IRONSHORE your safe harbour	IRONSHORE COMPANIES 175 Power Forest Drive Weatogue, CT 06089	BENEFIT PLAN SPONSOR LIABILITY NEW BUSINESS APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR WITHIN THE TIME PERIOD SET FORTH IN THE POLICY. 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.

PART I. GENERAL INFORMATION, OPERATIONS AND STRUCTURE

1. Name of **Applicant**: (Note: Wherever used, **Applicant** means this entity and any other entities listed in response to question 3)

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

2.

Applicant is:	☐ Employer	☐ Association
	☐ Union	☐ Other (describe):
Applicant is:	☐ Fully self-insured	☐ Partially self-insured
	☐ Other (describe):	
Date of Incorporation:		Date Operations Began:
State(s) where **Applicant's** employees/members reside:		

3. If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), 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

4. Is Applicant currently, or has the Applicant ever carried benefit plan sponsor, plan purchaser or any other type of managed care professional liability coverage? ☐ Yes ☐ No

If "Yes," please provide information on policy period, carrier, limits, retroactive date, deductible and annual premium.

5. List all health plans available through Applicant:

Name of Insurer, Plan, Network or Vendor	Type of Benefit (Health Care, Dental, Vision)	Type of Plan (HMO, PPO, POS, Indemnity, etc.)	Average Number of enrollees (covered lives including dependents) per year

6. Does the Applicant use a consultant for choosing health care plans or benefits? ☐ Yes ☐ No

If "Yes", provide the consultant's name and address:

Describe the process for selecting the insurer(s), plan(s), network(s), or vendors:

Who on the Applicant's staff makes the final selection of insurer(s), plan(s), network(s), or vendor(s)? :

Are all contracted insurer(s), plan(s), network(s), or vendor(s) required to maintain professional liability or errors and omissions insurance? ☐ Yes ☐ No

If "No", please explain:

Provide details of the Applicant's indemnification arrangements with contracted insurer(s), plan(s), network(s), or vendor(s) or attach copies of sample contracts.

7. RISK MANAGEMENT:

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

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

INTERNATIONAL EXPOSURE:

Does the Applicant subcontract for services such as utilization review or handling or processing of claims to any organization where the subcontracted services are performed outside of the United States? ☐ Yes ☐ No

If "Yes", please explain.

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":

- Are members provided with a financial inducement to have services performed outside of the United States (i.e., waiver of copayment, participation in cost savings)? ☐ Yes ☐ No
- Is the Applicant involved in the administration of this aspect of the plan? ☐ Yes ☐ No

HIPAA:

Has the Applicant modified its policies and procedures such that they are consistent with all of the elements of HIPAA including ongoing training? ☐ Yes ☐ No

COMPLIANCE:

Does the Applicant have a written Corporate Compliance program? ☐ Yes ☐ No

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

	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?	

PART II. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS

8.	Who does the credentialing of contracted health care providers?	**Applicant**:	☐ Yes ☐ No
		Network vendor:	☐ Yes ☐ No
		Other:	☐ Yes ☐ No
	If credentialing is subcontracted:	Provide name and address of network vendor or other subcontractor:	
		Does the **Applicant** review or audit the credentialing process?	☐ Yes ☐ No
		Is subcontractor required to maintain errors and omissions insurance? What minimum limits are required?	☐ Yes ☐ No
		Is the **Applicant** named as an additional insured?	☐ Yes ☐ No
		Does the **Applicant** indemnify the subcontractor?	☐ Yes ☐ No
		Does the subcontractor indemnify the **Applicant**?	☐ Yes ☐ No
9.	If credentialing is done by the **Applicant**:		
	Does the **Applicant** have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials?		☐ Yes ☐ No
	Do the written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws?		☐ Yes ☐ No
	Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final?		☐ Yes ☐ No
	Are all providers offered a hearing or appeal prior to termination? If "No", please explain:		☐ Yes ☐ No
	Are grounds for termination of providers clearly expressed by **Applicant** in its contracts?		☐ Yes ☐ No
	Is complete documentation maintained on all terminations? If "Yes", how long?		☐ Yes ☐ No
10.	Does the **Applicant** or its network vendor or other subcontractor have pay for performance programs and/or tiered networks for its providers?		☐ Yes ☐ No
	If "Yes",	Are the standards for these programs made available to providers?	☐ Yes ☐ No
		Is there an appeals process which is clearly outlined to all providers?	☐ Yes ☐ No
11.	Does the **Applicant** or its vendor include providers outside of the United States in its network?		☐ Yes ☐ No
	If "Yes" and the Applicant does the credentialing, please provide a copy of the policies and procedures utilized. If "Yes" and a network vendor or other subcontractor does the credentialing, please provide the name and address of the subcontractor:		

PART III. UTILIZATION REVIEW

12.	Who does utilization review?	**Applicant**:	☐ Yes ☐ No
		Subcontractor:	☐ Yes ☐ No
		Other:	☐ Yes ☐ No

	Percentage of benefits denied / avoided in the utilization review process (e.g. denial rate):	Last 12 months (actual): %	Next 12 months (projected): %
	Number of full-time reviewers:		
	Number of part-time reviewers:		
	Number of part-time reviewers expressed as full-time equivalents (FTE's):		

If utilization review is subcontracted:

- Does the **Applicant** review or audit the process? ☐ Yes ☐ No
- Is subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No
- What minimum limits are required?
- Is the **Applicant** named as an additional insured? ☐ Yes ☐ No
- Does the **Applicant** indemnify the subcontractor? ☐ Yes ☐ No
- Does the subcontractor indemnify the **Applicant**? ☐ Yes ☐ No

If utilization review is done by the Applicant:

- 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:
- Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No
- Does the **Applicant** utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? ☐ Yes ☐ No

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? ☐ Yes ☐ No

If "No", please explain:

	Last 12 months (actual):	Next 12 months (projected):
What percentage of decisions which go through the external review process are ultimately decided in favor of the enrollee?	%	%

PART IV. ADVERTISING / MARKETING / SALES / EMPLOYEE COMMUNICATIONS

13. Who prepares the plan booklet and other descriptive communications to the enrollees?

- **Applicant:** ☐ Yes ☐ No
- Subcontractor: ☐ Yes ☐ No
- Other: ☐ Yes ☐ No

Do all plan booklets, brochures or summary plan descriptions expressly identify covered and non-covered procedures? ☐ Yes ☐ No

Do all plan booklets, brochures or summary plan descriptions expressly refer to all contracted health care providers as independent contractors? ☐ Yes ☐ No

Do any plan booklets, brochures or summary plan descriptions make statements or warranties as to the quality of health care, breadth of plan, providing all the needed care, or being the "best" plan, etc.? ☐ Yes ☐ No

Does the **Applicant's** legal counsel review and approve all plan booklets, brochures or summary plan descriptions prior to their use? ☐ Yes ☐ No

If enrollee satisfaction surveys are conducted, please attach or describe the results from the most recent survey:

PART V. MEDICAL SERVICES PROVIDED BY APPLICANT

14.	Does the **Applicant** own, operate, or supervise an on-site clinic or sickroom, a hospital, inpatient or outpatient clinic, pharmacy, dispensary or any other medical facility? If "Yes", please provide the particulars:	☐ Yes ☐ No
	Does the **Applicant** employ physicians, surgeons, dentists, or any other health care professionals, in any medical capacity except to perform administrative duties, peer review or utilization review functions? If "Yes", please provide the particulars:	☐ Yes ☐ No

PART VI. CLAIMS INFORMATION

15. 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 15 IS EXCLUDED FROM THE PROPOSED INSURANCE.

16. 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 16 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 16 IS EXCLUDED FROM THE PROPOSED INSURANCE.

17. 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 17 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

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

a. **Applicant**'s last 2 audited or accountant–prepared financial statements with notes

b. Most recent actuarial report, if applicable

c. Sample TPA, ASO or other vendor contract(s)

d. Sample enrollee(s) plan booklets and summary plan descriptions

PART VIII. 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:

NOTE: This Application must be signed by the Chairman or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.