EXHIBIT B

NHMMJUA HARDSHIP GRANT APPLICATION

A. Applicant information:

Full Name_____ Tax Identification No. _____
Please print [If not provided, backup withholding of 28% will be made]

Address_____
Street City State Zip Phone

Is the applicant a midwife certified under RSA 326-D or other health care provider licensed or approved by the State of New Hampshire? Yes ___ or No ___
If yes, please specify and provide certificate, license or approval number:

_____

B. Applicant NHMMJUA policy information:
(1) NHMMJUA Policy Number: _____
(2) Annual premium for NHMMJUA coverage as of July 20, 2015: $_____
(3) Attach NHMMJUA policy declarations page or renewal certificate

C. Applicant replacement coverage information:
(1) Replacement annual coverage quote from another insurer: $_____
(2) Attach binding replacement coverage quote (including limits, deductible, effective date, expiration date, specific coverage quoted, and premium)
(3) Has applicant purchased the replacement coverage quoted?
Yes ___ or No ____ If yes, what is the effective date? _____

D. Significant adverse economic hardship information:
(1) Is the replacement annual premium quoted more than 25% greater than the applicant's NHMMJUA annual premium as of July 20, 2015? Yes ___ or No ___
(2) What percent of the applicant's 2014 annual gross revenue before expenses does the annual replacement premium quoted above represent? _____% (Annual replacement premium quoted divided by 2014 annual revenue times 100)
(3) Will the applicant suffer significant adverse economic hardship from the increase of at least 25% in the cost of medical malpractice insurance coverage? Yes ___ or No ___. If yes, please explain how:

_____
_____
_____
_____
_____

E. Hardship grant amount requested: $_____ (Under RSA 404-C:16, III, any grant provided may not exceed the difference between the cost of insurance through the NHMMJUA plus 25% and the premium charged in the private market for the most comparable coverage available.)

The statements and information provided above are true and accurate.

Date ___/____/____ Applicant signature_____

Return completed form and attachments to:

Receiver, NHMMJUA
C/O Hays Companies
133 Federal Street
Boston, MA 02110

(or Fax: 617-723-5155)