IRONSHORE
your safe harbour

IRONSHORE INDEMNITY INC.

(A Stock Company)
Mailing Address:
PO Box 3407
New York, NY 10008
(877) IRON-411

PROVIDER EXCESS OF LOSS INSURANCE POLICY APPLICATION - CALIFORNIA

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 Authorized individual to receive notices from Underwriter (*if different from contact person*):		Email Address:	

2. **Applicant** is:

☐ Hospital	☐ MSA
☐ PHO	☐ Medical Group
☐ IPA	☐ ASO
☐ ACO	☐ CCO
☐ IDO	☐ Other (describe):

State(s) where **Applicant** operates:

3. Coverage Type (check all that apply):

☐ Inpatient Hospital	☐ Ambulance
☐ Outpatient Services	☐ Durable Medical Equipment
☐ Physician Services	☐ Sub-Acute Care
☐ Pharmaceuticals	☐ Long-Term Care

4. Covered Population(s):

☐ Commercial HMO	☐ PPO	☐ Medicare Advantage
☐ POS	☐ Medicaid TANF/ AFDC	☐ Medicare SNP Please specify (Dual Eligible, Institutional, or Chronic Condition)
☐ Medicaid	☐ Medicaid SSI	☐ Other:

5. Coverage Requested:

Effective Date: / / (Month/ Day/ Year)

Eligible Expense Basis

Claims Incurred from: / / (Month/ Day/ Year)

Claims Incurred to: / / (Month/ Day/ Year)

Claims Paid to: / / (Month/ Day/ Year)

Claims Reporting Deadline: / / (Month/ Day/ Year)

Claims Submitting Deadline: / / (Month/ Day/ Year)

Insured Percentage: %

Maximum Benefit Covered for Each Covered Member: $

Retention Levels	Hospital	Professional	Combined
Commercial:	$	$	$
POS:	$	$	$
PPO:	$	$	$
Medicaid:	$	$	$
Medicare:	$	$	$
Other:	$	$	$

Special Endorsements	Terms/ Limits
Experience Refund:	
Aggregating Specific Deductible:	
31 Day Carry Forward:	
Other:	

6. A. Required Data

Capitated Contracts – Please include executed copies of the financial responsibility matrices for each Capitated Contract to be covered.

B. Historical Underwriting Information:

For the most recent two completed years and the current year to date, the following items must be submitted prior to or with this Application:

- Claims detail for all member who exceeded 50% of the lowest specific retention amount being requested.
- Historical member months by population; and
- Policy terms and conditions.

For the current period – Not applicable to professional only accounts:

- A listing of members who have been approved or who are under evaluation for an organ or tissue transplant.
- Hospital confined for 20 or more consecutive days as of the date coverage is bound; and
- Undergoing treatment which may, in the opinion of the Applicant's chief medical office or other authorized clinician, result in incurred charges exceeding 75% of the lowest specific retention amount requested.
- The information submitted should not include AIDS or HIV testing or test results.

C. Utilization Information – Not applicable to professional only accounts:

For the most recent complete year and the current year to date, the following items must be submitted prior to or with this Application:

- Days per 1,000; and
- Average Cost per Day

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.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a claim or potential claim.

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.

NOTICE TO CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant:		
Applicant (signature):		
By (Partner, Principal, Director or Officer – Print Name)	Title:	Date:

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

RETURN COMPLETED APPLICATION PLUS ANY SUPPLEMENTS AND ATTACHMENTS TO YOUR INSURANCE AGENT OR BROKER.

Produced by (*Insurance Agent*):	Insurance Agency:
Insurance Agency Taxpayer ID or Social Security Number:	Agent License Number:
Address (*No., Street, City, State, and ZIP Code)*	

Submitted by (*Insurance Agency*):	Insurance Agency Taxpayer ID or Social Security Number:	Agent License Number:
Address (*No., Street, City, State, and ZIP Code*)		

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