specialists who perform general anesthesia or acupuncture anesthesia	-	-	(5a) 80151
Broncho-Esophagology	-	-	(3) 80101
Cardiovascular Disease	(1) 80255	(2) 80281	(6) 80150
Dermatology	(1a) 80256	(2) 80282	-
Diabetes	(1) 80237	(2) 80271	-
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital, or rescue facility.	(4) 80102		(5) 80157
Endocrinology	(1) 80238	(2) 80272	(3) 80103
Family Physicians or General Practitioners – including obstetrical procedures	-	(3) 80421	(4) 80117
Family Physicians or General Practitioners – no obstetrical procedures	(1) 80420	(2) 80423	(4) 80117
Forensic Medicine	(1a) 80240	-	-
*CO, DE, IA, LA, MD, and NE Gastroenterology	(1) 80241	(2) 80274	(3) 80104

General Preventive Medicine	(1) 80231	-	-
Geriatrics	(1) 80243	(2) 80276	(3) 80105
Gynecology	(1) 80244	(2) 80277	(5) 80167
Hematology	(1) 80245	(2) 80278	-
Hypnosis	(1) 80232	-	-
Infectious Diseases	(1) 80246	(2) 80279	-
Intensive Care Medicine This classification applies to any general practitioner or specialist employed in an intensive care hospital unit.	(2) 80283	-	-
Internal Medicine	(1) 80257	(2) 80284	-
Laryngology	(1) 80258	(2) 80285	(5) 80106 (4) *
Legal Medicine	(1a) 80240	-	-
Neoplastic Diseases	(1) 80259	(2) 80286	(3) 80107
Nephrology	(1) 80260	(2) 80287	(3) 80108
Neurology – including child	(1) 80261	(2) 80288	(8) 80152
Nuclear Medicine	(1) 80262	-	-
Nutrition	(1) 80248	-	-
Occupational Medicine	(1) 80233	-	-
Ophthalmology	(1) 80263	(2) 80289	(3) 80114 (2) *
*CO, DE, IA, LA, MD, NE Otology	(1) 80264	(2) 80290	(5) 80158 (4) *
Otorhinolaryngology	(1) 80265	(2) 80291	(5) 80159 (4) *

Pathology	(1a) 80266	(2) 80292	-
Pediatrics	(1) 80267	(2) 80293	-
Pharmacology	(1) 80234	-	-
Physiatry	(1) 80235	-	-
Physician Medicine and Rehabilitation	(1) 80235	-	-
Physicians – This is a N.O.C. classification	(1) 80268	(2) 80294	-
Physicians – Major invasive procedures – This classification applies to all general practitioners or specialists except those performing major surgery, anesthesiology, or acupuncture anesthesiology, who perform any of the following medical techniques or procedures: • Acupuncture – other than acupuncture anesthesia • Angiography • Arteriography • Catheterization – arterial, cardiac or diagnostic – other than (1) the occasional emergency insertion of pulmonary wedge, pressure recording catheters or temporary pacemakers, (2) urethral catheterizations, or (3) umbilical cord catherterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen. • Cryosurgery – other than use on benign or pre-malignant dermatological lesions. Listing continued on next page	(2) 80422	-	-

*CO, DE, IA, LA, MD, NE

- Discograms
- Lasers-used in therapy
- Lymphangiography
- Mylegraphy
- Phlebography
- Pneumoencephalography
- Radiation therapy
- Shock therapy

Physicians – Minor invasive procedures – This classification applies to all general practitioners or specialists, except those performing major surgery, anesthesiology, or acupuncture anesthesiology, who perform any of the following medical techniques or procedures: • Colonoscopy • ERCP (endoscopic retrograde cholangiopancreatography) • Needle biopsy – including lung and prostrate, but not including liver, kidney, or bone marrow biopsy. • Pneumatic or mechanical esophageal dilation (not with bougie or olive) • Radiopaque Dye – injections into blood vessels, lymphatics, sinus tracts of fistulae (not applicable to Radiologists Code 80280)	(2) 80443	-	-
Psychiatry – including child	(1a) 80249	-	-
Psychoanalysis	(1a) 80250	-	-
Psychosomatic Medicine	(1a) 80251	-	-
Public Health	(1a) 80236	-	-
Pulmonary Diseases	(1) 80269	-	-
*CO, DE, IA, LA, MD, NE Radiology – diagnostic – Minor surgery includes radiopaque dye injections into blood vessels, lymphatics, sinus tracts, or fistulae	(1) 80253	(2) 80280	-

Rheumatology	(1) 80252	-	-
Rhinology	(1) 80247	(2) 80270	(5) 80160 (4) *
Surgery – abdominal	-	-	(5) 80166
Surgery – assist only	-	-	(4) 80445
Surgery – cardiac	-	-	(6) 80141
Surgery – colon and rectal	-	-	(3) 80115
Surgery – general – This is a N.O.C. classification. This classification does not apply to any general practitioners or specialists who occasionally performs major surgery	-	-	(5) 80143
Surgery – hand	-	-	(5) 80169
Surgery – head and neck	-	-	(5) 80170
Surgery – neurological	-	-	(8) 80152
Surgery – obstetrics	-	-	(7) 80168
Surgery – obstetrics/gynecology	-	-	(7) 80153
Surgery – orthopedic	-	-	(6) 80154
Surgery – plastic – This is a N.O.C. classification	-	-	(5) 80156
Surgery – plastic – Otorhinolaryngology	-	-	(5) 80155
Surgery – thoracic	-	-	(6) 80144
*CO, DE, IA, LA, MD, NE Surgery – traumatic	-	-	(6) 80171
Surgery – urological	-	-	(3) 80145
Surgery – vascular	-	-	(6) 80146

Urgent Care Physicians – This classification applies to any general practitioner or specialist providing immediate care in an outpatient clinic advertised as urgent care, urgicare, etc., but not involving emergency practice. Similar practice in a hospital setting or one that accepts ambulance service shall be considered emergency medicine.	(1) 80424	-	-

*CO, DE, IA, LA, MD, NE

SUBJECT: PROCEDURE LISTING	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-42	
EFFECTIVE DATE: 07/01/92	**REVISION DATE: 07/01/99**

The attached listing contains commonly asked about procedures. Several of the procedures indicate a range the classification could fall in. The final determination of these procedures is dependent on the overall practice of the physician.

Acupuncture	Class 2
Adolescent patients	Class 1
Allergy testing	Class 1
Anesthesia – Spinal	Refer to VP-Underwriting. Needs rated up from 5a
Angiography	Class2
Angioplasty – Coronary/Stints	Class 2 w/25% debit
Angioplasty – All Other	Class 2
Assisting in the performance of surgery on own patients	Class 2 or 3 (minor surgery)
Assisting in the performance of surgery on patients other that own	Class 4 (major surgery)
Arterial, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker). This does not apply to Swanz-Ganz, umbilical cord or urethral catheterization, or arterial line in a peripheral vessel. (Swanz-Ganz should not be performed by FP's – should be cardiologists or internal medicine only.	Class 2
Arteriography	Class 2
Audiogram	Class 1
Bone Marrow Transplants	Class2
Carpal Tunnel Injections	Borderline Class 1 or 2
Cervical conization	Class 2
Chemobrasion	Class2
Circumcision	Class 1 or 2 (depends on what else doing)
Closed reduction of fractures of the extremities, scapula, clavicle, and ribs requiring closed manipulation	Class 2
Colposcopy	Class 2 (borderline 1)
Colonoscopy	Class 1
Cryosurgery	Class 2

D&C	Class 2
Dermabrasion	Class2
DEXA scans (bone density imaging test)	Class 1
Diagnostic/therapeutic D&C	Class 2
Diagnostic Spinal Tap	Class 1
Diet/Weight Counseling	Class 1
Digital amputation	Class 2
EGD (esophago-gastro-duodenoscopy) (upper GI endoscopy)	Class 2
Electroshock therapy	Class2
Electroencephalography, Electroneuromyography, or Evoiced potentials	Class 1
Endocervical polyp removal	Class 1
Endometrial biopsies	Class 1 or 2 (what else doing i.e. lot's of gyn?)
Endoscopic procedures – bronchoscopy, colposcopy, diagnostic cystoscopy, gastoscopy and diagnostic laparscopy	Class 2
ERCP (endoscopic retroagrade cholangio-pacreatography)	Minor surgery (borderline major); Must review training.
Event Monitoring	Class 1
Excisional biopsy	Class 1
Extraocular surgery (includes surgery on cysts and lids)	Class 2
Flex Sigmoidoscopy	Class 1
Hair Transplantation	Class 2
Intervententional radiology such as embolization, percutaneous transluminal angioplasty, percutaneous nephrostomy and other drainage procedures.	Class 2
IUD insertion	Class 1
Joint injection	Class 1
Laryngoscopy	Class 1
Liquid nitrogen cryotherapy	Class 1
Lumbar puncture	Class 1
Lymphangiography	Class 2
Myelography	Class 2 if FP, Class 1 if radiologist
Needle biopsies of breast, lung, prostate	Class 2
Needle biopsies of liver, kidney, and bone marrow	Class 1
Neonatal	Class 2
Office Splinting	Class 1
Paracentesis	Class 1
Paronychia, I&D (puss pocket)	Class 1
Pediatrics – no surgery – no neonatal	Class 1

Pediatrician attending C-Sects	Must have PALS
Pericardiocentesis	Class 2
Pneumatic esophageal dilation for achalasia	Class 2
Pneumoencephalography	Class 2
Pulmonary Function	Class 1
Punch biopsy	Class 1
Radiopaque Dye Injections	Class 2
Radiation Therapy	Class 2
Rheumatology	Class 1
Sports Medicine patients	Class 1
Stress Testing	Class 1
Sutures	Class 1
Therapeutic radiology, deep (includes radium implants)	Class 2
Thoracentesis	Class 2 at least
Toenail removal	Class 1
Transplants	Class 6 or 7 (Training, how many done, age, etc.)
Treadmill test	Class 2
Trigger point injections	Class 1
Urgent Care	Class 1 or 3 dependent on state quoted in
Vasectomy	Class 2

SUBJECT: TERRITORIAL DEFINITIONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-43	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

Illinois Territorial Definitions

TERRITORY 1
The following Counties: Champaign, Macon, Sangamon

TERRITORY 2
The following Counties: Coles, DeKalb, LaSalle, Ogle, Randolph, Winnebago

TERRITORY 3
The following Counties: Cook, Madison, St. Clair

TERRITORY 4
The following Counties: DuPage, Kane, McHenry

TERRITORY 5
The following Counties: Jackson, Vermillion

TERRITORY 6
The following Counties: Kankakee

TERRITORY 7
The following Counties: Lake

TERRITORY 8: Remainder of State

TERRITORY 9
The following Counties: Will

* Independent Cities within the county described above are also included in the territory designated.

SUBJECT: INCREASED LIMIT FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-44	
EFFECTIVE DATE: 11/01/2007	REVISION DATE: 11/01/2007

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians not performing major surgery in classes 1 through 4:

Limits ($000s)	Factor
100/300	1.000
200/600	1.270
250/750	1.370
500/1,500	1.760
1,000/3,000	2.200
2,000/4,000	2.690

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians performing major surgery in classes 5A through 8:

Limits ($000s)	Factor
100/300	1.000
200/600	1.310
250/750	1.430
500/1,500	1.900
1,000/3,000	2.480
2,000/4,000	3.030

Actuarial equivalents apply to all other limits not specifically shown.

03/27/2008 02:48 PM D27C6_31492

Emalee K. Seaman

From: Neuman, Gayle [Gayle.Neuman@illinois.gov]
Sent: Wednesday, November 14, 2007 9:48 AM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

At this time, you have addressed all the issues. However, I have one last basic question about page numbering. When I requested information on territory definitions and additional liability limits on 11/1/07, you provided pages numbered 45 and 46. Pages 45 and 46 that were received with the filing on 10/23/07 seem to contain information required in the filing. It seems you have possibly reused the same page numbers. Please advise at your earliest convenience.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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November 14, 2007

Ms. Gayle Neuman
Property & Casualty Compliance
Illinois Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: Preferred Professional Insurance Company
NAIC #: 36234
Physicians & Surgeons Professional Liability
Policy Forms & Endorsements-Rule Manual
IL-PS-07-06

Preferred Professional Insurance Company
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dear Ms. Neuman:

The rate pages show rates for each class based on the 100,000/300,000 limit class relativity. A class 1 has a class relativity of 1.00 while a class 7 (OB/GYN) has a relativity of 6.00. If you review the first rate page for Territory 1 the mature rate at 100,000/300,000 for a class one is $8,190 and for a class 7 at the same base rate the premium is $49,140. A class 7 has a relativity factor of 6.00 so $8,190 x 6.00 = $49,140. The relativities used to express the base rates on the rate pages were determined by our actuaries and were determined at base limits of 100,000/300,000.

The Increase limits factors posted on page 46 of the manual pages are applied to each class. Those classes performing major surgery (5-8) have a higher increase limit factor to reflect the severity component of these specialties.

I hope we have explained this well enough. If you should have any more questions, please free to email me. Thank you for your continued consideration of our filing.

Sincerely,

Emalee Seaman
Corporate Compliance Paralegal

Enclosures

Dedicated to enhancing Catholic health care by being a unique insurance source for health care providers.

03/27/2008 02:48 PM D27C6_31492

Emalee K. Seaman

From: Jim McCoy
Sent: Monday, November 12, 2007 2:58 PM
To: Kristyn Atchley; Emalee K. Seaman; Denise Hill
Subject: RE: Preferred Professional Ins Co - Filing #IL-PS-07-06

I think I have this straight.

We need to explain to the state that the rate pages show rates for each class based on the 100,000/300,000 base rate and the 100,000/300,000 limit class relativity. A class 1 has a class relativity of 1.00 while a class 7 (OB/GYN) has a relativity of 6.00. If you review the first rate page for Territory 1 the mature rate at 100,000/300,000 for a class one is $8,190 and for a class 7 at the same base rate the premium is $49,140. A class 7 has a relativity factor of 6.00 so $8,190 x 6.00 = $49,140. The relativities used to express the base rates on the rate pages were determined by our actuaries and were determined at base limits of 100,000/300,000.

The Increase limits factors posted on page 46 of the rate pages are applied to each class. Those classes performing major surgery (5-8) have a higher increase limit factor to reflect the severity component of these specialties.

Please let me know if you have questions.

Thanks,

JTM

From: Kristyn Atchley
Sent: Thursday, November 08, 2007 2:33 PM
To: Emalee K. Seaman; Denise Hill
Cc: Jim McCoy
Subject: RE: Preferred Professional Ins Co - Filing #IL-PS-07-06

I am forwarding to Jim for response wording. This is beyond my scope. Jim, the last page of the attached manual is what she is questioning.

Kristyn Atchley
PPIC
11605 Miracle Hills Dr., Suite 200
Omaha, NE 68154
katchley@ppicins.com

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From: Emalee K. Seaman
Sent: Thursday, November 08, 2007 1:57 PM
To: Kristyn Atchley; Denise Hill
Subject: FW: Preferred Professional Ins Co - Filing #IL-PS-07-06

03/27/2008 02:48 PM D27C6_31492

Here is one more question from IL.

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, November 08, 2007 1:29 PM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

Thank you for your response dated November 6, 2007.

On page 46 of the manual is information on the increased limit factors. There are separate factors for physicians for the different classes. On the rate pages, different classes are charged different rates. Now, on the increased limit factors page, it seems they are again being assessed a charge for the same characteristic - that of major surgery. Please explain.

We request receipt of your response by no later than November 15, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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03/27/2008 02:48 PM D27C6_31492

Emalee K. Seaman

From: Emalee K. Seaman
Sent: Tuesday, November 06, 2007 9:35 AM
To: 'Neuman, Gayle'
Subject: RE: Preferred Professional Ins Co - Filing #IL-PS-07-06
Attachments: Response Cvr Ltr 2.pdf; Revised Rate Pages.pdf; Revised Rules 2.pdf; Side by Side Comparisons of Revised Rules 2.pdf

Ms. Neuman:

Attached you will find a cover letter in response to your concerns. I am also attaching a couple new manual pages and revised manual pages along with our rate pages. I did make side by side comparisons of the revised manual pages and I am attaching those. Thank you for your continued consideration of our filing.

Sincerely,

Emalee Seaman
Corporate Compliance Paralegal
Preferred Professional Insurance Company
11605 Miracle Hills Drive, Suite 200
Omaha, Nebraska 68154
Tel. (402) 392-1566 Ext. 248
Fax (402)392-2673

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Thursday, November 01, 2007 3:40 PM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

Upon review of your November 1, 2007 response, we request you address the following issues:

1. Where are the rating territories defined?

2. Previously, rate pages did not distinguish between "employed" and "non-employed" physicians and surgeons. Are there separate rates for each? Will the "non-employed" replace the previously filed manual pages that were effective January 1, 2004?

3. Is there more than one set of liability limits (100,000/300,000) available? In the previously filed version of this manual, 1M/3M was available. If the 1M/3M limits are still available, where are the factors that would be applied? If only 100,000/300,000 is available now, how does this affect insureds who previously had the higher limits?

4. On page 9, we request the manual indicate that there is no interest charge or installment charge.

5. On page 10, paragraph B was also changed although such changes were not highlighted. Paragraph B should be changed to indicate that
the extended reporting period (e.r.p.) must be offered when the policy is cancelled or nonrenewed for any reason including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. Additionally, there is still no language to indicate if the insured will be offered a 12 month e.r.p. or an unlimited e.r.p. The e.r.p. premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The factors provided would indicate the insured's premium is again affected by the maturity year.

03/27/2008 02:48 PM D27C6_31492

We request receipt of your response by November 9, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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November 6, 2007

Ms. Gayle Neuman
Property & Casualty Compliance
Illinois Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: Preferred Professional Insurance Company
NAIC #: 36234
Physicians & Surgeons Professional Liability
Policy Forms & Endorsements-Rule Manual
IL-PS-07-06

Preferred Professional Insurance Company
11605 Miracle Hills Drive
Suite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dear Ms. Neuman:

Per your letter, we have made the requested changes to our Physicians & Surgeons Rule Manual. The necessary changes are attached for your review.

For Item 1, I have attached page 45 that defines the territories in Illinois.

For Item 2, we had initially put non-employed at the top to reflect the employed relativity rule change that was also made with this filing. However, we understand how this caused confusion and we have removed non-employed from the rate pages.

In regards to Item 3, we have added page 46 to the manual that shows all the limits of liability that PPIC has available.

For Item 4, we have added the word interest, so the manual page states, "with no interest or installment charge".

In Item 5, we have amended paragraph B on page 10, to address your concerns on the duration of the ERP and that the ERP must be offered regardless of who cancels the policy and for what reason. We have also amended paragraph G to specify more clearly that the ERP factors are applied to the expiring annual premium. We have also added that the insured will be notified of this at policy inception.

Dedicated to enhancing Catholic health care by being a unique insurance resource for health care providers.

I hope we have made all the necessary changes. If you should have any more questions, please free to email me. Thank you for your continued consideration of our filing.

Sincerely,

Emalee Seaman

Emalee Seaman
Corporate Compliance Paralegal

Enclosures

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: PREMIUM PAYMENTS	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-08	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. Premium may be paid annually or quarterly, with no interest or installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-09	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. An extended reporting period of unlimited duration will be offered when a policy is cancelled or nonrenewed for any reason, including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

G. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at the time the coverage is purchased.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: TERRITORIAL DEFINITIONS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-43	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

Illinois Territorial Definitions

TERRITORY 1
The following Counties: Champaign, Macon, Sangamon

TERRITORY 2
The following Counties: Coles, DeKalb, LaSalle, Ogle, Randolph, Winnebago

TERRITORY 3
The following Counties: Cook, Madison, St. Clair

TERRITORY 4
The following Counties: DuPage, Kane, McHenry

TERRITORY 5
The following Counties: Jackson, Vermillion

TERRITORY 6
The following Counties: Kankakee

TERRITORY 7
The following Counties: Lake

TERRITORY 8: Remainder of State

TERRITORY 9
The following Counties: Will

* Independent Cities within the county described above are also included in the territory designated.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: INCREASED LIMIT FACTORS	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-44	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians not performing major surgery in classes 1 through 4:

Limits ($000s)	Factor
100/300	1.000
200/600	1.270
250/750	1.370
500/1,500	1.760
1,000/3,000	2.200
2,000/4,000	2.690

The following multipliers will apply to the Company's 100/300 Mature Claims-Made base rates for Physicians performing major surgery in classes 5A through 8:

Limits ($000s)	Factor
100/300	1.000
200/600	1.310
250/750	1.430
500/1,500	1.900
1,000/3,000	2.480
2,000/4,000	3.030

Actuarial equivalents apply to all other limits not specifically shown.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: PREMIUM PAYMENTS
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-08
EFFECTIVE DATE: 11/01/2007 | **REVISION DATE: 11/01/2007**

A. Premium may be paid annually or quarterly, with no installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: PREMIUM PAYMENTS
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-08
EFFECTIVE DATE: 11/01/2007 | **REVISION DATE: 11/01/2007**

A. Premium may be paid annually or quarterly, with no interest or installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

9

03/27/2008 02:49 PM D27C6_31492

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE
GUIDELINE NUMBER: UW-09
EFFECTIVE DATE: 11/01/2007 | **REVISION DATE: 11/01/2007**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. Physicians and their professional corporations choosing not to continue a claims-made contract with the Company shall be given the opportunity to purchase extended reporting period coverage. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

G. For an extended reporting period:

1. Number of PL Exposures x PL Base Rate at expiration x PI. ILF x PI. Territorial Factor x Business Type Adjustment Factor x PI. Extended Reporting Period Factor x any applicable schedule debits/credits
2. ERP factors based on expiring premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE
GUIDELINE NUMBER: UW-09
EFFECTIVE DATE: 11/01/2007 | **REVISION DATE: 11/01/2007**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. An extended reporting period of unlimited duration will be offered when a policy is cancelled or nonrenewed for any reason, including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

G. For an extended reporting period, ERP factors are based on expiring annual premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

The anticipated ERP premium will be shared with the insured at the time the coverage is purchased.

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PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 1

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,572	$3,407	$5,307	$6,028	$6,552
1	1,966	4,259	6,634	7,535	8,190
2	2,948	6,388	9,951	11,302	12,285
3	3,853	8,347	13,002	14,768	16,052
4	5,307	11,499	17,912	20,344	22,113
5A	4,265	9,242	14,396	16,351	17,772
5	7,607	16,482	25,673	29,160	31,695
6	9,887	21,422	33,369	37,900	41,196
7	11,794	25,553	39,803	45,209	49,140
8	16,118	34,922	54,398	61,785	67,158

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
[illegible] Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 2, 6, 8

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,081	$2,342	$3,649	$4,144	$4,505
1	1,351	2,928	4,561	5,180	5,631
2	2,027	4,392	6,841	7,770	8,446
3	2,649	5,739	8,939	10,153	11,036
4	3,649	7,905	12,314	13,986	15,203
5A	2,932	6,354	9,897	11,241	12,218
5	5,230	11,331	17,650	20,047	21,791
6	6,797	14,727	22,941	26,056	28,322
7	8,108	17,568	27,365	31,081	33,784
8	11,081	24,009	37,399	42,477	46,171

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 3, 9

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,966	$4,259	$6,634	$7,535	$8,190
1	2,457	5,324	8,292	9,419	10,238
2	3,686	7,985	12,439	14,128	15,356
3	4,816	10,434	16,253	18,460	20,066
4	6,634	14,373	22,389	25,430	27,641
5A	5,332	11,552	17,994	20,438	22,215
5	9,509	20,602	32,091	36,450	39,619
6	12,359	26,777	41,711	47,375	51,495
7	14,742	31,941	49,754	56,511	61,425
8	20,147	43,653	67,997	77,232	83,948

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 4, 5, 7

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,769	$3,833	$5,971	$6,781	$7,371
1	2,211	4,791	7,463	8,477	9,214
2	3,317	7,187	11,195	12,715	13,821
3	4,334	9,391	14,628	16,614	18,059
4	5,971	12,936	20,150	22,887	24,877
5A	4,799	10,397	16,195	18,394	19,994
5	8,558	18,542	28,882	32,805	35,657
6	11,123	24,099	37,540	42,638	46,345
7	13,268	28,747	44,779	50,860	55,283
8	18,133	39,287	61,198	69,509	75,553

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 1

Class	Years Retroactive Date Precedes Policy Expiration Date							
	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$2,968	$5,392	$7,070	$8,740	$9,428	$10,110	$10,405	$10,699
1	3,710	6,740	8,837	10,925	11,785	12,637	13,006	13,374
2	5,565	10,111	13,256	16,388	17,678	18,956	19,509	20,061
3	7,272	13,211	17,321	21,414	23,099	24,769	25,491	26,214
4	10,017	18,199	23,860	29,499	31,821	34,120	35,115	36,111
5A	8,051	14,627	19,176	23,708	25,574	27,423	28,222	29,022
5	14,358	26,085	34,199	42,282	45,610	48,906	50,332	51,758
6	18,662	33,904	44,450	54,955	59,281	63,565	65,419	67,273
7	22,260	40,442	53,022	65,553	70,712	75,823	78,034	80,246
8	30,423	55,271	72,463	89,589	96,640	103,625	106,647	109,669

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 2, 6, 8

Class	Years Retroactive Date Precedes Policy Expiration Date							
	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$2,041	$3,707	$4,860	$6,009	$6,482	$6,950	$7,153	$7,356
1	2,551	4,634	6,075	7,511	8,102	8,688	8,941	9,195
2	3,826	6,951	9,113	11,267	12,154	13,032	13,412	13,792
3	4,999	9,083	11,908	14,722	15,881	17,029	17,525	18,022
4	6,887	12,512	16,404	20,280	21,877	23,458	24,142	24,826
5A	5,535	10,056	13,184	16,299	17,582	18,853	19,403	19,953
5	9,871	17,934	23,512	29,069	31,357	33,623	34,603	35,584
6	12,830	23,309	30,559	37,782	40,755	43,701	44,975	46,250
7	15,304	27,804	36,453	45,068	48,615	52,128	53,649	55,169
8	20,916	37,999	49,819	61,592	66,440	71,242	73,320	75,397

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 3, 9

Class	Years Retroactive Date Precedes Policy Expiration Date							
	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$3,710	$6,740	$8,837	$10,925	$11,785	$12,637	$13,006	$13,374
1	4,638	8,425	11,046	13,657	14,732	15,796	16,257	16,718
2	6,956	12,638	16,569	20,485	22,098	23,695	24,386	25,077
3	9,090	16,514	21,651	26,767	28,874	30,961	31,864	32,767
4	12,521	22,749	29,825	36,873	39,776	42,650	43,894	45,138
5A	10,064	18,283	23,970	29,635	31,968	34,278	35,278	36,278
5	17,947	32,607	42,749	52,852	57,012	61,132	62,915	64,698
6	23,327	42,380	55,563	68,694	74,101	79,456	81,773	84,091
7	27,826	50,553	66,278	81,941	88,391	94,779	97,543	100,307
8	38,028	69,089	90,579	111,986	120,800	129,531	133,309	137,086

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 4, 5, 7

	Years Retroactive Date Precedes Policy Expiration Date							
Class	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$3,339	$6,066	$7,953	$9,833	$10,607	$11,373	$11,705	$12,037
1	4,174	7,583	9,942	12,291	13,259	14,217	14,631	15,046
2	6,261	11,374	14,912	18,437	19,888	21,325	21,947	22,569
3	8,181	14,863	19,486	24,091	25,987	27,865	28,678	29,490
4	11,269	20,474	26,842	33,186	35,798	38,385	39,505	40,624
5A	9,057	16,455	21,573	26,672	28,771	30,850	31,750	32,650
5	16,153	29,346	38,474	47,567	51,311	55,019	56,624	58,228
6	20,994	38,142	50,006	61,824	66,691	71,511	73,596	75,682
7	25,043	45,497	59,650	73,747	79,552	85,301	87,789	90,276
8	34,225	62,180	81,521	100,787	108,720	116,578	119,978	123,378

03/27/2008 02:49 PM D27C6_31492

Emalee K. Seaman

From: Neuman, Gayle [Gayle.Neuman@illinois.gov]
Sent: Thursday, November 01, 2007 3:40 PM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

Upon review of your November 1, 2007 response, we request you address the following issues:

1. Where are the rating territories defined?

2. Previously, rate pages did not distinguish between "employed" and "non-employed" physicians and surgeons. Are there separate rates for each? Will the "non-employed" replace the previously filed manual pages that were effective January 1, 2004?

3. Is there more than one set of liability limits (100,000/300,000) available? In the previously filed version of this manual, 1M/3M was available. If the 1M/3M limits are still available, where are the factors that would be applied? If only 100,000/300,000 is available now, how does this affect insureds who previously had the higher limits?

4. On page 9, we request the manual indicate that there is no interest charge or installment charge.

5. On page 10, paragraph B was also changed although such changes were not highlighted. Paragraph B should be changed to indicate that
the extended reporting period (e.r.p.) must be offered when the policy is cancelled or nonrenewed for any reason including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. Additionally, there is still no language to indicate if the insured will be offered a 12 month e.r.p. or an unlimited e.r.p. The e.r.p. premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The factors provided would indicate the insured's premium is again affected by the maturity year.

We request receipt of your response by November 9, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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03/27/2008 02:49 PM D27C6_31492

Emalee K. Seaman

From: Emalee K. Seaman
Sent: Thursday, November 01, 2007 8:46 AM
To: 'Neuman, Gayle'
Subject: RE: Preferred Professional Ins Co - Filing #IL-PS-07-06
Attachments: Response Cvr Ltr 1.pdf; Revised Rules.pdf; Side by Side Comparisons of Revised Rules.pdf

Dear Ms. Neuman:

I am attaching a cover letter and our revised rule pages, including side by side comparisons of the changes we have made. If you would like me to send a copy of all this in the mail please let me know.

Thank you,

Emalee Seaman
Corporate Compliance Paralegal
Preferred Professional Insurance Company
11605 Miracle Hills Drive, Suite 200
Omaha, Nebraska 68154
Tel. (402) 392-1566 Ext. 248
Fax (402)392-2673

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Wednesday, October 24, 2007 1:06 PM
To: Emalee K. Seaman
Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

We are reviewing the above referenced filing. We request your response to the following questions and/or issues:

1. Where are the pages indicating the base rates? With the 10% rate decrease, such pages must be updated and filed.

2. All companies writing medical liability insurance in Illinois shall file a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. Insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

a) An initial payment of no more than 40% of the estimated total premium due at policy inception; b) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; c) No interest charges;

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d) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less; e) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

3. On page 10 of the manual under Extended Reporting Period Coverage - Non-Slot-Rated, you should make your initial reference to show the term "tail" used later in the manual is referring to the extended reporting period. The extended reporting period (e.r.p.) must be offered when the policy is cancelled or nonrenewed for any reason including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. Pursuant to Company Bulletin CB88-50, the company must offer an e.r.p. of at least 12 months on claims-made policies. The insured must be allowed 30 days after the end of the policy period to purchase the e.r.p. Extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium. The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the e.r.p. coverage to tell the insured what the premium will be or how the premium will be calculated.

4. On page 35 of the manual under Deductibles, is there an aggregate amount or limit for the insured during each policy period?

5. On page 36 of the manual under Clinics, D. states use "5%/10%" - please explain.

6. On page 44, B. indicates prior to a slot-rated program being issued, the insured must indicate they will purchase prior acts coverage. However, I. states PPIC will not offer prior acts coverage on a slot-rated program. Please explain.

7. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

We request receipt of your response by no later than November 2, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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The link between coverage and caring®

November 1, 2007

Ms. Gayle Neuman
Property & Casualty Compliance
Illinois Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001

RE: Preferred Professional Insurance Company
NAIC #: 36234
Physicians & Surgeons Professional Liability
Policy Forms & Endorsements-Rule Manual
IL-PS-07-06

Preferred Professional Insurance Company
11605 Miracle Hills Drive
ite 200
Omaha, NE 68154-4467
Tel 402.392.1566
Fax 402.392.2673
www.ppicins.com

Dear Ms. Neuman:

Per your letter, we have made the requested changes to our Physicians & Surgeons Rule Manual. The necessary changes are attached for your review.

For Item 1, I have attached the pages indicating the base rates we will use in Illinois.

For Item 2, we have attached a revised page 9, Premium Payments, to show our quarterly installment premium payment plan. The rule now explains how quarterly installments should be made by the insured.

In regards to Item 3, we do offer an unlimited extended reporting period to our insureds. Also, we give them 60 days after the end of the policy period to purchase the extended reporting period. We have amended the rule and this information is also contained in our policy under Section V-Extended Reporting Period. Also, we have added to Page 10, how we calculate the extended reporting period.

For Item 4, we have added the aggregate amount on Page 35. It is attached for your review

In Item 5, we have removed 5% from %5/10% because we used to use it as a range. However, we no longer use a range, we just use 10%. Page 36, has been amended to reflect this change.

Dedicated to enhancing Catholic health care by being a unique insurance esource for health care providers.

For Item 6, we have amended page 44, to clearly explain that the insured will purchase tail coverage from PPIC or the insured will obtain prior acts coverage from another carrier.

Last, Item 7, we gather and report our own statistics.

I hope we have made all the necessary changes. If you should have any more questions, please free to email me. Thank you for your continued consideration of our filing.

Sincerely,

Emalee Seaman

Emalee Seaman
Corporate Compliance Paralegal

Enclosures

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: PREMIUM PAYMENTS	
LINE OF COVERAGE: HEALTH CARE PROVIDERS – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-08	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. Premium may be paid annually or quarterly, with no installment charge. Quarterly premiums require an initial deposit of 25% of the total premium at inception. The remaining premium will be spread equally among the 2nd, 3rd and 4th installments. Installment billing dates are January 1, April 1, July 1, and October 1. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

B. If the full annual premium is paid in advance, a 2% premium reduction will be applied. (Applicable in states where filed and approved only)

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED	
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE	
GUIDELINE NUMBER: UW-09	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.

B. Physicians and their professional corporations choosing not to continue a claims-made contract with the Company shall be given the opportunity to purchase extended reporting period coverage. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.

C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.

D. Extended reporting period coverage may be provided at no charge for the following reasons:

1. The death of the health care provider;
2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)

E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.

F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

G. For an extended reporting period:

1. Number of PL Exposures x PL Base Rate at expiration x PL ILF x PL Territorial Factor x Business Type Adjustment Factor x PL Extended Reporting Period Factor x any applicable schedule debits/credits
2. ERP factors based on expiring premium. ERP factors are:

1st year claims made:	2.28
2nd year claims made:	2.00
3rd year claims made:	1.82
4th year claims made:	1.77
5th year claims made:	1.63

ERP premiums are prorated.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: DEDUCTIBLES	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-34	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. The following credits apply for the deductible indicated. To determine deductible premium, apply the following percentage to the 100/300 premium and deduct the result from the increased limit premium.

Deductible Applies to Indemnity Only — Credit

Deductible	Physician	Surgeon
$5,000/$15,000	5%	5%
$10,000/$30,000	10%	10%
$25,000/$75,000	20%	18%
$50,000/$150,000	35%	35.5%
$100,000/$300,000	57.5%	58.5%

Deductible Applies to both Indemnity and Loss Adjustment Expense — Credit

Deductible	Physician	Surgeon
$25,000/$75,000	35%	34%
$50,000/$150,000	50%	49%
$100,000/$300,000	72.5%	72.5%

B. On group policies the total amount an insured may pay for a deductible may be capped. Pricing will vary depending on experience, the number of health care providers, and the cap selected. Refer to underwriting.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: CLINICS	
LINE OF COVERAGE: HEALTH CARE PROVIDER	
GUIDELINE NUMBER: UW-35	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. PPIC must insure all physicians in the clinic.

B. The clinic cannot provide overnight patient stays and must meet all company requirements.

C. Limits equal to the limits provided for the physician are available to the clinic, on a separate policy (use form CP-101). All physicians utilizing the clinic must carry limits equal to or greater than the limits available to the clinic and proof of coverage.

D. To determine the rating for the clinic, (A) use 10% of the total physicians premium divided by the total number of patients expected in the clinic that year, (b) add 1.4% of a class 1 fully mature physician rate at the limits purchased to allow for employees, and (c) multiply the sum by 100. The total is the rate per 100 outpatient visits.

EXAMPLE:

Total premium of all physicians in clinic: $35,000 x 10% = $3,500
Total number of patient visits expected: 10,000

Physician charge per patient = $3,500 10,000 = $.35
$.35 x 100 = $35.00 per 100 visits

PLUS

Class 1 physician mature rate (at policy limits): $5,000
Employee Charge = 1.4% x 5,000 = $70.00 per 100 visits

CLINIC CHARGE PER 100 VISITS =

$35.0 + $70.00 = $105.00 per 100 visits
10,000 visits = 100 x $105.00 = $10,500

E. Long term treatment clinic (i.e. dialysis, etc.) are rated per 100 outpatient visits:
1. California: 3% of Class 1 rate
2. All other states 1% of Class 1 rate

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: SLOT-RATED GROUP PROGRAM	
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE	
GUIDELINE NUMBER: UW-39	
EFFECTIVE DATE: 11/01/2007	**REVISION DATE: 11/01/2007**

A. These rating programs are available to those facilities that tend to have a constant number of Full Time Equivalencies (FTE's), with high health care provider turnover.

B. Prior to a slot-rated program being bound, the insured must sign a written agreement indicating the entity will purchase tail coverage from PPIC or obtain prior acts coverage from another carrier. If prior acts coverage is obtained, the new carrier must hold PPIC harmless for certificates of insurance regarding tail coverage that were issued to prior occupants of the slot.

C. The policy provides coverage for all previously terminated and all current health care providers who are scheduled. Only if the program or a slot is terminated will a reporting endorsement be required to cover all past and present individuals.

D. "Slots" (or positions) will be used to determine the exposure base. A "slot" is based on an average of a 50 hour work week for one or more part-time health care providers. Slots may be based on full time equivalent of 50 hours (FTE) if more than one health care provider fills the "slot" during a work week. (A health care provider working full time occupies a "slot" regardless of the number of hours worked.)

E. If .50 or less of a slot is the hours contemplated, round the slot down. If .51 or more of a slot is the hours contemplated, round the slot up. A minimum of one slot is required if any health care provider is working in a particular specialty.

F. Rating for the claims made process will reflect the retroactive date of the slot.

G. RESIDENTS AND INTERNS: Rating for the claims made process will reflect the retroactive date of the program or of the new slot.

H. If a slot remains empty for an extended period of time (90+ days), it will be closed and tail coverage must be purchased. The first slot opened is the first slot closed for rating purposes.

I. PPIC will not offer prior acts coverage on a slot-rated program.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE – NON-SLOT-RATED
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE
GUIDELINE NUMBER: UW-09
EFFECTIVE DATE: 07/01/92 | **REVISION DATE: 07/01/99**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.
B. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.
C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.
D. Extended reporting period coverage may be provided at no charge for the following reasons:
   1. The death of the health care provider;
   2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
   3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
   4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

   This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)
E. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: EXTENDED REPORTING PERIOD COVERAGE (ERP) – NON-SLOT-RATED
LINE OF COVERAGE: HEALTH CARE PROVIDER – CLAIMS MADE
GUIDELINE NUMBER: UW-09
EFFECTIVE DATE: 11/01/2007 | **REVISION DATE: 11/01/2007**

A. A supplemental aggregate limit of liability is available for an extra premium charge. The supplemental aggregate limit of liability provided is equal to the limit of liability provided by the policy that the extended reporting endorsement is attached to.
B. Physicians and their professional corporations choosing not to continue a claims-made contract with the Company shall be given the opportunity to purchase extended reporting period coverage. A written request and payment for the extended reporting period coverage must be received in our office within 60 days of the termination of the policy.
C. Once in effect, an extended reporting period cannot be cancelled. The premium is fully earned upon receipt.
D. Extended reporting period coverage may be provided at no charge for the following reasons:
   1. The death of the health care provider;
   2. The health care provider becomes continuously and permanently disabled and is unable to carry out his/her profession or practice as a physician, surgeon, dentist or other Health Care Provider.
   3. The health care provider retires permanently from the profession or practice as a physician, surgeons, dentist, or other health care provider after accumulating five or more years of claims-made coverage from PPIC.
   4. The health care provider retires permanently as a result of suffering a terminal disease with no known cure.

   This "no charge" extended reporting period does not reinstate or increase the limits of insurance available. (If the insured desires a "new" supplemental aggregate limit of liability, this may be purchased. See item A above.)
E. Unless otherwise specified, miscellaneous professional employee's share in the limits purchased for the corporation, if any. No additional charge is made for miscellaneous professional employees.
F. Any credit or debit applied to the policy premium will also apply to the extended reporting period premium.
G. For an extended reporting period:
   1. Number of PL Exposures x PL Base Rate at expiration x PL ILF x PL Territorial Factor x Business Type Adjustment Factor x PL Extended Reporting Period Factor x any applicable schedule debits/credits
   2. ERP factors based on expiring premium. ERP factors are:
      1st year claims made: 2.28
      2nd year claims made: 2.00
      3rd year claims made: 1.82
      4th year claims made: 1.77
      5th year claims made: 1.63
      ERP premiums are prorated.

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PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: DEDUCTIBLES
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-34
EFFECTIVE DATE: 07/01/92 | REVISION DATE: 07/01/99

A. The following credits apply for the deductible indicated. To determine deductible premium, apply the following percentage to the 100/300 premium and deduct the result from the increased limit premium.

Deductible Applies to Indemnity Only

Deductible	Credit Physician	Credit Surgeon
$5,000	5%	5%
$10,000	10%	10%
$25,000	20%	18%
$50,000	35%	35.5%
$100,000	57.5%	58.5%

Deductible Applies to both Indemnity and Loss Adjustment Expense

Deductible	Credit Physician	Credit Surgeon
$25,000	35%	34%
$50,000	50%	49%
$100,000	72.5%	72.5%

B. On group policies the total amount an insured may pay for a deductible may be capped. Pricing will vary depending on experience, the number of health care providers, and the cap selected. Refer to underwriting.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: DEDUCTIBLES
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-34
EFFECTIVE DATE: 11/01/2007 | REVISION DATE: 11/01/2007

A. The following credits apply for the deductible indicated. To determine deductible premium, apply the following percentage to the 100/300 premium and deduct the result from the increased limit premium.

Deductible Applies to Indemnity Only

Deductible	Credit Physician	Credit Surgeon
$5,000/$15,000	5%	5%
$10,000/$30,000	10%	10%
$25,000/$75,000	20%	18%
$50,000/$150,000	35%	35.5%
$100,000/$300,000	57.5%	58.5%

Deductible Applies to both Indemnity and Loss Adjustment Expense

Deductible	Credit Physician	Credit Surgeon
$25,000/$75,000	35%	34%
$50,000/$150,000	50%	49%
$100,000/$300,000	72.5%	72.5%

B. On group policies the total amount an insured may pay for a deductible may be capped. Pricing will vary depending on experience, the number of health care providers, and the cap selected. Refer to underwriting.

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PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: CLINICS
LINE OF COVERAGE: HEALTH CARE PROVIDER
GUIDELINE NUMBER: UW-35
EFFECTIVE DATE: 07/01/92 | REVISION DATE: 07/01/99

A. PPIC must insure all physicians in the clinic.
B. The clinic cannot provide overnight patient stays and must meet all company requirements.
C. Limits equal to the limits provided for the physician are available to the clinic, on a separate policy (use form CP-101). All physicians utilizing the clinic must carry limits equal to or greater than the limits available to the clinic and proof of coverage.
D. To determine the rating for the clinic, (A) use 5%/10% of the total physicians premium divided by the total number of patients expected in the clinic that year, (b) add 1.4% of a class 1 fully mature physician rate at the limits purchased to allow for employees, and (c) multiply the sum by 100. The total is the rate per 100 outpatient visits.

EXAMPLE:

Total premium of all physicians in clinic: $35,000 x 10% = $3,500
Total number of patient visits expected: 10,000

Physician charge per patient = $3,500 10,000 = $.35
$.35 x 100 = $35.00 per 100 visits

PLUS

Class 1 physician mature rate (at policy limits): $5,000
Employee Charge = 1.4% x 5,000 = $70.00 per 100 visits

CLINIC CHARGE PER 100 VISITS =

$35.0 + $70.00 = $105.00 per 100 visits
10,000 visits = 100 x $105.00 = $10,500

E. Long term treatment clinic (i.e. dialysis, etc.) are rated per 100 outpatient visits:
1. California: 3% of Class 1 rate
2. All other states 1% of Class 1 rate

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: CLINICS
LINE OF COVERAGE: HEALTH CARE PROVIDER
GUIDELINE NUMBER: UW-35
EFFECTIVE DATE: 11/01/2007 | REVISION DATE: 11/01/2007

A. PPIC must insure all physicians in the clinic.
B. The clinic cannot provide overnight patient stays and must meet all company requirements.
C. Limits equal to the limits provided for the physician are available to the clinic, on a separate policy (use form CP-101). All physicians utilizing the clinic must carry limits equal to or greater than the limits available to the clinic and proof of coverage.
D. To determine the rating for the clinic, (A) use 10% of the total physicians premium divided by the total number of patients expected in the clinic that year, (b) add 1.4% of a class 1 fully mature physician rate at the limits purchased to allow for employees, and (c) multiply the sum by 100. The total is the rate per 100 outpatient visits.

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PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: SLOT-RATED GROUP PROGRAM
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-39
EFFECTIVE DATE: 07/01/92 | REVISION DATE: 07/01/99

A. These rating programs are available to those facilities that tend to have a constant number of Full Time Equivalencies (FTE's), with high health care provider turnover.
B. Prior to a slot-rated program being bound, the insured must sign a written agreement indicating the entity will purchase tail coverage or obtain prior acts coverage. If prior acts coverage is obtained, the new carrier must hold PPIC harmless for certificates of insurance regarding tail coverage that were issued to prior occupants of the slot.
C. The policy provides coverage for all previously terminated and all current health care providers who are scheduled. Only if the program or a slot is terminated will a reporting endorsement be required to cover all past and present individuals.
D. "Slots" (or positions) will be used to determine the exposure base. A "slot" is based on an average of a 50 hour work week for one or more part-time health care providers. Slots may be based on full time equivalent of 50 hours (FTE) if more than one health care provider fills the "slot" during a work week. (A health care provider working full time occupies a "slot" regardless of the number of hours worked.)
E. If .50 or less of a slot is the hours contemplated, round the slot down. If .51 or more of a slot is the hours contemplated, round the slot up. A minimum of one slot is required if any health care provider is working in a particular specialty.
F. Rating for the claims made process will reflect the retroactive date of the slot.
G. RESIDENTS AND INTERNS: Rating for the claims made process will reflect the retroactive date of the program or of the new slot.
H. If a slot remains empty for an extended period of time (90+ days), it will be closed and tail coverage must be purchased. The first slot opened is the first slot closed for rating purposes.
I. PPIC will not offer prior acts coverage on a slot-rated program.

PREFERRED PROFESSIONAL INSURANCE COMPANY
UNDERWRITING GUIDELINES

SUBJECT: SLOT-RATED GROUP PROGRAM
LINE OF COVERAGE: HEALTH CARE PROVIDER – OCCURRENCE AND CLAIMS MADE
GUIDELINE NUMBER: UW-39
EFFECTIVE DATE: 11/01/2007 | REVISION DATE: 11/01/2007

A. These rating programs are available to those facilities that tend to have a constant number of Full Time Equivalencies (FTE's), with high health care provider turnover.
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I. PPIC will not offer prior acts coverage on a slot-rated program.

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PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 1

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,572	$3,407	$5,307	$6,028	$6,552
1	1,966	4,259	6,634	7,535	8,190
2	2,948	6,388	9,951	11,302	12,285
3	3,853	8,347	13,002	14,768	16,052
4	5,307	11,499	17,912	20,344	22,113
5A	4,265	9,242	14,396	16,351	17,772
5	7,607	16,482	25,673	29,160	31,695
6	9,887	21,422	33,369	37,900	41,196
7	11,794	25,553	39,803	45,209	49,140
8	16,118	34,922	54,398	61,785	67,158

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 2, 6, 8

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,081	$2,342	$3,649	$4,144	$4,505
1	1,351	2,928	4,561	5,180	5,631
2	2,027	4,392	6,841	7,770	8,446
3	2,649	5,739	8,939	10,153	11,036
4	3,649	7,905	12,314	13,986	15,203
5A	2,932	6,354	9,897	11,241	12,218
5	5,230	11,331	17,650	20,047	21,791
6	6,797	14,727	22,941	26,056	28,322
7	8,108	17,568	27,365	31,081	33,784
8	11,081	24,009	37,399	42,477	46,171

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 3, 9

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,966	$4,259	$6,634	$7,535	$8,190
1	2,457	5,324	8,292	9,419	10,238
2	3,686	7,985	12,439	14,128	15,356
3	4,816	10,434	16,253	18,460	20,066
4	6,634	14,373	22,389	25,430	27,641
5A	5,332	11,552	17,994	20,438	22,215
5	9,509	20,602	32,091	36,450	39,619
6	12,359	26,777	41,711	47,375	51,495
7	14,742	31,941	49,754	56,511	61,425
8	20,147	43,653	67,997	77,232	83,948

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Claims-Made Rates
$100,000 / $300,000 Limits
Illinois
Territory 4, 5, 7

Class	1st Year	2nd Year	3rd Year	4th Year	Mature
1A	$1,769	$3,833	$5,971	$6,781	$7,371
1	2,211	4,791	7,463	8,477	9,214
2	3,317	7,187	11,195	12,715	13,821
3	4,334	9,391	14,628	16,614	18,059
4	5,971	12,936	20,150	22,887	24,877
5A	4,799	10,397	16,195	18,394	19,994
5	8,558	18,542	28,882	32,805	35,657
6	11,123	24,099	37,540	42,638	46,345
7	13,268	28,747	44,779	50,860	55,283
8	18,133	39,287	61,198	69,509	75,553

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 1

	Years Retroactive Date Precedes Policy Expiration Date							
Class	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$2,968	$5,392	$7,070	$8,740	$9,428	$10,110	$10,405	$10,699
1	3,710	6,740	8,837	10,925	11,785	12,637	13,006	13,374
2	5,565	10,111	13,256	16,388	17,678	18,956	19,509	20,061
3	7,272	13,211	17,321	21,414	23,099	24,769	25,491	26,214
4	10,017	18,199	23,860	29,499	31,821	34,120	35,115	36,111
5A	8,051	14,627	19,176	23,708	25,574	27,423	28,222	29,022
5	14,358	26,085	34,199	42,282	45,610	48,906	50,332	51,758
6	18,662	33,904	44,450	54,955	59,281	63,565	65,419	67,273
7	22,260	40,442	53,022	65,553	70,712	75,823	78,034	80,246
8	30,423	55,271	72,463	89,589	96,640	103,625	106,647	109,669

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 2, 6, 8

	Years Retroactive Date Precedes Policy Expiration Date							
Class	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$2,041	$3,707	$4,860	$6,009	$6,482	$6,950	$7,153	$7,356
1	2,551	4,634	6,075	7,511	8,102	8,688	8,941	9,195
2	3,826	6,951	9,113	11,267	12,154	13,032	13,412	13,792
3	4,999	9,083	11,908	14,722	15,881	17,029	17,525	18,022
4	6,887	12,512	16,404	20,280	21,877	23,458	24,142	24,826
5A	5,535	10,056	13,184	16,299	17,582	18,853	19,403	19,953
5	9,871	17,934	23,512	29,069	31,357	33,623	34,603	35,584
6	12,830	23,309	30,559	37,782	40,755	43,701	44,975	46,250
7	15,304	27,804	36,453	45,068	48,615	52,128	53,649	55,169
8	20,916	37,999	49,819	61,592	66,440	71,242	73,320	75,397

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 3, 9

	Years Retroactive Date Precedes Policy Expiration Date							
Class	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$3,710	$6,740	$8,837	$10,925	$11,785	$12,637	$13,006	$13,374
1	4,638	8,425	11,046	13,657	14,732	15,796	16,257	16,718
2	6,956	12,638	16,569	20,485	22,098	23,695	24,386	25,077
3	9,090	16,514	21,651	26,767	28,874	30,961	31,864	32,767
4	12,521	22,749	29,825	36,873	39,776	42,650	43,894	45,138
5A	10,064	18,283	23,970	29,635	31,968	34,278	35,278	36,278
5	17,947	32,607	42,749	52,852	57,012	61,132	62,915	64,698
6	23,327	42,380	55,563	68,694	74,101	79,456	81,773	84,091
7	27,826	50,553	66,278	81,941	88,391	94,779	97,543	100,307
8	38,028	69,089	90,579	111,986	120,800	129,531	133,309	137,086

PREFERRED PROFESSIONAL INSURANCE COMPANY

Physicians and Surgeons Professional Liability
Non-Employed Extended Reporting Endorsement
$100,000 / $300,000 Limits
Illinois
Territory 4, 5, 7

	Years Retroactive Date Precedes Policy Expiration Date							
Class	0.5	1	1.5	2	2.5	3	3.5	4+
1A	$3,339	$6,066	$7,953	$9,833	$10,607	$11,373	$11,705	$12,037
1	4,174	7,583	9,942	12,291	13,259	14,217	14,631	15,046
2	6,261	11,374	14,912	18,437	19,888	21,325	21,947	22,569
3	8,181	14,863	19,486	24,091	25,987	27,865	28,678	29,490
4	11,269	20,474	26,842	33,186	35,798	38,385	39,505	40,624
5A	9,057	16,455	21,573	26,672	28,771	30,850	31,750	32,650
5	16,153	29,346	38,474	47,567	51,311	55,019	56,624	58,228
6	20,994	38,142	50,006	61,824	66,691	71,511	73,596	75,682
7	25,043	45,497	59,650	73,747	79,552	85,301	87,789	90,276
8	34,225	62,180	81,521	100,787	108,720	116,578	119,978	123,378

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Emalee K. Seaman

From: Neuman, Gayle [Gayle.Neuman@illinois.gov]

Sent: Wednesday, October 24, 2007 1:06 PM

To: Emalee K. Seaman

Subject: Preferred Professional Ins Co - Filing #IL-PS-07-06

Ms. Seaman,

We are reviewing the above referenced filing. We request your response to the following questions and/or issues:

1. Where are the pages indicating the base rates? With the 10% rate decrease, such pages must be updated and filed.

2. All companies writing medical liability insurance in Illinois shall file a plan to offer each medical liability insured the option to make premium payments, in at least quarterly installments. Insurers may, but are not required to, offer such premium installment plans to insureds whose annual premiums are less than $500, or for premium for any extension of a reporting period. Quarterly installment premium payment plans shall be included in the initial offer of the policy, or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer may, but need not re-offer such payment plan, but if an insured requests such payment plan at a later date, the insurer must make it available. All quarterly installment premium payment plan provisions shall be contained in the filed rate and/or rule manual in a section entitled, "Quarterly Installment Option" or a substantially similar title. If the company uses a substantially similar title, the Rule Submission Letter must indicate the name of the section that complies with this requirement. All quarterly installment premium payment plans shall include the minimum standards listed below. Insurers may provide for quarterly installment premium payment plans that differ from these minimum standards, as long as such plans have terms that are at least as or more favorable than those listed below.

a) An initial payment of no more than 40% of the estimated total premium due at policy inception; b) The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; c) No interest
charges;
d) Installment charges or fees of no more than 1% of the total premium or $25.00, whichever is less; e) A provision stating that additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

3. On page 10 of the manual under Extended Reporting Period Coverage - Non-Slot-Rated, you should make your initial reference to show the term "tail" used later in the manual is referring to the extended reporting period. The extended reporting period (e.r.p.) must be offered when the policy is cancelled or nonrenewed for any reason including nonpayment of premium, and whether the policy is cancelled by the company or at the insured's request. Pursuant to Company Bulletin CB88-50, the company must offer an e.r.p. of at least 12 months on claims-made policies. The insured must be allowed 30 days after the end of the policy period to purchase the e.r.p. Extended reporting period (tail coverage) premium must be priced as a factor of one of the following: (1) the last twelve months premium; (2) the premium in effect at policy issuance; or (3) the expiring annual premium. The form must list the factor(s) to be used to figure the premium, which of the three premiums the factor will be applied to, and any credits, discounts, etc. that will be added or removed when determining the final premium. The company must inform the insured of the e.r.p. premium at the time the last policy is purchased. The company may not wait until the insured requests purchase of the e.r.p. coverage to tell the insured what the premium will be or how the premium will be calculated.

4. On page 35 of the manual under Deductibles, is there an aggregate amount or limit for the insured during each policy period?

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5. On page 36 of the manual under Clinics, D. states use "5%/10%" - please explain.

6. On page 44, B. indicates prior to a slot-rated program being issued, the insured must indicate they will purchase prior acts coverage. However, I. states PPIC will not offer prior acts coverage on a slot-rated program. Please explain.

7. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

We request receipt of your response by no later than November 2, 2007.

Gayle Neuman
Property & Casualty Compliance, Division of Insurance
Illinois Department of Financial & Professional Regulation
(217) 524-6497

Please refer to the Property and Casualty Review Requirement Checklists before submitting any filing. The checklists can be accessed through the Department's website (http://www.idfpr.com/) by clicking on: Insurance; Industry; Regulatory; IS3
Review Requirements Checklists; Property Casualty IS3 Review Requirements Checklists.

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Emalee K. Seaman

From: Neuman, Gayle [Gayle.Neuman@illinois.gov]
Sent: Tuesday, October 23, 2007 3:40 PM
To: Emalee K. Seaman
Subject: RE: IL-PS-07-06 Rate Filing

Ms. Seaman,

I will just add this e-mail to the file to show why we processed it with a different effective date.

Gayle Neuman
Division of Insurance

From: Emalee K. Seaman [mailto:eseaman@ppicins.com]
Sent: Tuesday, October 23, 2007 3:38 PM
To: Neuman, Gayle
Subject: IL-PS-07-06 Rate Filing

Dear Ms. Neuman:

In regards to the filing you received today for the 10% decrease. Could we change the effective date to January 1, 2008 or do we need to withdraw the filing and re-file it with a different effective date? Please let me know the way you would prefer us to go with this.

Thank you,

Emalee Seaman
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Preferred Professional Insurance Company
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