

CONFIRMATION OF FORMS REVIEW AND ACKNOWLEDGEMENT OF
UNDERSTANDING

I am a Potential Member applying for membership in the group self insured program known as 'Healthcare Industry Self Insurance Program of California, Inc.' (hereinafter "GROUP" or GROUP PROGRAM").

I hereby acknowledge that I am supplying the documents listed on the attached list as part of the application for membership in GROUP and that the information contained in said documents is true and correct.

I understand the risks associated with membership in GROUP and the concept of joint and several liability among GROUP Members.

I UNDERSTAND AND AGREE THAT HEALTHCARE FACILITIES OF AMERICA, LLC ("HCF") HAS MADE NO AGREEMENTS, REPRESENTATIONS OR PROMISES REGARDING THE ADVISABILITY OF GROUP SELF INSURANCE OR MY PARTICIPATION IN GROUP AND THAT I EITHER SOUGHT OR HAD THE OPPORTUNITY TO SEEK LEGAL ADVICE REGARDING THE FOREGOING AND ANY QUESTIONS REGARDING THE VARIOUS FORMS AND AGREEMENTS SUBMITTED AS PART OF THIS APPLICATION

(Legal Name of Potential Member)

Date: _____

By: _____
(name) _____
(title) _____
(address) _____

