NAS Insurance Services, inc.

Renewal Application for:

Managed Care Errors and Omissions, Directors and Officers, including Corporate Entity Coverage and/or Employment Practices Liability Coverage (Claims Made)

Notice: The Policy for which this application is made, subject to its terms, applies only to any Claim (as applicable in the Coverage Section for which application is made) made against any of the Insureds during the Policy Period. The Limit of Liability available to pay damages or settlements shall be reduced and may be exhausted by amounts incurred as Costs, Charges and Expenses (as defined in the Coverage Section for which Application is made), and Costs, Charges and Expenses shall be applied to the retentions. Submission of this Application does not guarantee coverage.

General Instructions for completing this Application:

1. **Please type or print in ink.**
2. **Please read carefully and answer all questions. If a question is not applicable, so state by writing "Not Applicable".**
3. **The Application must be signed by an executive officer.**
4. **The Application and all exhibits shall be used for purposes of this coverage only.**
5. **Please read the Policy for which application is made (the "Policy") prior to completing this Application.**
6. **The terms as used herein shall have the meanings as defined in the Policy.**

SECTION I. GENERAL INFORMATION

1. Name of proposed Named Insured ("Applicant"): _____

   a) Are there subsidiaries to be covered? ☐ Yes ☐ No

   If "Yes," please list on a separate page.

   b) Address: _____
   (Number) (Street)

   _____
   (City) (State) (Zip Code)

   ( ) _____ ( ) _____
   (Phone Number) (FAX Number)

2. Structure: ☐ Sole Proprietor ☐ Corporation ☐ LLC ☐ Partnership
   ☐ For Profit ☐ Not for Profit

3. Type of Organization:
   ☐ PHO ☐ IPA ☐ Medical Group ☐ MSO
   ☐ Hospital ☐ Clinic ☐ Other _____

If "TPA" or "Other," then please provide details of services offered on a separate page.

For questions 4 through 8, if the answer is "Yes," then please provide details on a separate page.

4. Within the last 12 months, has the Applicant transacted or attempted a private debt or equity offering of securities? ☐ Yes ☐ No

5. Within the next 12 months does the Applicant anticipate any:
   a) private debt equity offering of securities? ☐ Yes ☐ No
   b) public offering of securities? ☐ Yes ☐ No

6. Has the Appplicant in the past 12 months been involved with any actual, negotiated or attempted merger, acquisition or divestment? ☐ Yes ☐ No

7. Does the Applicant contemplate transacting any mergers or acquisitions in the next 12 months? ☐ Yes ☐ No

8. For hospital applicants: Is the Applicant accredited by JCAHO? ☐ Yes ☐ No

SECTION II. FINANCIAL INFORMATION

9. Is the Applicant currently in compliance with all loan and bond covenants? ☐ Yes ☐ No

10. **Please attach the latest years' full financial statements, and a current profit/loss statement including a balance sheet if the audit is not available.**

SECTION III. THE APPLICANT REQUESTS QUOTATIONS FOR:

			Limits of Liability (in Millions)				
			$1.0	$1.0/3.0	$2.0	$5.0	Retention
Managed Care Errors and Omissions	☐ Yes	☐ No	☐	☐	☐	☐	$ _____
Directors and Officers	☐ Yes	☐ No	☐	☐	☐	☐	$ _____
Employment Practices Liability	☐ Yes	☐ No	☐	☐	☐	☐	$ _____

SECTION IV. OTHER INFORMATION

1. The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

2. It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

3. It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

Submitted by: _____
(Agent)

Date: _____
(Month) (Day) (Year)

Signed: _____
Must be Signed by an Executive

Name: _____
Please Print or Type

Capacity: _____

Applicant Organization: _____

Date: _____
(Month) (Day) (Year)

For purposes of creating a binding contract of Insurance by this Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that any such copies shall be deemed as one and the same document.

Please fully complete and attach the Information for the Coverage Section(s) desired.

NAS Insurance Services, inc.
16501 VENTURA BLVD • SUITE 200 • ENCINO, CA 91436
PHONE 818/382-2030 • FAX 818/382-2040 • www.nasinsurance.com
LIC. #0677191

Section For: Managed Care Professional Errors and Omissions Coverage

Is the Applicant seeking Managed Care Errors and Omissions coverage? ☐ Yes ☐ No

If "Yes," please answer the following questions.

For questions 1 and 3, if the answer is "Yes," please provide details on a separate page.

1. Is the Applicant owned, managed or controlled by any other entity? ☐ Yes ☐ No
2. Is the Applicant involved in any joint ventures? ☐ Yes ☐ No
3. Please provide details of insurance/reinsurance currently in force (If "None", so state): _____

Type of Coverage	Insurance Carrier(s)	Policy Period	Limits	Deductible	Premium
Medical Malpractice					
Stop Loss					

4. Does the Applicant assume capitated or a percentage of premium risk on behalf of itself or any of its contracted providers? ☐ Yes ☐ No

   If "No," is the assumption of such risk contemplated within the next 12 months? ☐ Yes ☐ No

5. Has the Applicant ever been cited for any violation of federal, state or local licensing requirements for operation? ☐ Yes ☐ No
6. Has the Centers for Medicare and Medicaid Services, Department of Health and Human Services, or similar federal, state of local agency ever sanctioned the Applicant? ☐ Yes ☐ No
7. Has the Applicant ever had Medicare participation status revoked or restricted in any manner? ☐ Yes ☐ No
8. Is the Applicant licensed by any entity for insurance or managed care professional services? ☐ Yes ☐ No

9. Number of Providers:	Employed/Owned		Contracted	
	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months
a) Physicians (not including Phychiatrists)				
b) Psychiatrists/Psychologists				
c) Other Practioners				
d) Hospitals				
e) Other Institutions (e.g. clinics or outpatient facilities)				

10. If an MSO, provide number of clients: _____

For questions 11 through 13, if the answer is "Yes," then please provide details on a separate page.

11. Does the Applicant employ physicians, psychologists, dentists, or any other health care professional in any medical capacity, other than in peer review, utilization or administrative duties? ☐ Yes ☐ No
12. Excluding General and Internal medicine, is there any medical specialty in which more than 20% of your contracted providers specialize? ☐ Yes ☐ No

13. In any of the Applicant's marketing regions:

a) Do Applicant's exclusive participating providers constitute greater than 20% of the market for such providers? ☐ Yes ☐ No

b) Do Applicant's non-exclusive participating providers constitute greater than 30% of the market for such providers? ☐ Yes ☐ No

CREDENTIALING

14. Does the Applicant perform credentialing of health care providers which it:

a) Employs? ☐ Yes ☐ No

b) Contracts with or on behalf of? ☐ Yes ☐ No

c) Refers enrollees/patients to? ☐ Yes ☐ No

If answer is "Yes" to any of the above, then please answer all questions in this Section.

15. a) Is the Applicant delegated to perform credentialing activities on behalf of any health plan that Applicant contracts with? ☐ Yes ☐ No

b) Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No

If answer is "Yes" to 15b, then please provide details of circumstances and corrected plan of action on a separate page.

16. Is credentialing performed in accordance with NCQA standards? ☐ Yes ☐ No

17. Does the Applicant sub-delegate credentialing to any third party, (i.e. primary source verification)? ☐ Yes ☐ No

If answer is "Yes," then please describe oversight process to audit the third party on a separate page.

18. a) Does the Applicant contract with any specialty provider organizations? ☐ Yes ☐ No

b) If "Yes," does the Applicant credential each provider in the contracted organization or is credentialing sub-delegated? ☐ Yes ☐ No

If answer is "Yes, " then please describe oversight process to audit the third party on a separate page.

19. Are insufficient patient encounters, excessive utilization or any other economic factors grounds to disqualify or remove a provider from the Applicant's panel? ☐ Yes ☐ No

a) Have any providers been terminated from the Applicant's provider panel in the past 12 months? ☐ Yes ☐ No

If the answer is "Yes" to 19a, then please indicate how many were terminated and for what reasons on a separate page.

b) Were the terminated providers notified of their due process rights, as applicable? ☐ Yes ☐ No

20. Have any providers, who applied, been denied membership to the panel in the last 12 months? ☐ Yes ☐ No

If the answer is "Yes" to 20, then please indicate how many were denied, and for what reasons on a separate page.

UTILIZATION MANAGEMENT

21. a) Is the Applicant delegated to perform utilization management activities on behalf of any health plan that you contract with? ☐ Yes ☐ No

b) Has any health plan ever revoked previously delegated activites? ☐ Yes ☐ No

If answer is "Yes" to 21b, then please provide details on a separate page.

22. Does the Applicant utilize guidelines such as Milliman and Robertson and/or InterQual for its utilization decisions? ☐ Yes ☐ No

23. What activities is the Applicant delegated to perform:

Prospective utilization review	☐ Yes	☐ No	Case management	☐ Yes	☐ No
Concurrent utilization review	☐ Yes	☐ No	Referrals to specialists	☐ Yes	☐ No
Retrospective utilization review	☐ Yes	☐ No			

24. Is the Applicant delegated to process requests for:

Organ transplants	☐ Yes	☐ No	Experimental procedures	☐ Yes	☐ No

25. Does the Applicant follow a written prescribed process for the appeals to the Payer(s)? ☐ Yes ☐ No

26. Does the Applicant sub-delegate utilization management to any third party? ☐ Yes ☐ No
If the answer is "Yes," then please identify such third parties and describe oversight process to audit the third party on a separate page.

27. Does the Applicant provide utilization management services to any third party for a fee? ☐ Yes ☐ No

If the answer is "Yes," then please indicate the percentage of total revenues for this year and anticipated for next year:
This year: _____ % Next year: _____ %

28. In any of the Applicant's contracts, does the Applicant have the reponsibility to make the final determination as to whether or not a procedure is covered? ☐ Yes ☐ No

29. What are the credentials of the personnel who draft and/or issue denial(s) of benefits?

_____

_____

CLAIMS ADJUDICATION

30. a) Is the Applicant delegated to perform claims adjudication activities on behalf of any health plans that you contract with? ☐ Yes ☐ No

b) Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No

If the answer to 30b is "Yes," then please provide details on a separate page.

31. If Applicant is delegated to perform claims adjudiction activities, what activities is the Applicant delegated to perform:

Review of claims	☐ Yes	☐ No	Processing of reimbursement	☐ Yes	☐ No
Issuance of denial of claims	☐ Yes	☐ No	Claims appeals	☐ Yes	☐ No

OTHER SERVICES

32. If Applicant provides any of the following services to third parties for a fee, please indicate all that apply:

Actuarial consulting	☐ Yes	☐ No	Staffing	☐ Yes	☐ No
Collections of account receivable	☐ Yes	☐ No	Placement Insurance	☐ Yes	☐ No
Billings	☐ Yes	☐ No	Enrollment processing	☐ Yes	☐ No
Accounting	☐ Yes	☐ No	Design of employee benefit plans	☐ Yes	☐ No

Other: _____

MARKETING/SALES

33. a) Is any sales or promotional material bearing the name or identity of the Applicant distributed to:

i) Enrollees/beneficiaries	☐ Yes	☐ No
ii) Providers	☐ Yes	☐ No
iii) Payers	☐ Yes	☐ No

b) Does such material always refer to contracted providers as Independent Contractors? ☐ Yes ☐ No

HEALTH INSURANCE PORTABIITY AND ACCOUNTABILITY ACT (HIPAA) SECTION INFORMATION

34. a) Has there been any change to your HIPAA Program in the past 12 months? ☐ Yes ☐ No

i) If "Yes," please provide details? **(Use separate sheet if necessary):** _____

b) Do you have a HIPAA compliance officer/manager? ☐ Yes ☐ No

i) If "Yes," who is it, how are they qualified, and to whom do they report? _____

ii) If "No," who insures compliance? _____

PRIOR ACTIVITIES INFORMATION

35. Has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries, which have occurred in the past 12 months?

☐ Yes ☐ No ☐ None to Report

If "Yes," please indicate number of events in the last 12 months: _____

If "No," please forward notice to NAS Insurance Services, Inc., immediately.

Section For: Directors & Officers and Insured Organization Coverage

Is the Applicant seeking Directors & Officers and Insured Organization coverage? ☐ Yes ☐ No

If "Yes," please answer the following questions.

1. Do the Directors and Officers as a whole, directly or indirectly, own or control the voting rights of more than 5% of the outstanding securities of the Applicant? ☐ Yes ☐ No

If "Yes," please list each name and their ownership amount.

For questions 2 through 5, if the answer is "Yes," then please provide details on a separate page.

2. Does the Applicant render any professional services for others for a fee or compensation? ☐ Yes ☐ No

3. Does the Applicant act as a general partner in any partnership? ☐ Yes ☐ No

4. Does the Applicant have any direct or indirect insurance operations? ☐ Yes ☐ No

5. Is coverage requested for Outside Service positions on any for-profit or public corporate boards or other joint venture? ☐ Yes ☐ No

If "Yes," please submit the following for the outside company: name, audited financial statement, schedule of primary D&O, and schedule of proposed Insured Persons and their capacity.

6. Prior Activities Information

Has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries, which have occurred in the past 12 months?

☐ Yes ☐ No ☐ None to Report

If "Yes," please indicate number of events in the last 12 months: _____
If "No," please forward notice to NAS Insurance Services, Inc., immediately.

Section For: Employment Practices Coverage

Is the Applicant seeking Employment Practices coverage? ☐ Yes ☐ No

If "Yes," please answer the following questions for the Applicant.

1. Total number of employees: Full time _____ Part time _____ Temporary _____ Seasonal _____
   Independent contractors working exclusively for the Applicant _____

2. Have any officers or senior management voluntarily or involuntarily left the employ of the Applicant within the last 12 months? ☐ Yes ☐ No

   If "Yes," provide details on a separate page.

3. Does the Applicant anticipate in the next 12 months, or transacted in the last 12 months, any plant, facilty, branch or office closing, consolidations or layoffs affecting 20% or more of the total employees or affecting an entire division, location or business unit? ☐ Yes ☐ No

   If "Yes," please provide details on a separate page.

4. Describe the internal controls maintained for Employment Practices:

   a) Have all supervisors and officers attending training on sexual harrassment and discrimination within the last 18 months? ☐ Yes ☐ No

   b) Does labor relations counsel review the employment policies/procedures at least annually? ☐ Yes ☐ No

   c) Have there been any changes to the employee handbook? ☐ Yes ☐ No
   If "Yes," please provide details on a separate page.

   d) Are all mandatory federal and state posting requirements met? ☐ Yes ☐ No

   e) Are terminations reviewed by either Human Resources, Senior Management or outside labor relations counsel? ☐ Yes ☐ No

5. Annual percentage turnover rate for employees:
   Current Year: 200 ___ _____ % Previous Year: 200 ___ _____ %

6. Are stock options offered to employees, officers or directors as part of their compensation? ☐ Yes ☐ No
   If "Yes," please provide details on separate page.

7. Prior Activities Information

   Has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries, including any investigation by the Department of Labor or the Equal Opportunity Commission which have occurred in the past 12 months?

   ☐ Yes ☐ No ☐ None to Report

   If "Yes," please indicate number of events in the last 12 months: _____

   If "No," please forward notice to NAS Insurance Services, Inc., immediately.

NAS Insurance Services, inc.
16501 VENTURA BLVD • SUITE 200 • ENCINO, CA 91436
PHONE 818/382-2030 • FAX 818/382-2040 • www.nasinsurance.com
LIC. #0677191