MANAGED CARE DIRECTORS AND
OFFICERS LIABILITY INCLUDING
EMPLOYMENT PRACTICES 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.

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 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. 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. **Applicant** is:

☐ HMO (network or IPA model)	☐ HMO (staff model)	☐ HMO (combined network and staff)
☐ PPO	☐ PHO	☐ IPA
☐ MSO	☐ Third Party Administrator	☐ Utilization Review Organization
☐ Peer Review Organization	☐ Medical Group or Clinic	☐ Other:

5. Please provide details of insurance / self-insurance / reinsurance currently in force (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 Malpractice *						

* Would the **Applicant** be interested in proposals for these coverages? ☐ Yes ☐ No

6. Have any of the **Applicant's** D&O or EPL carriers indicated an intent not to offer renewal terms? ☐ Yes ☐ No

If "Yes," please provide details as an attachment to this Application.

7. Does the **Applicant** contract with any third party to manage, operate, or administer its operations? ☐ Yes ☐ No

If "Yes", please identify:

8. Stock Ownership of **Applicant** (If Not-For-Profit, proceed to #9):

Total number of voting shareholders:

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. FINANCIAL INFORMATION

Please provide the following financial information for the **Applicant** and its **Subsidiaries**. Information must be based on the most recent audited financials or interim financials if audited financials are not available.

Based on financial statements dated:	(Month / Year)
Total assets	$
Total liabilities	$
Total revenues/income	$
☐ Net income ☐ Net loss	$
Cash flow from operations	$

10. 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 offering or private placement of securities? ☐ Yes ☐ No

Any new joint ventures or new business activities or services? ☐ 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:

11. ANTITRUST MARKET POSITION

Does the **Applicant** contract with more than 25% of the physicians in any given field of practice (including without limitation primary care, family practice or any specialty) within its geographic service area? ☐ Yes ☐ No

If "Yes", please explain:

Do the **Applicant's** members control more than 25% of the hospital beds or specialty services within its geographic area? ☐ Yes ☐ No

If "Yes", please explain:

Does the **Applicant** have exclusive contracts with any physicians, hospitals or other providers? ☐ Yes ☐ No

If "Yes", please explain:

Has the **Applicant** obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? ☐ Yes ☐ No

If "Yes", please explain:

12. REGULATORY/COMPLIANCE INFORMATION

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?

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

13. EMPLOYMENT PRACTICES INFORMATION

Number of employees and independent contractors:	Current Year	Previous Year
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:		

Percentage of employees with salaries (including bonuses):

Less than $50,000	%
$50,000 - $100,000	%
$100,000 - $250,000	%
Greater than $250,000	%

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

What percentage (%) of the **Applicant's** employees has turned over in the past two (2) years?

Last 12 months % Last 24 months %

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 or layoffs? ☐ Yes ☐ No

If "Yes," please provide details by attachment to this Application.

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 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 supervisory employees receive ongoing employment practices training	☐ Yes	☐ No
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
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

CLAIMS INFORMATION

14. 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 14 IS EXCLUDED FROM THE PROPOSED INSURANCE.

15. 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 15 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 15 IS EXCLUDED FROM THE PROPOSED INSURANCE.

16. 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 16 IS EXCLUDED FROM THE PROPOSED INSURANCE.

ATTACHMENTS

17. 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. List of Applicant's Directors and Officers

f. Summary and status of any litigation filed within the last five (5) years by or against any person(s) or entity(ies) proposed for this insurance (including any litigation that has been resolved)

g. Copy of employee handbook (if the Applicant has more than one hundred (100) employees)

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: