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IRONSHORE COMPANIES
175 Powder Forest Drive
Weatogue, CT 06089

ACCOUNTABLE CARE ORGANIZATION
LIABILITY INSURANCE
NEW BUSINESS APPLICATION

NOTICE: WITH THE EXCEPTION OF THE GENERAL LIABILITY COVERAGE PART, THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES ON A CLAIMS MADE AND REPORTED BASIS. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS OR JUDGMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE EXPENSES AND DEFENSE EXPENSES SHALL BE APPLIED AGAINST THE RETENTION. READ THE ENTIRE APPLICATION BEFORE SIGNING.

Section A: GENERAL INFORMATION, OPERATIONS AND STRUCTURE – All Applicants Must Complete Section A of This Application

1. Name of Accountable Care Organization Applicant: (Note: Wherever used, Applicant means this entity and any other entities listed in response to question 4)

Address:				
City:		State:	ZIP:	
Website:	www.	Telephone No:	( ) -	
Contact Person:		Title:		
Email Address:		Telephone No:	( ) -	
Name of Risk Manager (*if different from contact person*):		Email Address:		

2. Applicant is:

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

Date of Incorporation:		Date Operations Began:	
State(s) where Applicant operates:			

3. Tell us about any organizations that own, comprise or otherwise participate in your Accountable Care Organization. (Check all those that apply and indicate whether you seek coverage for that organization):

☐ Hospital or Health System	(Coverage sought? ☐ Yes ☐ No)
☐ Medical Group	(Coverage sought? ☐ Yes ☐ No)
☐ HMO	(Coverage sought? ☐ Yes ☐ No)
☐ PPO	(Coverage sought? ☐ Yes ☐ No)
☐ PHO	(Coverage sought? ☐ Yes ☐ No)
☐ IPA	(Coverage sought? ☐ Yes ☐ No)
☐ Medical Home	(Coverage sought? ☐ Yes ☐ No)
☐ MSO	(Coverage sought? ☐ Yes ☐ No)
☐ Third Party Administrator	(Coverage sought? ☐ Yes ☐ No)
☐ Utilization Review Organization	(Coverage sought? ☐ Yes ☐ No)
☐ Peer Review Organization	(Coverage sought? ☐ Yes ☐ No)

	☐ Other: (Coverage sought? ☐ Yes ☐ No)				
4.	If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), including those listed in #3 above, please list each such entity below. If required, list additional entities or provide any additional information on a separate attachment. Please note that coverage for such entities is not automatically available; the terms and conditions of the policy, if issued, will determine actual coverage.				
	Name and Address	Relationship to Applicant	Description of Operations	Tax Status	Percent Owned
					0.00%
					0.00%
					0.00%
					0.00%
					0.00%

5. LICENSING / ACCREDITATION

a) Is the ACO Applicant approved by CMS for participation in the Medicare Shared Savings Program? ☐ Yes ☐ No

b) Are the Applicants licensed by federal, state, or local government? ☐ Yes ☐ No

If "Yes," identify the Applicant participant and the licensing government:

c) Have any of the Applicant's licenses, certifications, or accreditations ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐ Yes ☐ No

If "Yes," please explain:

d) In what capacity or capacities does the Applicant do business with the state or federal government (i.e., TPA for a government employee health plan, offers a Medicare plan, etc.):

e) Is the Applicant accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? ☐ Yes ☐ No

If "Yes," identify the accrediting or certifying organization(s) for each Applicant and expiration date of the accreditation:

6. ANTITRUST MARKET POSITION

a) Within the past 5 years, has the Applicant obtained advice from antitrust legal counsel, including advice related to ACO formation, mergers, acquisitions or network development? ☐ Yes ☐ No

If "Yes", please explain:

b) Does the ACO Applicant fall within the antitrust ACO "safety zone?" ☐ Yes ☐ No

c) Is the combined share of any "common service" provided in its "primary service area" by the ACO's participants equal to or greater than 30% of that service in each participant's "primary service area"? ☐ Yes ☐ No

If "Yes", please explain and specify percent:

d) Has the ACO Applicant submitted to a voluntary antitrust review by the Federal Trade Commission and/or the United States Department of Justice? ☐ Yes ☐ No

If "Yes", please describe the outcome of the Agency determination:

e) Does the Applicant have exclusive contracts with any hospitals or ambulatory surgery centers? ☐ Yes ☐ No

If "Yes", please explain:

f) Does the Applicant have exclusive contracts with any other healthcare providers (besides hospitals or ASCs)? ☐ Yes ☐ No

If "Yes", please explain:

g) Does the Applicant:

i) use "anti-steering", "anti-tiering", "guaranteed inclusion", "most-favored-nation" or similar clauses to discourage payors from directing or incentivizing patients to choose certain providers; ☐ Yes ☐ No

ii) share competitively sensitive information; ☐ Yes ☐ No

iii) use tying arrangements, including pricing policies tying the ACO's services to a payor's purchase of other services from providers outside the ACO (or vice versa); or ☐ Yes ☐ No

iv) place restrictions on commercial payers' ability to share cost, quality, efficiency or performance data with enrollees. ☐ Yes ☐ No

If "Yes", please explain:

h) Do lawyers review the Applicant's provider contracts? ☐ Yes ☐ No

If "No", please explain:

7. REGULATORY / COMPLIANCE INFORMATION / RISK MANAGEMENT

a) Does the Applicant have a written corporate compliance program? ☐ Yes ☐ No

If "Yes", how long has it been in place?

b) Does the Applicant have a corporate compliance officer? ☐ Yes ☐ No

If "Yes", is this a full time position? ☐ Yes ☐ No

c) To whom does the compliance officer report?

d) How many employees are in the Applicant's corporate compliance department?

e) Does the Applicant have an employee hotline as part of the compliance program? ☐ Yes ☐ No

If "Yes", how many calls per month are made to the hotline?

f) Do employees regularly participate in ongoing compliance education/training? ☐ Yes ☐ No

g) Does the Applicant have a formal risk management program (i.e., a formal overall approach to avoiding situations that might give rise to a claim)? ☐ Yes ☐ No

If "Yes," please explain:

h) Who is in charge of implementing this risk management program and any changes?

Name: Phone:

Fax:

Title: Email:

i) To whom does the Risk Manager or Director of Risk Management report?

j) Does the Applicant have someone designated as a "legislative or executive" inquiry ombudsman (i.e., someone who investigates all problems or complaints once they rise to a certain level)? ☐ Yes ☐ No

k) Does the Applicant have contracts with any employers or other member groups in which the Applicant assumes any of the employer's liability, fiduciary obligations or decision-making? ☐ Yes ☐ No

If "Yes," please explain and attach a copy of the contract:

8. OWNERSHIP (If Not-For-Profit, proceed to next question):

Stock Ownership of Applicant

a) Total number of voting shareholders:

Please list all directors and officers and their respective percentage of voting shares owned whether directly or beneficially:

b) Other than those identified above, are there any shareholders who hold greater than five percent (5%) of the voting shares of the Applicant whether directly or beneficially? ☐ Yes ☐ No

If "Yes," please list all such shareholders and their respective percentage of voting shares owned whether directly or beneficially:

9. INSURANCE Please provide details of insurance / self-insurance / reinsurance currently in force for each entity looking for coverage (if none, so state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible / Retention	Premium	Policy Period	If Claims Made, Retroactive Date
D&O						
EPLI						
Managed Care E&O						
Medical Professional						
General Liability						
Employee Benefits Liability						
Privacy and Network Security Liability						
Fiduciary Liability						
Government Billing E&O						
Medical Expense Stop Loss						
Fidelity / Crime						
Other						

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

Section B: DIRECTORS AND OFFICERS LIABILITY INFORMATION – Complete Section B only if you are applying for D&O Coverage and provide information for each organization for which coverage is sought.

1. Has the Applicant been involved in within the past 36 months, or does the Applicant contemplate being involved in within the next 12 months, any of the following, whether or not such transactions were or will be completed?

Merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No

Sale, distribution or divestiture of any assets or stock, other than in the ordinary course of business? ☐ Yes ☐ No

	Any registration for a public debt or equity offering or private placement of debt or equity securities?	☐ Yes ☐ No
	Any reorganization or arrangement with creditors under federal or state law?	☐ Yes ☐ No
	Any new joint ventures or new business activities or services?	☐ Yes ☐ No
	Any new Medicare or Medicaid contracts?	☐ Yes ☐ No
	If "Yes", to any of the above, please explain and describe the essential terms of each such transaction either here or as an attachment to this Application.	

Section C: EMPLOYMENT PRACTICES INFORMATION – Complete Section C only if you are applying for EPL coverage and provide information for each organization for which coverage is sought.

1.	Number of employees and independent contractors: Full-time employees (include employed physicians): Part-time employees (include leased and seasonal, and employed physicians): Employed physicians (full and part-time): Independent contractors: Employees located in California:	Last 12 Months	Next 12 Months (est.)
2.	Percentage of employees with salaries (including bonuses): Less than $50,000 % $50,000 - $100,000 % $100,000 - $250,000 % Greater than $250,000 %		
3.	How many of the Applicant's employees or officers have been involuntarily terminated in the past two (2) years? Last 12 months Last 24 months		
4.	What percentage (%) of the Applicant's employees has turned over in the past two (2) years? Last 12 months % Last 24 months %		
5.	Has the Applicant in the past twenty-four (24) months had, or does the Applicant anticipate in the next twenty-four (24) months any consolidations, layoffs or facility closings? ☐ Yes ☐ No If "Yes," please provide details by attachment to this Application.		
6.	Does the Applicant: have a full-time human resources coordinator? ☐ Yes ☐ No have a written policy prohibiting discrimination? ☐ Yes ☐ No have a written policy prohibiting sexual harassment and for handling complaints of sexual harassment? ☐ Yes ☐ No require all employees to complete an application for employment? ☐ Yes ☐ No have a written policy for Family Medical Leave? ☐ Yes ☐ No have an employee handbook and require employee signature upon receipt of the handbook? ☐ Yes ☐ No have a formal "At-Will" statement in the employee handbook and employment application? ☐ Yes ☐ No use outside counsel for employment advice, including about terminations? ☐ Yes ☐ No require independent contractors performing services under the exclusive direction of the Applicant be subject to the Applicant's human resources policies? ☐ Yes ☐ No have annual written performance evaluations for all employees? ☐ Yes ☐ No Have policies that assure supervisory employees receive ongoing employment practices training? ☐ Yes ☐ No		

7.	Does the Applicant have policies or procedures outlining employee conduct when dealing with the general public or persons outside of the Applicant's direction or control? If "Yes," please provide a copy.	☐ Yes ☐ No
8.	Does the Applicant have policies or procedures for dealing with complaints from the general public, customers, clients, patrons, visitors, or other third parties for issue involving harassment or discrimination? If "Yes," please provide a copy.	☐ Yes ☐ No

Section D: MANAGED CARE ERRORS AND OMISSIONS INFORMATION – Complete Section D only if you are applying for MCE&O coverage and provide information for each organization for which coverage is sought.

1. ENROLLMENT/REVENUE:

Number of Enrollees (Note: wherever used, "enrollees" means covered lives not just covered employees and not member months.) If enrollees are in more than one state, please provide breakdown by state on a separate attachment.	Last 12 Months as of	Next 12 Months as of
ASO/TPA		
HMO		
PPO		
POS		
Indemnity		
Medicare (including MSSP Program)		
Medicaid		
Other (please describe)		
Total Enrollees		

Revenue:	Last 12 Months as of	Next 12 Months as of
Billed for direct medical services provided	$	$
Capitation Revenue	$	$
Medicare Shared Savings Program Revenue	$	$
Other Quality Incentive Revenue	$	$
Revenue from services provided to others (unaffiliated entities):	$	$
Utilization Review / Case Management	$	$
Claims Administration	$	$
Peer Review / Credentialing	$	$
Other (Describe)	$	$
Total Revenue (All operations)	$	$

2. HEALTH CARE PROVIDERS:
   a) Total number of physicians employed by or under contract with Applicant:
   Total number of employed physicians:

Total number of independent contractor physicians:

b) Does Applicant require and verify that all contracted health care providers (physicians, hospitals, physician extenders and others) maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? ☐ Yes ☐ No
If "No," what minimum limits are required?

c) Does Applicant have any provider agreements in which the Applicant assumes responsibility for overseeing the quality of the services provided by the health care providers? ☐ Yes ☐ No

3. MANAGED CARE SERVICES / ACTIVITIES: Please indicate those managed care activities or services which the Applicant performs or subcontracts now or intends to begin performing or subcontracting within the next 12 months (Note: not all checked services may be covered):

Activity or Service	Yes	No	Yes, For Others For a Fee
a) Credentialing or peer review of health care providers	☐ (Complete Section D.5)	☐	☐ (Complete Section D.5)
b) Utilization Review	☐ (Complete Section D.6)	☐	☐ (Complete Section D.6)
c) Drafting practice guidelines/clinical pathways	☐	☐	☐
d) Case management	☐	☐	☐
e) Disease management	☐	☐	☐
f) Handling and adjusting of enrollees' health care benefit claims	☐ (Complete Section D.7)	☐	☐ (Complete Section D.7)
g) Application or enrollment processing for enrollees of health care plans	☐	☐	☐
h) Billing/other processing of enrollees' claims under health care plans	☐	☐	☐
i) Advertising, marketing, or selling health care plans/products	☐ (Complete Section D.8)	☐	☐ (Complete Section D.8)
j) Establishing health care provider networks to provide managed care	☐	☐	☐
k) Actuarial services for health care plans	☐	☐	☐
l) Assisting customers in securing reinsurance	☐	☐	☐

m) Banking services such as debit cards for health care spending accounts (please describe):

n) Providing, developing or licensing computer hardware or software to others either as a part of the Applicant's basic services or for a fee (please describe):

o) Services for automobile liability or disability plans (please describe):

p) Third party administration services (please describe):

q) Employee Assistance Program (EAP) services (please describe):

r) Nurse call line (please describe):

s) Any other services (please describe):

4.	SUBCONTRACTING (WITHIN AND OUTSIDE THE UNITED STATES) a) Are any of your operations subcontracted? Credentialing / Peer Review / Provider Selection ☐ Yes ☐ No Utilization Review / Case Management/Disease Management ☐ Yes ☐ No Claim Handling ☐ Yes ☐ No Other (describe) If "Yes": Do you review or audit the process? ☐ Yes ☐ No Are written contracts used for all subcontracted work? ☐ Yes ☐ No Do you require all subcontractors to carry their own errors and omissions insurance? ☐ Yes ☐ No What are required minimum limits? Do you indemnify the subcontractor? ☐ Yes ☐ No Does the subcontractor indemnify you? ☐ Yes ☐ No b) Are any of your operations subcontracted outside of the United States? ☐ Yes ☐ No If "Yes," please describe: c) Does the Applicant have any programs which afford members the opportunity to have medical services performed in countries outside of the United States? ☐ Yes ☐ No If "Yes," please explain:
5.	CREDENTIALING/PROVIDER SELECTION: Last 12 months / Next 12 months a) Total revenue for credentialing/peer review/provider selection services performed for others for a fee: $ / $ b) Does the Applicant have written policies and procedures in place for provider selection, peer review, credentialing, re-credentialing, de-credentialing and making decisions which adversely affect a provider's credentials? ☐ Yes ☐ No If "Yes", do those procedures follow JACHO or NCQA standards and comply with all applicable laws? ☐ Yes ☐ No c) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges, credentials or contract becomes final? ☐ Yes ☐ No d) Are all providers offered a hearing or appeal prior to termination? ☐ Yes ☐ No If "No," please explain: e) Are grounds for termination of providers clearly expressed by Applicant in its contracts? ☐ Yes ☐ No f) Does the Applicant disclose its compensation reimbursement policies for out-of-network providers on its website? ☐ Yes ☐ No If "No," please explain: g) Do the Applicant's members / subscribers have access to out-of-network provider rates? ☐ Yes ☐ No If "No," please explain: h) Does the Applicant have pay for performance programs and/or tiered networks for its providers? ☐ Yes ☐ No If "Yes:" 1) Are the standards for these programs made available to all providers? ☐ Yes ☐ No 2) Is there an appeals process which is clearly outlined to all providers? ☐ Yes ☐ No
6	UTILIZATION REVIEW Last 12 months / Next 12 months a) Total revenue for utilization review services performed for others for a fee: $ / $

	b) Percentage of benefits denied/avoided in the utilization review process (e.g. denial rate): % %	
	c) Number of full-time reviewers: Number of part-time reviewers:	
	d) Does the Applicant have written policies and procedures in place for utilization review, including denials and appeals, which follow NCQA or URAC standards and comply with all applicable laws?	☐ Yes ☐ No
	If "No," please explain: e) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals?	☐ Yes ☐ No
	f) Does Applicant utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers?	☐ Yes ☐ No
	If "Yes," please explain:	
	g) Does the Applicant have an external review process in all states where it operates?	☐ Yes ☐ No
	If "Yes," does the Applicant abide by the external review decisions in all cases? If "No", please explain:	☐ Yes ☐ No
	h) What percentage of decisions which go through the external review process are ultimately decided in favor of the enrollee? % %	
7	HANDLING AND ADJUSTING OF ENROLLEES' HEALTH CARE BENEFIT CLAIMS Last 12 months Next 12 months	
	a) Number of claims processed:	
	b) Number of full-time claim adjusters:	
	c) Number of part-time claim adjusters expressed as full-time equivalents (FTEs):	
	d) Percentage of claims denied: % %	
	e) Does the Applicant utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claims handlers or adjusters? If "Yes," please explain:	☐ Yes ☐ No
8	ADVERTISING/MARKETING/SALES	
	a) Do all contracts, sales literature, and brochures expressly identify covered and non-covered procedures?	☐ Yes ☐ No
	b) Do contracts, sales literature, and brochures expressly refer to all contracted health care providers as independent contractors?	☐ Yes ☐ No
	c) Do any contracts, sales literature, or brochures make statements or warranties as to the quality of health care, breadth or plan, providing all the needed care or being the "best" plan, etc.?	☐ Yes ☐ No
	d) Does the Applicant's legal counsel review and approve all contracts, sales literature, brochures, advertisements, and other marketing materials prior to their use?	☐ Yes ☐ No
	e) Does the Applicant offer now or plan to offer Medicare Shared Savings Program, Medicare Advantage or other government sponsored health care plans?	☐ Yes ☐ No
	If "Yes," does the Applicant have policies and procedures that assure compliance with government imposed standards for marketing such plans?	☐ Yes ☐ No

Section E: HEALTHCARE PROFESSIONAL LIABILITY INFORMATION – Complete Section E only if you are applying for Healthcare Professional Liability Coverage and provide information for each organization for which coverage is sought.

1. GENERAL INFORMATION: *(check all that apply)*

☐ General Hospital	☐ Other Specialty Hospital	☐ Medical Group / Physician Practice
☐ Critical Access Hospital	☐ Teaching Hospital	☐ Clinic
☐ Long Term Acute Care Hospital	☐ Research Hospital	☐ Medical Home
☐ Psychiatric Hospital	☐ Government Hospital	☐ Other Healthcare Provider
☐ Children's Hospital	☐ Nursing Home	

a) Is this facility licensed by the State? ☐ Yes ☐ No

b) Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? ☐ Yes ☐ No

If "Yes," please explain:

c) Has the Applicant entered into any joint ventures or limited partnerships? ☐ Yes ☐ No

If "Yes," please explain:

d) Is any part of the Applicant operated/leased by a management corporation? ☐ Yes ☐ No

If "Yes," please give the name of the corporation and details of structure:

e) Does the Applicant participate in any teaching programs? ☐ Yes ☐ No

If "Yes," please explain:

f) Is the program hospital-sponsored? ☐ Yes ☐ No

If "Yes," please provide the name of the sponsoring institution:

g) Does the Applicant anticipate any facility expansions (increase in licensed beds) within the next year? ☐ Yes ☐ No

If "Yes," please explain:

2. PERSONNEL:

Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

Classification	FTE's		Classification	FTE's		Classification	FTE's
Physicians & Surgeons**			Nurse Practitioner*			Nurses Aides	
Residents*			Midwives*			Paramedics	
Dentists			Pharmacists			Emergency Medical Technicians	
CRNA*			Registered Nurses			Respiratory Therapists	
Physician Assistant*			Licensed Vocational / Practical Nurses			Laboratory or X-Ray Technicians	

** Please provide additional information as required in the Physician Addendum *and* Departed Physicians and Surgeons Addendum
(A separate application may be required for each Physician or Surgeon prior to commencement of coverage)
* Please provide additional information as required in Allied Healthcare and Mid-Level Provider Addendum

If coverage is requested for the following, please indicate:

CRNA ☐ Yes ☐ No	Nurse Midwives	☐ Yes ☐ No	
Physician Assistant ☐ Yes ☐ No	Employed Physicians & Surgeons	☐ Yes ☐ No	
Nurse Practitioner ☐ Yes ☐ No	Residents	☐ Yes ☐ No	

3. SERVICES:

Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following:

☐ Abortion Clinic	☐ Oncology	☐ Inhalation Therapy
☐ Ambulance Service	☐ Open Heart Surgery	☐ Intensive Care Unit

☐ Base Hospital	☐ Off- Premise Care	☐ Organ Bank
☐ Blood Bank	☐ Day Care	☐ Organ Transplants
☐ Burn Units	☐ Outpatient SurgiCenters	☐ Dental Services
☐ Cardiac Cather Centers	☐ Emergency Room	☐ Lifeline
☐ Coronary care Unit	☐ Home Health Care	☐ Nursery
☐ Dialysis	☐ Hospice	☐ Neonatal
☐ OB/GYN	☐ Hospital Foundation	☐ Pharmacy
☐ HMO	☐ Off Premises Labs	
☐ Transportation Services	☐ Mobile Unit (bloodmobiles, mammography, CAT scan, etc.)	

4. OCCUPANCY/SERVICE COUNTS:

BEDS: Provide average number of occupied beds in projected and current year categories

	Licensed	Current Year	Projected		Licensed	Current Year	Projected
Acute / ICU				Psychiatric			
Cribs / Bassinets				Rehabilitation			
General Medical				Chemical Dependency			
Long Term Acute Care				Hospice			
Extended Care				Other			
Skilled Nursing							

INPATIENT SERVICES:

	Current Year	Projected		Current Year	Projected
Inpatient Surgery			Cesarean Sections		
Deliveries (excluding C-Sections and VBAC's)			VBAC's		

OUTPATIENT SERVICES:

Emergency Room			Rehabilitation		
Outpatient Surgery			Home Health Care		
Other Outpatient Visits (Patient Per Registration Day)			Clinic Visits		
Psychiatric Visits			Physician Visits		
Alcohol / Drug Abuse			Reference Labs		

5. ANESTHESIA SERVICES:

a) Staffing is by: ☐ Contracted Physicians ☐ Employed Physicians ☐ Residents ☐ CRNA's

b) Are all physicians board certified? ☐ Yes ☐ No

c) If under contract, to whom is staffing contracted?

d) Are contracted physicians required to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," what limits are required?

e) If staffing is provided by CRNA's, are CRNA's: ☐ Employed by Applicant ☐ Employed by the Anesthesiologist ☐ Employed by the Surgeon ☐ Independent

f) Do CRNA's work under the direct supervision of an anesthesiologist? ☐ Yes ☐ No

6. RADIOLOGY SERVICES:

a) Staffing is by: ☐ Contracted Physicians ☐ Residents ☐ Employed Physicians ☐ CRNA's

b) Are all physicians board certified? ☐ Yes ☐ No

c) If under contract, to whom is staffing contracted?

d) Are contracted physicians required to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," what limits are required?

7. OBSTETRICS:

a) Is the Applicant a regional referral center for newborns requiring extensive care? ☐ Yes ☐ No

If "No," does a written procedure exist for transferring all high risk mothers and/or ☐ Yes ☐ No

b) Does the Applicant have a separate birthing center? ☐ Yes ☐ No

c) Can cesarean sections be performed within thirty (30) minutes at all times? ☐ Yes ☐ No

d) Do CNM's practice at your hospital? ☐ Yes ☐ No

If "Yes," are they supervised by OB physicians? ☐ Yes ☐ No

If employed, do CNM's deliver babies at home? ☐ Yes ☐ No

e) Do Family Physicians perform obstetrical services? ☐ Yes ☐ No

f) Do Family Physicians or CNM's perform VBAC's or C-Sections? ☐ Yes ☐ No

g) If the Applicant has a neonatal intensive care unit (NICU), state:

Total number of neonates admitted to NICU in the past twelve (12) months:

Total number of neonates admitted to NICU who were transferred from other facilities:

Whether full-time attending neonatologists on-site in NICU twenty-four (24) hours per day:

h) If the Applicant does not have a NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months:

8. EMERGENCY ROOM:

a) Does the Applicant provide emergency room (ER) service? ☐ Yes ☐ No

If "Yes," please answer all of the questions in this section:

b) Staffing is by: ☐ Contracted Physicians ☐ Residents ☐ Employed Physicians ☐ Physician Assistants

c) Are all physicians board certified? ☐ Yes ☐ No

d) If under contract, to whom is staffing contracted?

e) Are contracted physicians required to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," what limits are required?

9. SURGERY:

a) Are any of the following performed at your facility:

	☐ Experimental Surgery ☐ Open Heart Surgery			☐ Neurosurgery ☐ Weight Reduction Surgery			
10.	SPECIAL SERVICES:						
	Ambulance	Number of Vehicles			Blood Banks	Number of donors (pints)	
		Number of runs per year				Number of pints purchased from others	
	Organ Tissue Bank	Number of donors			Day Care	Number of children per day	
		Number of organ/tissue donations per year				Number of days per week	
						On hospital premises?	☐ Yes ☐ No
						Open to the public?	☐ Yes ☐ No
11.	STAFF PRIVILEGES:						
	a) Are credentials for new staff members checked and approved prior to granting staff privileges? ☐ Yes ☐ No						
	If "No", please explain:						
	b) Does the Applicant have any staff members who have restricted licenses or privileges? ☐ Yes ☐ No						
	If "Yes", please explain:						
	c) Are all staff privileges reviewed at least every two (2) years? ☐ Yes ☐ No						
	d) Does the Applicant require all foreign school graduates to be certified by the Education Council for Foreign Medical School graduates? ☐ Yes ☐ No						
	e) Are all staff members required to maintain professional liability insurance? ☐ Yes ☐ No						
12.	CONTRACTUAL AGREEMENTS:						
	a) Are any of the following services performed at the hospital by contract professionals?						
	☐ Pathology ☐ Laboratory						
	☐ Pharmacy ☐ Other						
	b) Does the Applicant require these contractors to provide evidence of insurance? ☐ Yes ☐ No						
	If "Yes", what limits of liability does the Applicant require?						
	c) Are there any other service contracts in effect? ☐ Yes ☐ No						
	If "Yes", please describe services:						
	d) Does the Applicant indemnify (hold harmless) the service provider? ☐ Yes ☐ No						

SECTION F. GENERAL LIABILITY – Complete Section F only if you are applying for General Liability Coverage and provide information for each organization for which coverage is sought.			
1	Please indicate below all the buildings the Applicant owns, controls or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.		
	Address:		Year Built:
	Construction (brick, fire-resistive, etc.):	No. of Stores:	Total Sq. Feet:
	Use:	Inpatient / Outpatient:	
2.	Does the Applicant use security guards? ☐ Yes ☐ No		
	If "Yes", complete the following questions:		
	Services are provided by: ☐ Employees ☐ Contractors		
	Do guards carry guns? ☐ Yes ☐ No		

Section G: FIDUCIARY LIABILITY – Complete Section G only if you are applying for Fiduciary Liability Coverage and provide information for each organization for which coverage is sought.

1. Please complete the following chart for all Employee Benefit Plans or other Plans for which the Applicant is requesting Fiduciary Liability Coverage. List additional Plans on a separate attachment.

Full Plan Name	Plan Type*	Sponsorship**	Total Assets of Plan ($)	Current Number of Plan Participants	Plan Status***
			$		
			$		
			$		
			$		

* Plan Types: Defined Benefit (DB); Defined Contributions (DC); ESOP (E); Self-Funded Welfare Benefit Plan (W); Health & Welfare Plan (HW); Cash Balance (CB); Other (O)

** Sponsorship: Multiple Employer (ME); Government (G); Church (C); Other (O)

*** Plan Status: Active (A); Frozen (F); Sold (S); Terminated (T). If any Plan has been terminated, indicate date of termination.

2. Is the Applicant delinquent in making any contributions under any Plan? ☐ Yes ☐ No
   If "Yes", please explain:

3. Is the Applicant planning any action which, over the next 12 months, would result in a reduction of benefits for any Plan participants, or in any Plan being terminated, frozen, sold or merged into another Plan? ☐ Yes ☐ No

   If "Yes," please provide details, including the approximate value of assets affected and the proposed date of action:

4. Are all Plans in compliance with Employee Retirement Income Security Acts ("ERISA"), or similar foreign laws if applicable? ☐ Yes ☐ No

Section H: PRIVACY LIABILITY – Complete Section H only if you are applying for Privacy Liability Coverage and provide information for each organization for which coverage is sought.

As used in this Application, Personally Identifiable Information ("PII") means information from which an individual may be uniquely and reliably identified, such as an individual's name, address, or telephone number, in combination with his/her social security number, account relationships, account numbers, passwords, PIN numbers, credit or debit card numbers and biometric information. Personally Identifiable Information includes Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and nonpublic Personal Information as defined by the Gramm-Leach Bliley Act of 1999.

1. Does the Applicant transmit, receive, store, handle or have access to any of the following PII:

   ☐ Medical Records
   ☐ Credit Card numbers
   ☐ Social Security Numbers
   ☐ Drivers License Numbers
   ☐ Other (describe):

2. Does the Applicant store PII on laptops, PDAs or other mobile devices or web servers? ☐ Yes ☐ No
   If "Yes", is all such data encrypted during transmission, receipt and storage? ☐ Yes ☐ No
   If "No", please explain:

3. Complete the following table with respect to encryption of technology assets within the Applicant's Network:

Technology Assets	Encrypted?
Laptops	☐ Yes ☐ No
Mobile Devices	☐ Yes ☐ No
Backups	☐ Yes ☐ No
Wireless Network	☐ Yes ☐ No
Other:	☐ Yes ☐ No

4.	a) If persons or entities are permitted to connect to the Applicant's network from an off-site location, how is that done and kept secure? b) Do you use vendors to facilitate such off-site connection? ☐ Yes ☐ No If "Yes," please provide full details, including on how you ensure their compliance with HIPAA, HITECH and other privacy laws and or whether such vendors have an obligation to indemnify you for their negligence:	
5.	Does the Applicant have a corporate-wide privacy policy? ☐ Yes ☐ No If "Yes", does it: a) comply with HIPAA and HITECH? ☐ Yes ☐ No b) include a plan for ongoing HIPAA privacy and HITECH training? ☐ Yes ☐ No c) address the responsibilities of its "Business Partners" under HIPAA? ☐ Yes ☐ No If "Yes", have the Applicant's privacy policies been reviewed and approved by an attorney? ☐ Yes ☐ No If "Yes" how recently were these privacy policies reviewed and updated?	
6.	Does the Applicant restrict employee access to PII? ☐ Yes ☐ No	
7.	Does the Applicant have a formal, documented user and password procedure in place? ☐ Yes ☐ No	
8.	Does Applicant have an Incident Response Plan in place for dealing with a data breach? ☐ Yes ☐ No	

Section I: GOVERNMENT BILLING ERRORS AND OMISSIONS – Complete Section I only if you are applying for Government Billing E&O Option coverage and provide information for each organization for which coverage is sought.	
1.	BILLING / AUDIT INFORMATION Does the Applicant have an in-house billing department? ☐ Yes ☐ No If "Yes", please provide information on the number of staff members, staff turnover, credentials and training of the staff by attachment to this Application. If "No", and billing is subcontracted: What is the name of the subcontractor? Does the Applicant review or audit the process? ☐ Yes ☐ No Is the subcontractor required to maintain errors and omissions coverage? ☐ Yes ☐ No What minimum limits are required? $ Does the Applicant indemnify the subcontractor? ☐ Yes ☐ No Does the subcontractor indemnify the Applicant? ☐ Yes ☐ No
2.	Has the Applicant ever been terminated or suspended from participation in any governmental health program? ☐ Yes ☐ No If "Yes", please provide details by attachment to this Application.
3.	Has the Applicant ever been subject to a medical billing audit by any payor, governmental or commercial? ☐ Yes ☐ No If "Yes", please provide details by attachment to this Application including but not limited to: • Any money that was required to be repaid as a result of the audit including all stratified and extrapolated amounts • Any fines or penalties which were levied as a result of the audit • Any settlement amounts paid as a result of the audit
4.	Has the Applicant ever been involved in any criminal or civil litigation involving allegations regarding the appropriateness or accuracy of the Applicant's medical claims billing? ☐ Yes ☐ No If "Yes," please provide details by attachment to this Application.
5.	Has the Applicant ever been the target or subject of an investigation regarding medical billings? ☐ Yes ☐ No

If "Yes", please provide details by attachment to this Application including but not limited to:

- Name of the investigating agency
- Subject matter of the investigation
- Resolution (voluntary settlement, declination letter, litigation, prosecution, etc.)

SECTION J: CLAIMS INFORMATION

1. During the past five (5) years, no claims such as would fall within the scope of the proposed insurance have been made against the Applicant or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs):

   If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION J.(1) IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. During the past five (5) years, neither the Applicant nor any individual or entity proposed for coverage, has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument, except as follows:

   If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION J.(2) IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION J.(2) IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Neither the Applicant 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 give rise to a claim that may fall within the scope of the proposed insurance, except as follows:

   If answer is "none", so state:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION J.(3) IS EXCLUDED FROM THE PROPOSED INSURANCE.

SECTION K: ATTACHMENTS

1. Please attach copies of the following documents. These documents shall become a part of this Application:

   a. Audited financial statements with any notes and schedules (interim statements if audited is more than 6 months old).
   b. If the Applicant is newly formed, Pro-Forma financial statements and Business Plan
   c. Applicant's By-Laws and Articles of Incorporation
   d. Applicant's organization chart
   e. Any registration statements filed with the SEC or any private placement memoranda within the last twelve (12) months
   f. Copy of employee handbook (if the Applicant has more than one hundred (100) employees)
   g. EEO-1 Report
   h. Written credentialing and peer review procedures
   i. Sample contract(s) with health care providers (physicians, hospitals, and others)
   j. Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet)

k. Applicant's Corporate Compliance program

l. Loss history for the last seven (7) years, including any claim paid or outstanding. Detailed losses should be provided including any paid or reserved amounts. Loss should be valued no earlier than ninety (90) days prior to the proposed effective date.

2. If you are applying for medical professional liability coverage, please also attach the following items for each Applicant seeking such coverage:

a. Employed Physician Addendum which includes the name, specialty and retro date for each employed physician and other provider information as noted in Section E 2. of this Application

b. A copy of the most recent JCAHO report and response to any contingencies

c. Copy of expiring Medical Professional Liability insurance policy

d. Current balance of the self-insured trust fund*

e. Trust Agreement*

f. Recent actuarial study supporting the funding of the self-insured trust*

*These items apply if Applicant has set up a self-insured trust fund

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 reasonable inquiry, the statements in this Application and any attachments or information submitted 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 information contained in and submitted with this Application is on file with the Underwriter, and along with the Application 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 Applicant 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 Applicant will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand;

a) the policy, if issued, shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Underwriter in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and

b) the limit of liability available under the policy if issued, to pay damages, settlements, or judgments shall be reduced, and may be exhausted by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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 APPLICANTS: WARNING – IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATON TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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 MAINE, TENNESSEE, VIRGINIA AND WASHINGTON 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 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 MINNESOTA, OHIO, AND ARKANSAS 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 NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK 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 EACH 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.

Applicant (signature):		
By (Chairman and / or President – Print Name)	Title:	Date: