

RESPONSE TO SUPPORT DOCPAC

YES, I wish to contribute \$ _____ to DOCPAC.

Federal law requires the following information. PLEASE PRINT CLEARLY.

1 **I have enclosed a CHECK payable to DOCPAC.**

Name _____ Policy Number _____

Address _____ City _____ State _____ Zip Code _____

Daytime Telephone _____ My Email Address _____

Name of Employer _____ Occupation _____

If contributing from a limited liability company ("LLC"), please write the name of the individual primarily responsible for approving this contribution.

Name _____

Contributions to DOCPAC are voluntary and will be used for political purposes. You have the right to refuse to contribute. You may contribute more or less than the suggested amount. The Doctors Company will not favor or disadvantage anyone by reason of their contribution or their decision not to contribute. DOCPAC is a voluntary political organization.

Contributions are not tax deductible.

By making this political contribution, you are affirming that you are eligible to do so. Federal law requires PAC contributors to be U.S. Citizens or Permanent Legal Residents (green card holders).

We have established DOCPACs in multiple states, as well as a Federal DOCPAC. We direct contributions from subscribers in states with an active DOCPAC to their state DOCPAC. When we receive contributions from individuals in a state without an active DOCPAC, we direct funds to the Federal DOCPAC. Contributions from corporate subscribers with no active state DOCPAC, and from states that prohibit the use of corporate funds for political contributions, are directed to California DOCPAC. If a contribution comes from a limited liability company ("LLC") in certain states, it may be directed to an alternate PAC.

2 **I authorize the use of my** **Visa** **MasterCard** **American Express**

Name _____ Policy Number _____

Daytime Telephone _____ Fax _____

My Email Address _____ Billing Address _____

City _____ State _____ Zip Code _____

If not self-employed, name of employer _____ Occupation _____

Credit Card Number _____ Expiration Date _____

Cardholder or billing name as it appears exactly on the card _____

Authorized cardholder's signature _____ Date _____

Yes, I am interested in attending DOCPAC-sponsored political events in my legislative district.

Yes, I am interested in communicating with my legislative representatives regarding medical liability reform issues via:

Meeting Telephone Letters Email

Please complete and mail or email this form with your financial support to:

Government Relations • The Doctors Company • 185 Greenwood Road, Napa, CA 94558
Advocacy@thedoctors.com • thedoctors.com/docpac

