Applicant Company Name: _CONNECTICUT MEDICAL INSURANCE COMPANY NAIC No. 15890
FEIN: 06-1117483

Uniform Certificate of Authority Application (UCAA)
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

CONNECTICUT MEDICAL INSURANCE COMPANY

80 GLASTONBURY BLVD

GLASTONBURY CONNECTICUT 06033 (860) 633-7788

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

1. Affiant's Full Name (Initials Not Acceptable): First: **WILLIAM** Middle: **SOMMERVILLE** Last: **POTTER**

2. a. Are you a citizen of the United States?

   Yes [X] No [ ]

   b. Are you a citizen of any other country?

   Yes [ ] No [X]

   If yes, what country? _____

3. Affiant's occupation or profession: **PHYSICIAN**

4. Affiant's business address: **2046 W. MAIN ST STAMFORD CT**

   Business telephone: **203-869-3082** Business Email: **GREENWICHEYE.COM**

5. Education and training:

College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
DARTMOUTH COLLEGE	**HANOVER, NH**	**9/1975 – 6/1979**	**A.B**

Graduate Studies	College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
MEDICAL DOCTOR	**NY MED COLLEGE**	**VALHALLA, NY**	**8/1981 – 6/1985**	**M.D.**

Other Training: Name	City/State	Dates Attended (MM/YY)	Degree/Certification Obtained
WILLS EYE HOSPITAL	**PHIL, PA**	**06/1989 – 06/1990**	**PEDIATRIC OPHT FELLOWSHIP**

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

Applicant Company Name: _CONNECTICUT MEDICAL INSURANCE COMPANY NAIC No. 15890 ____________
FEIN: 06-1117483 ____________

6. List of memberships in professional societies and associations:

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
AAPOS		**SAN FRAN, CA**	
AAO		**SAN FRAN, CA**	
FAIRFIELD COUNTY MED.		**NEW HAVEN, CT**	

7. Present or proposed position with the Applicant Company: **MEMBER / BOARD OF DIRECTORS**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending
Dates (MM/YY): **02/1995 – PRESENT** Employer's Name: **GREENWICH OPTHALMOLOGY ASSOCIATES**

Address: ____________ City: ____________ State/Province: ____________

Country: **203 869-3082** Postal Code: ________ Phone: ________ Offices/Positions Held: **MANAGING PARTNER**
Type of Business: **OPHTHALMOLOGY** Supervisor/Contact: **SELF**

Beginning/Ending
Dates (MM/YY): ________ - ________ Employer's Name: ____________

Address: ____________ City: ____________ State/Province: ____________

Country: ________ Postal Code: ________ Phone: ________ Offices/Positions Held: ____________

Type of Business: ____________ Supervisor/Contact: ____________

Beginning/Ending
Dates (MM/YY): ________ - ________ Employer's Name: ____________

Address: ____________ City: ____________ State/Province: ____________

Country: ________ Postal Code: ________ Phone: ________ Offices/Positions Held: ____________

Type of Business: ____________ Supervisor/Contact: ____________

Beginning/Ending
Dates (MM/YY): ________ - ________ Employer's Name: ____________

Address: ____________ City: ____________ State/Province: ____________

Country: ________ Postal Code: ________ Phone: ________ Offices/Positions Held: ____________

Type of Business: ____________ Supervisor/Contact: ____________

9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [X]

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [X]

If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: **CT DEPARTMENT OF PUBLIC HEALTH** Address:

City: **HARTFORD** State/Province: **CT** Country: **USA** Postal Code:

License Type: **MEDICAL** License #: **030761** Date Issued (MM/YY): **08/16**

Date Expired (MM/YY): _____ Reason for Termination:

Non-Insurance Regulatory Phone Number (if known):

Organization/Issuer of License: Address:

City: State/Province: Country: Postal Code:

License Type: License #: Date Issued (MM/YY):

Date Expired (MM/YY): Reason for Termination:

Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [X]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the

power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity (including entities controlled by the holding company) for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If employed at the holding company level provide the group code. _____

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

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FEIN: 06-1117483

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 20th day of January 2020 at Greenwich, CT. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

X I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Connecticut County of: Hartford

The foregoing instrument was acknowledged before me this 20th day of January, 2020 by William Potter, and:

X who is personally known to me, or

who produced the following identification: _____.

[SEAL]

Notary Public

Janet Scalise
Printed Notary Name

My Commission Expires

Janet Scalise
Notary Public, State of Connecticut
My Commission Expires June 30, 2024

Applicant Company Name: _CONNECTICUT MEDICAL INSURANCE COMPANY NAIC No. 15890
FEIN: 06-1117483

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

CONNECTICUT MEDICAL INSURANCE COMPANY
80 GLATONBURY BLVD
GLASTONBURY CT 06033
860 633-7788

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1. Affiant's Full Name (Initials Not Acceptable): First: **WILLIAM** Middle: **S** Last: **POTTER**
IF ANSWER IS "NO" OR "NONE," SO STATE. ALL FIELDS MUST HAVE A RESPONSE. INCOMPLETE FORMS COULD DELAY THE APPLICATION PROCESS or RESULT IN REJECTION OF THE APPLICATION.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes [ ] No [X]

If yes, give the reason if any, if NONE indicate such, and provide the full name(s) and date(s) used.

Beginning/Ending Date(s) Used (MM/YY)	Name(s) Specify: First, Middle or Last Name	Reason (If NONE, indicate such)

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [redacted]

4. Government Identification Number if not a U.S. Citizen: _____

5. Foreign Student ID# (if applicable) : _____

Applicant Company Name: _CONNECTICUT MEDICAL INSURANCE COMPANY NAIC No. 15890
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6. Date of Birth: (MM/DD/YY) : **08/17/57** Place of Birth, City: **ATLANTIC CITY** State/Province: **CT** Country: **USA**

7. Name of Affiant's Spouse (if applicable) : [redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
[redacted]					

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 20th day of January, 2020 at Greenwich, CT. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

_X__ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Connecticut County of: Hartford

The foregoing instrument was acknowledged before me this 20th day of January, 20 20 by William Potter and:

X who is personally known to me, or

who produced the following identification: _____

[SEAL]

Janet Scalise
Notary Public
Janet Scalise
Printed Notary Name

My Commission Expires

Janet Scalise
Notary Public, State of Connecticut
My Commission Expires June 30, 2024

Applicant Company Name: _CONNECTICUT MEDICAL INSURANCE COMPANY NAIC No. 15890

FEIN: 06-1117483

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of **CONNECTICUT MEDICAL INSURANCE COMPANY** ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact **MIKE CONNEELY, CFO 860 781-8439.**

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) six (6) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

[redacted]

(Printed Full Name and Residence Address)

(Signature) 1/20/20 (Date)

State of: Connecticut County of: Hartford

The foregoing instrument was acknowledged before me this 20th day of January, 2020 by William Potter, and:

X who is personally known to me, or

who produced the following identification: _____

[SEAL]

Janet Scalise
Notary Public
Janet Scalise
Printed Notary Name

My Commission Expires

Janet Scalise
Notary Public, State of Connecticut
My Commission Expires June 30, 2024