



Application for Health Care Consultant Professional Liability Insurance Policy

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES.

- This application must be completed in full, including all required attachments.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all applications as confidential.

1. Name of **Applicant**: _____

DBA (if any): _____

Home Office Mailing Address: _____

Physical Address: _____

Phone: () _____ FAX: () _____ EMAIL: _____

Additional Locations: _____

2. a) Date Business Established: _____

If in operation less than three (3) years, please attach resume(s) for all principals.

b) Form of Organization

- Individual
- Non-profit or Not-for-profit
- Partnership
- Corporation
- Privately Held
- LLC

c) Is the Applicant controlled or owned by (in whole or part), or associated or affiliated with, or does it own, any other firm or business enterprise? Yes No

If "Yes," please explain relationship: _____

3. Number of consultants to be covered: _____

Total number of employees: _____

4. Estimated annual revenue:

Last twelve (12) months _____ Next twelve (12) months _____

5. Please identify the professional services for which coverage is desired (please check all that apply):

SERVICES	YES	NO	% Annual Revenues
a) Credentialing or peer review of health care providers	<input type="checkbox"/>	<input type="checkbox"/>	_____
b) Utilization review	<input type="checkbox"/>	<input type="checkbox"/>	_____
c) Drafting practice guidelines/critical pathways	<input type="checkbox"/>	<input type="checkbox"/>	_____
d) Case management	<input type="checkbox"/>	<input type="checkbox"/>	_____
e) Disease management	<input type="checkbox"/>	<input type="checkbox"/>	_____
f) Handling, adjusting or paying claims	<input type="checkbox"/>	<input type="checkbox"/>	_____
g) Application or enrollment processing for enrollees of health care plans	<input type="checkbox"/>	<input type="checkbox"/>	_____
h) Billing/submitting claims	<input type="checkbox"/>	<input type="checkbox"/>	_____
i) Billing/coding/reimbursement consulting	<input type="checkbox"/>	<input type="checkbox"/>	_____
j) Advertising, marketing, or selling health care plans/products /services	<input type="checkbox"/>	<input type="checkbox"/>	_____
k) Physician practice/office management services	<input type="checkbox"/>	<input type="checkbox"/>	_____
l) Actuarial services	<input type="checkbox"/>	<input type="checkbox"/>	_____
m) Accounting services	<input type="checkbox"/>	<input type="checkbox"/>	_____
n) Employee benefit advice or services	<input type="checkbox"/>	<input type="checkbox"/>	_____
o) Telephone triage or counseling	<input type="checkbox"/>	<input type="checkbox"/>	_____
p) Investment management or financial advising	<input type="checkbox"/>	<input type="checkbox"/>	_____
q) Legal services	<input type="checkbox"/>	<input type="checkbox"/>	_____
r) Other (describe in detail): _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

s) Are these services provided to others for a fee? Yes No

If "No," please explain: _____

6. Please list the Applicant's five (5) largest contracts and associated annual revenue:

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

7. a) Has the Applicant ever acted, or will the Applicant act, in any capacity in which it has the ability to exercise decision-making authority for a client or an assignment? Yes No

If "Yes," please explain: _____

- b) Does the Applicant assist in negotiating or have any authority to alter or enter into contractual relationships on any client's behalf? Yes No

If "Yes," please explain: _____

8. a) During the past three (3) years, has the Applicant's name been changed or has the Applicant purchased, or merged or consolidated with, any other business or has the Applicant been purchased? Yes No

If "Yes," please explain: _____

9. Are any material changes in the nature or size of the Applicant's business anticipated over the next twenty-four (24) months? Yes No

If "Yes," please attach a detailed explanation.

10. Please list professional associations to which the Applicant belongs: _____

11. Does the Applicant provide services to any governmental entities or programs (Medicaid, Medicare, CHAMPUS, etc.), or does it plan to do so? Yes No

If "Yes," please explain: _____

12. Does the Applicant provide services to any employee benefit plans, including any pension plans, or does it plan to do so? Yes No

If "Yes," please explain: _____

13. a) Does the Applicant use a written contract with clients?
 In all cases Sometimes Never

b) Does the **Applicant** agree to hold its clients "harmless" or agree to indemnify its clients? Yes No

14. Does the Applicant subcontract work to others? Yes No

If "Yes," please explain: _____

15. Does the Applicant have promotional literature? Yes No

16. a) Is any errors and omissions or professional liability insurance currently in force? Yes No

If "Yes," please indicate:
Name of Insurer: _____ Expiration Date: _____
Limit: \$ _____ Deductible: \$ _____ Premium: \$ _____
Length of time coverage has been continuously in force: _____

b) Limits of Liability desired: \$ _____ each Claim or Related Claims.
\$ _____ aggregate for all Claims.

c) Retention desired: \$5,000 \$10,000 \$25,000 Other: \$ _____

17. Has any errors and omissions or professional liability insurance ever been declined or canceled? Yes No

If "Yes," please explain: _____

18. Does any director, officer, employee, or partner of the Applicant have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim? Yes No

If "Yes," please explain: _____

Please Note: Without prejudice to any other rights and remedies of the Underwriter, it is agreed that any claim arising out of or related to information required to be disclosed in response to Question 18 is excluded from the proposed insurance.

19. Please attach a list and the current status of all errors and omissions claims made during the past three (3) years against the Applicant or any director, officer, employee, or partner of the Applicant. If none, please check here: None

Please note: Without prejudice to any other rights and remedies of the underwriter, any claim or related claim thereto required to be disclosed in response to Question 19 is excluded from proposed insurance.

20. Has the Applicant or any director, officer, employee, or partner of the Applicant ever been the subject of disciplinary action as a result of professional activities? Yes No

If "Yes," please explain: _____

Please Note: Information provided in response to questions 17-20 does not constitute notice of claim or potential claim under any insurance policy. All such notices must be submitted in accordance with the policy.

21. The basic policy for which the Applicant has applied will not cover acts committed before the inception date of the policy. If the Applicant desires a quote for these prior acts, please enter the date from which the Applicant wants prior acts covered: _____

Please note: Coverage does not apply to known or expected claims or those which any insured could have reasonably foreseen.

ATTACHMENTS

Please attach to this Application copies of the following documents. These documents shall be a part of this Application:

1. Sample copies of all types of client contracts, including sub-contractor contracts.
2. Copies of all promotional or marketing materials.
3. The Applicant's most recent interim and/or accountant-prepared financial statement.
4. Resumes (including professional qualifications or designations) of all partners, principals, and key employees.
5. Description of the Applicant's services, if not described in promotional or marketing materials or in Question 5 above.

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAG COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY DARWIN IN WRITING OF SUCH CHANGES. DARWIN RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS/ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH HEREIN AND ATTACHED HERETO ARE TRUE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE UNDERWRITER ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE UNDERWRITER.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

Signature of Applicant: _____ Date: _____

(MUST be signed by an Owner, Partner, Director, or Officer of the Named Insured. It is agreed the signer has authority to act on behalf of all insureds.)

Printed Name of Applicant: _____ Title _____