



# 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):
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hospital       | <input type="checkbox"/> Third Party Administrator | <input type="checkbox"/> HMO If so, please indicate: |
| <input type="checkbox"/> Health System  | <input type="checkbox"/> Peer Review Organization  | <input type="checkbox"/> Staff Model                 |
| <input type="checkbox"/> Medical Group  | <input type="checkbox"/> Managed Behavioral Health | <input type="checkbox"/> Network/Panel Model         |
| <input type="checkbox"/> Surgery Center | <input type="checkbox"/> MSO                       | <input type="checkbox"/> Combined                    |
| <input type="checkbox"/> Nursing Home   | <input type="checkbox"/> PHO                       | <input type="checkbox"/> PPO                         |
| <input type="checkbox"/> URO            | <input type="checkbox"/> CVO                       | <input type="checkbox"/> PBM                         |
| <input type="checkbox"/> IPA            | <input type="checkbox"/> Other (describe): _____   |  |

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

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:

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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/ Full time: \_\_\_\_\_ Part time: \_\_\_\_\_  
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  NoIf "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 Act or 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:

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**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: \_\_\_\_\_