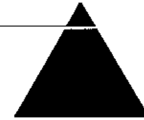
Executive Risk Indemnity Inc.
Home Office
Wilmington, Delaware 19805-1297

Administrative Offices/Mailing Address:



RENEWAL APPLICATION
FOR DIVERSIFIED HEALTHCARE ORGANIZATION
DIRECTORS AND OFFICERS LIABILITY INSURANCE POLICY
INCLUDING EMPLOYMENT PRACTICES LIABILITY COVERAGE

NOTICE: THIS APPLICATION IS FOR A CLAIMS MADE POLICY WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED, AND MAY BE EXHAUSTED, BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION. THE COVERAGE AFFORDED UNDER THIS POLICY DIFFERS IN SOME RESPECTS FROM THAT AFFORDED UNDER OTHER POLICIES. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION SECTION

1. Name of **Applicant**: ______________________________
   (Whenever used in this Application, the term **"Applicant"** shall mean the **Parent Corporation** and all **Subsidiaries.**)
   Principal address: ______________________________
   City: ______________________ State: ______ ZIP: __________
   Website address: ______________________________
   Email address: ______________________________

2. a) **Applicant** is (check all that apply):

   ☐ HMO (If so, please indicate: ☐ Staff Model ☐ Network or Panel Model ☐ Combined)
   ☐ PPO ☐ PHO ☐ IPA
   ☐ MSO ☐ Third-Party Administrator ☐ Medical Group
   ☐ Utilization Review Contractor Organization ☐ Physician Practice Organization ☐ Peer Review
   ☐ Other (please describe): ______________________________

   b) The **Applicant** is (check all that apply):

   ☐ Open Panel ☐ Closed Panel
   ☐ Exclusive Model ☐ Non-exclusive Model

   c) The **Applicant** is:

   ☐ For-Profit Corp. ☐ Not-For-Profit Tax-Exempt Corp.
   ☐ Not-For-Profit Taxable Corp. ☐ Limited Liability Company
   ☐ Partnership ☐ Joint Venture
   ☐ Other (please describe): ______________________________

3. 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
Errors & Omissions					
Medical Malpractice					
Stop Loss or Provider Excess					
Fiduciary					
Crime					

4. Stock or equity ownership:

   a) Total number of voting securities outstanding: _________

   b) Total number of voting security holders: ___________

   c) Total number of voting securities owned by the **Applicant's** directors and officers (direct and beneficial): ____________

   d) Does any security holder own five percent (5%) or more of the voting securities directly or beneficially? ☐ Yes ☐ No
   If "Yes," please designate the names and percentages of holdings.
   (If no such security holders, check here ☐ "None.")

NAME	PERCENTAGE OF HOLDINGS
	%
	%
	%
	%

5. a) Total Gross Revenue last twelve (12) months: ________________ Next twelve (12) months: ___________

   b) Total number of enrollees last twelve (12) months: _____________ Next twelve (12) months: ___________

6. Has the **Applicant** in the past thirty-six (36) months completed or agreed to, or does it contemplate within the next twelve (12) months, any of the following, whether or not such transactions were or will be completed? If "Yes," please describe the essential terms of each such transaction as an attachment to this **Application**.

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

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

   c) Any registration for a public offering or any private placement of securities? ☐ Yes ☐ No

   d) Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No

   e) Enter into new governmental contracts? ☐ Yes ☐ No

   f) Undertake new areas of business? ☐ Yes ☐ No

7. Have any providers been removed or disqualified from the **Applicant's** panel in the last twelve (12) months? ☐ Yes ☐ No
   If "Yes,": how many? _______
   how many for reasons other than professional competence? _________

8. Does the **Applicant** anticipate any facility, branch or office closing, consolidations, or layoffs within the next twenty-four (24) months? ☐ Yes ☐ No
   If "Yes," please provide details by attachment to this Application.

9. a) Total number of employees:
   Currently Full time: _____________ Part time: ____________
   Employee physicians Full time: _____________ Part time: ____________

   b) How many employees or officers have been involuntarily terminated in the past twelve (12) months? _________

   c) What percentage (%) of the **Applicant's** employees has turned over in the past twelve (12) months? _________%

   d) How many employees have an annual salary, including bonuses, of: Less than $25,000? _____________
   More than $100,000? ____________

   e) How many employees have a written employment contract? _________

II. REGULATORY CLAIM SECTION

PART A. GENERAL INFORMATION, COMPLIANCE ACTIVITIES

1. Name of Compliance Officer and title: ____

2. Compliance Program in effect? Yes No If "Yes," date implemented?
   ____

3. a) Proposed entities to be insured ("**Entity(ies)**"), including **Parent Organization** (please attach additional pages if more space is necessary):

Entity name:				Entity type (Hospital, HMO, etc.):	Compliance program in place? (Y/N)

   b) Does any **Entity(ies)** proposed for this insurance have publicly traded securities? ☐ Yes ☐ No
   If "Yes," which **Entity(ies)**? ____

4. Has each **Entity** developed and distributed written standards of conduct (such as a compliance code) to employees? (If so, enclose a copy.) ☐ Yes ☐ No
   List any **Entity(ies)** with "No" answers:
   ____

5. Did each **Entity**'s Governing Board formally adopt the compliance program? ☐ Yes ☐ No
   List any **Entities** with "No" answers: ____

6. Has each **Entity** developed and implemented regular compliance education and training programs? ☐ Yes ☐ No
   List any **Entity(ies)** with "No" answers
   ____

7. Does new employee orientation for each **Entity** include training on compliance? ☐ Yes ☐ No
   List any **Entity(ies)** with "No" answers:
   ____

8. Do employees at each **Entity** receive continuing education and compliance training to keep abreast of technical and regulatory changes? ☐ Yes ☐ No
   List any **Entity(ies)** with "No" answers:
   ____

9. Does each **Entity** maintain a process, such as a hotline, to receive complaints and allegations of wrongdoing? ☐ Yes ☐ No
   List any **Entity(ies)** with "No" answers:
   ____

   a) For "Yes" **Entities**, what is the average number of hotline complaints or allegations per month? ______

   b) Are all hotline complaints or allegations investigated? ☐ Yes ☐ No
      If "No," please explain:
      ____

10. Does each **Entity** use audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem and risk areas such as billing, coding and claims processing? ☐ Yes ☐ No
    List any **Entity(ies)** with "No" answers:
    ____

11. Has each **Entity** implemented policies and procedures addressing the non-employment or retention of sanctioned individuals? ☐ Yes ☐ No
    List any **Entity(ies)** with "No" answers:
    ____

12. Has any **Entity** invested in billing edit-checking software? ☐ Yes ☐ No
    If "Yes," which **Entity(ies)**?
    ____

13. Does any **Entity** utilize an external audit firm to monitor billing and coding compliance? ☐ Yes ☐ No
    If "Yes," please identify the name of the firm: ______________________________

PART B. UNDERWRITING SUPPLEMENTAL INFORMATION

14. Has any **Entity** proposed for this insurance been subjected to any type of audit investigating whether it allegedly: (1) received overpayments for services provided or (2) violated any law ? ☐ Yes ☐ No
    If "Yes," please explain: ______________________________

15. Has any **Entity** proposed for this insurance voluntarily disclosed to any governmental entity any violations or potential violations of the Civil False Claims Act (31 U.S.C. § 3729-3732); the Physician Ownership & Referral law {Stark Self-Referral Law} (42 U.S.C. § 1395 nn); acts potentially giving rise to Medicare/Medicaid Civil Money Penalties (including false claims and kickbacks) (42 U.S.C. § 1320a-7a(a)) or acts potentially giving rise to Program Fraud Civil Remedies (31 U.S.C. § 3801)? ☐ Yes ☐ No
    If "Yes," please explain: ______________________________

16. Has any **Entity** proposed for this insurance retained outside legal counsel to provide an opinion as to whether or not a certain course of conduct would be in violation of the Civil False Claims Act (31 U.S.C. § 3729-3732); the Physician Ownership & Referral Law {Stark Self Referral Law} (42 U.S.C. § 1395 nn); Medicare/Medicaid Civil Money Penalties (including false claims and kickbacks) (42 U.S.C. § 1320a-7a(a)) or Program Fraud Civil Remedies (31 U.S.C. § 3801)? ☐ Yes ☐ No
If "Yes," please explain: ______________________________

17. Has any **Entity** proposed for this insurance entered into a criminal or civil settlement with the United States or with some party acting on behalf of the United States by which claims against such entity were resolved? ☐ Yes ☐ No
If "Yes," please explain: ______________________________

18. Does any **Entity** proposed for this insurance have plans to merge with or acquire any other entity within the next three (3) years? ☐ Yes ☐ No
If "Yes," please explain: ______________________________

19. Has any **Entity** proposed for this insurance merged with or acquired any other entity in the past six (6) years? ☐ Yes ☐ No
If "Yes," please explain: ______________________________

20. Does any **Entity** proposed for this insurance have plans to enter into new service contracts with any government program within the next three (3) years? ☐ Yes ☐ No
If "Yes," please explain: ______________________________

21. During the past six (6) years, no **Entity** proposed for coverage has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission to any insurer, except as follows. If answer is "None," so state:

____

____

____

Without prejudice to any other rights and remedies of the Underwriter, it is agreed that any claim required to be disclosed in response to Questions 14, 15, 16, 17 or 21 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 Questions 14, 15, 16, 17 or 21 is excluded from the proposed insurance.

22. No **Entity** nor any individual proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they r should reasonably have known may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "None," so state:

____

____

____

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 22 is excluded from the proposed insurance.

III. ATTACHMENT SECTION

1. As part of this Application, submit the following documents with respect to the **Applicant**:

   (a) Last two CPA-audited financial statements with notes, schedules and management letters.
   (b) Any registration statements filed with the SEC or any private placement memorandums within the last twelve (12) months.
   (c) Current organizational chart listing each **Subsidiary**, including the ownership percentage and tax status of each.
   (d) Any amendments or revisions to the **Applicant's** charter and bylaws within the last twelve (12) months.
   (e) Any amendments or revisions to the **Applicant's** Employee Handbook within the last twelve (12) months.
   (f) Any amendments or revisions to primary contracts with payors and providers within the last twelve (12) months.
   (g) Copy of each **Entity**'s Compliance Program and/or Code of Conduct.

NOTICE TO APPLICANT - PLEASE READ CAREFULLY.

FOR THE PURPOSE OF THIS RENEWAL APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS RENEWAL APPLICATION, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO COMPLETE, OR THE APPLICANT TO PURCHASE, THE INSURANCE.

THIS RENEWAL APPLICATION AND THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS RENEWAL APPLICATION ARE SUPPLEMENTS TO THE APPLICATION(S) WHICH ARE PART OF THE EXPIRING POLICY, AND THOSE APPLICATION(S), TOGETHER WITH THIS RENEWAL APPLICATION AND ANY ATTACHED INFORMATION, WILL CONSTITUTE THE COMPLETE APPLICATION FOR RENEWAL AND WILL BECOME PART OF, AND BE CONSIDERED PHYSICALLY ATTACHED TO, ANY POLICY ISSUED. IF, AS A RESULT OF THIS RENEWAL APPLICATION, A POLICY IS ISSUED, THE UNDERWRITER WILL HAVE RELIED ON THIS RENEWAL APPLICATION, ON SUCH PREVIOUS APPLICATION(S) (AS SUPPLEMENTED OR MODIFIED BY THIS RENEWAL APPLICATION) AND ON SUCH ATTACHMENTS.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL NOTIFY THE UNDERWRITER, WHO MAY MODIFY OR WITHDRAW ANY QUOTATION.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT:

(I) THE POLICY FOR WHICH THIS RENEWAL APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE DURING THE "POLICY PERIOD," OR, ANY EXTENDED REPORTING PERIOD;

(II) THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED, AND MAY BE EXHAUSTED, BY "DEFENSE EXPENSES," AND, IN SUCH EVENT, THE UNDERWRITER WILL NOT BE RESPONSIBLE FOR THE CONTINUED "DEFENSE EXPENSES" OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT ANY OF THE FOREGOING EXCEED ANY APPLICABLE LIMIT OF LIABILITY; AND

(III) "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO 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 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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, MAINE AND VIRGINIA 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 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 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 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		
BY *(President and/or CEO Signature)*	TITLE	DATE

NOTE: This **Application** must be signed by the President and/or CEO of the **Applicant** acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

REQUIRED INFORMATION

PRODUCED BY *(Insurance Agent)* Please print and sign name ______________________________ ______________________________	
INSURANCE AGENCY	
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and Zip)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS *(No., Street, City, State, and Zip)*		

ExecutivePerils

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