Renewal Application for Health Care Directors & Officers Liability Insurance

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.**
- **"Insured Entity" means the Parent Company proposed for insurance and any subsidiaries.**
- **We treat all applications as confidential. If additional assurances of confidentiality are required, we are willing to address the applicant's needs.**

I. GENERAL INFORMATION:

1. a) Name of Insured Entity:____
   b) Address:____
   City:__________________State:__________ZIP:__________
   c) Website address:________________Telephone Number (___)________
   d) Date of Incorporation:__________
   e) States where Insured Entity operates:______________________________
   f) Name of Risk Manager:________________Telephone Number (___)________
   Mailing Address:____
   Email Address:______________________

2. a) Insured Entity is (check all that apply):
   - ☐ Hospital
   - ☐ Health System
   - ☐ Medical Group
   - ☐ Surgery Center
   - ☐ Nursing Home
   - ☐ URO
   - ☐ IPA
   - ☐ Third Party Administrator
   - ☐ Peer Review Organization
   - ☐ Managed Behavioral Health
   - ☐ MSO
   - ☐ PHO
   - ☐ CVO
   - ☐ Other (describe):______________________
   - ☐ HMO If so, please indicate:
     - ☐ Staff Model
     - ☐ Network/Panel Model
     - ☐ Combined
   - ☐ PPO
   - ☐ PBM

   b)
   - ☐ Not-For-Profit Tax Exempt
   - ☐ Not-For-Profit Taxable
   - ☐ For-Profit
   - ☐ Other (describe):______________________________________
   - ☐ Limited Liability Company
   - ☐ Partnership
   - ☐ Joint Venture

   c) List all subsidiary companies:

Name	Description of Operations	Date Acquired/ Created	Tax Status	Percent Owned

II. ADDITIONAL INFORMATION:

1. Current Coverage:

Type of Coverage	Insurance Carrier	Limits	Retention/ Deductible	Premium	Policy Period
Errors & Omissions					
Medical Malpractice					
Stop Loss/ Provider XS					
Fiduciary					
Crime					

MISSOURI APPLICANTS: DO NOT ANSWER QUESTION 2

2. Have any of the Insured Entity's current Insurance carriers indicated an intent to not offer renewal terms? ☐ Yes ☐ No
   If "Yes", please provide details as an attachment.

3. Is any of the Insured Entity's medical malpractice/HPL exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk sharing arrangement? ☐ Yes ☐ No

4. Stock or equity ownership: **(If Not-For-Profit, proceed to #5)**
   a) Total number of voting securities outstanding:______________________________
   b) Total number of voting security holders:____________________________
   c) Total number of voting securities owned by the Insured Entity's directors and officers:
   ____
   d) Does any security holder own five percent (5%) or more of the voting securities directly or beneficially? ☐ Yes ☐ No
   If "Yes", list names and percentages of holdings.
   ____
   ____

5. Have there been any changes in the Board of Directors or Senior Management within the past two (2) years? ☐ Yes ☐ No
   If "Yes", please explain:
   ____
   ____

6. a) Total Gross Revenue last 12 months:____________ Next 12 months:__________
   b) Total number of enrollees last 12 months:______________ Next 12 months:__________

7. Have there been any changes made to the By-Laws in the past 12 months? If "Yes", please explain:

____

____

8. Has the Insured Entity in the past thirty-six (36) months completed, or agreed to, or within the next twelve (12) months contemplate, any of the following:
   a) Merger, acquisition or consolidation with another entity? ☐ Yes ☐ No
   b) Sale, distribution or divestiture of any assets or stock? ☐ Yes ☐ No
   c) Any registration for a public offering or private placement of securities? ☐ Yes ☐ No
   d) Bankruptcy, receivership, liquidation or reorganization? ☐ Yes ☐ No
   e) Enter into any new governmental contracts? ☐ Yes ☐ No
   f) Undertake any new areas of business? ☐ Yes ☐ No
   Please explain_____________________________________

   If the answer to any of the questions above is "Yes",
   a) Has it been approved by the Board of Directors? ☐ Yes ☐ No
   b) Has it been submitted to the shareholders for approval? ☐ Yes ☐ No

9. Antitrust Market Position:
   a) Do you contract with more than 25% of the physicians in any given field of practice within its geographical service area? ☐ Yes ☐ No
   If "Yes", please explain:_____________________________________
   b) Do you control more than 25% of the hospital beds or specialty services within your geographic service area? ☐ Yes ☐ No
   If "Yes", please explain:_____________________________________
   c) Do you have exclusive contracts with any hospitals or providers? ☐ Yes ☐ No
   d) Have you obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? ☐ Yes ☐ No
   e) Have you received an opinion from the Federal Trade Commission (FTC) confirming that these activities will not violate antitrust laws? ☐ Yes ☐ No
   f) Do you have any provider agreements that contain "Most Favored" pricing clauses? ☐ Yes ☐ No
   g) Do you have any provider agreements that contain non-compete clauses? ☐ Yes ☐ No

10. Peer Review/Credentialing:
   Does the Insured Entity perform any peer review or credentialing? ☐ Yes ☐ No
   a) If so, have there been any changes in policies and procedures over the past 12 months? ☐ Yes ☐ No
   b) Have any providers been removed or disqualified from the Insured Entity's Panel in the last twelve (12) months? ☐ Yes ☐ No
   If "Yes":
   (1) How many?_______________
   (2) How many for reasons other than professional competence?_____________

III. EMPLOYMENT PRACTICES INFORMATION:

1. Total number of employees:
   Currently: Full time:__________ Part time:__________
   1 year ago: Full time:__________ Part time:__________
   Independent Contractors/
   Leased Employees Full time:__________ Part time:__________
   Employed Physicians Full time:__________ Part time:__________

2. Please provide a breakdown of employees in the states in which you operate:
   _________%__________%__________%__________%__________%

3. How many employees or officers have been involuntarily terminated in the past:
   12 months?_________________

4. What percentage of employees has turned over in the past:
   12 months?_________________%

5. What percentage of employees have an annual salary, including bonuses, of:
   Less than $50,000 ____________%
   $50,000-$100,000 ____________%
   $100,000-$250,000 ____________%
   Greater than $250,000 ____________%

6. What percentage of employees are:
   Union ____________%
   Non-union ____________%

7. Has the Insured Entity undergone within the last 12 months or plan on undergoing during the next 12 months any of the following:
   a) Restructuring that may lead to employee layoffs, early retirements or reassignment of duties? ☐ Yes ☐ No
   b) Sale of any business division, subsidiary or unit? ☐ Yes ☐ No
   c) Closure of any business division, subsidiary or unit? ☐ Yes ☐ No
   If "Yes", what is the percentage of total employees affected?__________________________
   Name of outside labor counsel, if applicable, that is involved?____________________

8. Have there been any changes to the Human Resource/Personnel department in the past 12 months? ☐ Yes ☐ No
   If "Yes", please explain:
   ____
   ____

9. Have there been any changes to the employee handbook? ☐ Yes ☐ No
   If "Yes", please explain:
   ____
   ____

10. Do you track, monitor and react to pay equity studies and promotional practice studies? ☐ Yes ☐ No

11. Do you review terminations to look at trends which might indicate discrimination? ☐ Yes ☐ No

12. Do you perform self-critical analysis of workforce diversity? ☐ Yes ☐ No

IV. REGULATORY INFORMATION

1. Name of Compliance Officer and title:____

2. Have there been changes made to the Compliance Plan in the past 12 months? ☐ Yes ☐ No

   If "Yes", please provide details:
   ____
   ____

3. Does new employee orientation include training on compliance? ☐ Yes ☐ No

4. Does the Insured Entity continue to maintain a process, such as a hotline, to receive complaints and allegations of wrongdoing? ☐ Yes ☐ No
   If "Yes", what is the average number of hotline complaints or allegations per month?________________________
   Are all hotline complaints investigated? ☐ Yes ☐ No

5. Has the Insured Entity invested in billing edit-checking software? ☐ Yes ☐ No

6. Does the Insured Entity utilize an external audit firm to monitor billing and coding compliance? ☐ Yes ☐ No

7. Has the Insured Entity been subjected to any type of audit investigating overpayments received for services provided? ☐ Yes ☐ No
   If "Yes", please explain:____

8. Has the Insured Entity voluntarily disclosed to any Governmental entity any violations or potential violations of the Civil False Claims Actor the Physician Ownership & Referral Law (Stark Self-Referral Law)? ☐ Yes ☐ No

9. Has the Insured Entity retained outside legal counsel to provide an opinion as to whether or not a certain course of conduct would be in violation of the Civil False Claims Act or the Physician Ownership & Referral Law? ☐ Yes ☐ No
   If "Yes", please explain:____

PART V. REPRESENTATION APPLICABLE TO INCREASED LIMIT REQUEST

1. If the Insured Entity requests limit(s) of liability for the renewal of its expiring policy with the Insurer that are larger than the limit(s) of such expiring policy, the Insured Entity must complete the following statement, which applies to such larger limit(s) of liability.

   Neither the Insured Entity nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may or could reasonably be foreseen to result in a claim that may fall within the scope of the proposed larger limits of liability, except as follows. If the answer is none, so state:

   ____

   ____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE INSURER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN QUESTION 1 OF THIS SECTION IS EXCLUDED FROM THE PROPOSED LARGE LIMITS OF LIABILITY.

PART VI. ATTACHMENTS

1. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:
   a) Most current CPA-audited financial statements with notes and Management letters and Interim financials if the audit is more than six (6) months old;
   b) List of current Board of Directors;
   c) Current organizational chart listing each subsidiary, including the current ownership percentage and tax status of each;
   d) Any amendments or revisions to the Insured Entity's Bylaws and Articles of Incorporation within the last twelve (12) months;
   e) Any amendments or revisions to the Employee Handbook within the last twelve (12) months;
   f) Any amendments or revisions to the Insured Entity's Compliance Program and/or Code of Conduct within the last twelve (12) months;
   g) Any registration statements filed with the SEC or any private placement memorandums within the last twelve (12) months.

PART VII. SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Underwriter in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract. The Application is on file with the Underwriter, and will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Insured Entity or the Underwriter to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Insured Entity will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

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:____

(MUST be signed by President, CEO, Owner, or Partner.
It is agreed the signer has authority to act on behalf of all Insureds.)

Printed Name of Applicant:______________________ Title______________________

Date:______________________

Agent Name: ____

Florida License No.: ______________________