

One Beacon Lane
Canton, MA 02021



MANAGED CARE ERRORS AND OMISSIONS LIABILITY APPLICATION

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS AND CONDITIONS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED.

APPLICATION INSTRUCTIONS: Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1 of PART I TELL US WHO YOU ARE ("Applicant") and all other entities and individuals proposed for this insurance.

PART I. TELL US WHO YOU ARE

1. Name of Applicant: _____
2. Address: _____
 City: _____ State: _____ ZIP: _____
 Website: _____ Telephone: _____
3. Risk Manager or Contact person and title: _____
 Email address: _____ Telephone: _____
4. Are you:

<input type="checkbox"/> For-Profit Corp.	<input type="checkbox"/> Not-for-Profit Tax-Exempt Corp.
<input type="checkbox"/> Not-for-Profit Taxable Corp.	<input type="checkbox"/> Limited Liability Company
<input type="checkbox"/> Partnership	<input type="checkbox"/> Joint Venture
<input type="checkbox"/> Other (describe): _____	
5. Date you were incorporated: _____ Date you began operations: _____
 State(s) where you operate: _____
6. If you are seeking coverage for any other entities (e.g., subsidiaries, joint ventures, or partnerships), list each entity below and **include all exposure data**. If needed, list additional entities on a separate attachment. (Please note that coverage for these entities is not automatically included. The policy, if issued, will determine actual coverage.)

Name & Address	Relationship	Description of Operations	Tax Status	Percent Owned

7. You are:

<input type="checkbox"/> HMO (If so, please indicate:	<input type="checkbox"/> Staff Model	<input type="checkbox"/> Network/IPA Model	<input type="checkbox"/> Combined [both]
<input type="checkbox"/> PPO	<input type="checkbox"/> PHO	<input type="checkbox"/> IPA	<input type="checkbox"/> Peer Review
<input type="checkbox"/> Third Party Administrator	<input type="checkbox"/> Utilization Review Organization		<input type="checkbox"/> MSO
<input type="checkbox"/> Medical Group or Clinic	<input type="checkbox"/> Accountable Care Organization		<input type="checkbox"/> Medical Home
<input type="checkbox"/> Other (describe): _____			

PART II. GIVE US YOUR NUMBERS

A. ENROLLMENT:

Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months.

ENROLLMENT TYPE	ENROLLEES LAST 12 MONTHS As of	ENROLLEES ESTIMATE NEXT 12 MONTHS As of
Commercial		
ASO		
Medicare/Medicaid		
Individual		
Vision, Dental or Other Carve-Out		
Other		
TOTAL ENROLLEES		

B. REVENUE:

	LAST 12 MONTHS As of	ESTIMATE NEXT 12 MONTHS As of
Total Revenue (all operations)		

Revenue from services provided to others (unaffiliated entities)	LAST 12 MONTHS As of	ESTIMATE NEXT 12 MONTHS As of
Utilization Review / Case Management		
Claims Administration		
Peer Review		

C. NUMBER OF HEALTH CARE PROVIDERS:

Provider type	LAST 12 MONTHS As of	ESTIMATE NEXT 12 MONTHS As of
Contracted Physicians		
Employed Physicians		

D. MANAGED CARE ACTIVITIES:

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. (Note: not all checked services may be covered):

Activity or Service	YES	NO	YES, to others for FEE
Credentialing or peer review of health care providers			
Utilization review			
Drafting practice guidelines/Critical Pathways			
Case management			
Disease management			
Handling and adjusting of enrollees' health care benefit claims			
Application or enrollment processing for enrollees of health care plans			
Billing/other processing of enrollees' claims under health care plans			
Advertising, marketing, or selling health care plans/products			
Establishing health care provider networks to provide managed care			
Actuarial services for health care plans			
Assisting customers in securing reinsurance			
Services for automobile liability or disability			
Third party administration (TPA) services			
Employee Assistance Program (EAP)			
Nurse call line			
OTHER (DESCRIBE):			

IF YOU ARE AN **IPA, PHO OR MEDICAL GROUP OR CLINIC** AND **DO NOT** HAVE CLAIM HANDLING OR UTILIZATION REVIEW RESPONSIBILITIES SKIP PART III C. D. & E.

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Are you licensed by federal, state, or local government? Yes No NA
 If "Yes," identify the licensing government: _____
2. Are you accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? Yes No NA
 If "Yes," identify the accrediting/certifying organization: _____
3. Has your license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? Yes No NA
 If "Yes," please explain: _____
4. Do you have a formal risk management program? Yes No NA

- | | | | | |
|--|--------------------|------------------------------|-----------------------------|-----------------------------|
| 5. Are any of your operations subcontracted? | Credentialing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| | Utilization Review | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| | Claim Handling | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 6. Are written contracts used for all subcontracted work? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 7. Do you require all subcontractors to carry their own errors and omissions insurance? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 8. What are required minimum limits? _____ | | | | |
| 9. Do you indemnify the subcontractor? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 10. Does the subcontractor indemnify you? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 11. Are any of your operations subcontracted outside of the United States?
If "Yes," please describe: | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |

B. HEALTHCARE REFORM:

- | | | | | |
|--|--|------------------------------|-----------------------------|-----------------------------|
| 1. Have you ever provided customer rebates based on Medical Loss Ratio obligations?
If yes, please provide details: | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 2. Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio rebates? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 3. Do you publish your Medical Loss Ratio calculation process? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 4. Have you ever been sanctioned, fined, investigated or sued for non-compliance related to your Medical Loss Ratio requirements? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 5. Do you have an individual that is responsible for compliance with health care reform? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 6. Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 7. Have you made changes to your policies and procedures to comply with all healthcare reform acts? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 8. Do you offer quality incentives to providers? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 9. Do you disclose and explain the provider incentives to members?
If yes, please provide details re: how and where the information is disclosed: | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 10. Do you have or plan to form a Medical Home facility?
If yes, please provide details: | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |

C. CREDENTIALING:

- | | | | | |
|---|--|------------------------------|-----------------------------|-----------------------------|
| 1. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 2. Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 3. Are providers allowed a hearing or appeal prior to termination? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 4. Do you clearly express grounds for termination of providers in your contracts? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 5. Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of \$1,000,000/\$3,000,000?
If "No," what minimum limits are required? _____ | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |
| 6. Do you perform on-site visits of contracted health care providers?
If "Yes," how often? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA |

7. Do you disclose your reimbursement policies for non-par providers on your website? Yes No NA
 If "No," please explain: _____
8. Do your subscribers have access to non-par provider rates? Yes No NA
 If "No," please explain: _____
9. Do you have a provider tiering program? Yes No NA
 If "Yes," please provide details on tiering criteria and appeal process:

D. UTILIZATION REVIEW: **SKIP THIS SECTION if you are an IPA or Medical Group/CliniVand do not provide this service.**

1. Do you have written policies and procedures for utilization review, including for denials and appeals? Yes No NA
2. Do your written Utilization Review Procedures:
- a) Follow NCQA or URAC standards and comply with all applicable laws? Yes No NA
 - b) Require physician review of all proposed denials? Yes No NA
 - c) State that enrollees must be notified of all denials and appeals in writing including the identity of the person who makes decisions regarding appeals? Yes No NA
 - d) Require consultation with legal counsel when considering appeals? Yes No NA
 - e) Allow for a physician to override a practice guideline? Yes No NA
 - f) Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? Yes No NA
 - g) Utilize same specialty reviewers for benefit/coverage denials? Yes No NA
 - h) Adhere to government mandated external review requirements in the states where you operate? Yes No NA
 - i) Utilize the external review process in states where it is not mandated? Yes No NA

E. CLAIM HANDLING: **SKIP THIS SECTION if you are an IPA or Medical Group/CliniVand do not provide this service.**

1. Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? Yes No NA

F. ADVERTISING/MARKETING/SALES: **SKIP THIS SECTION if you are an IPA or Medical Group/CliniVand do not provide this service.**

1. Do all contracts, sales literature, brochures and marketing materials:
- a) Expressly identify covered and non-covered procedures? Yes No NA
 - b) Expressly refer to all contracted providers as independent contractors? Yes No NA
 - c) Make statements or warranties as to the quality of health care, breadth of plan? Yes No NA
 - d) Go through legal counsel review and approval prior to their use? Yes No NA

PART IV. TELL US WHAT YOU HAVE

Please provide details of insurance/self-insurance/reinsurance currently in force (if none, please state):

Type of Coverage	Insurance Carrier(s)	Limits	Deductible/Retention	Premium	Policy Period	If Claims Made, Retroactive Date
Managed Care Errors & Omissions						
Medical Malpractice*						
D&O*						
EPL*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Fidelity*						
Network Security & Privacy *						
Other						

*Would you be interested in proposals for these coverages? If yes, please complete the appropriate section below:

OPTIONAL COVERAGES

For an option containing D&O, EPL, Fiduciary and Crime please fill out the following:

1. a. Stock ownership of the Applicant:
 - Total number of authorized common shares: _____
 - Total number of outstanding common shares: _____
 - Total number of common shareholders: _____
 - Total number of common shares owned by Applicant's directors and officers: _____
- b. As an attachment to this Application, please provide the names and number of shares for all persons or entities that presently own or control, or have stated the intention to acquire, of record or beneficially, more than 5% of Applicant's outstanding stock.
- c. Have there been any changes in Applicant's board of directors or senior management within the past 3 years for reasons other than death or retirement? Yes No NA
 If "Yes," please explain: _____

d. Number of your: Full-time employees: _____
 Part-time employees: _____

- e. Within the past 36 months, have you or do you expect to:
- (1) Merge, acquire, or consolidate with another entity? Yes No NA
 - (2) Sell, distribute, or divest of any assets or stock? Yes No NA
 - (3) Register for a public offering or private placement of securities? Yes No NA
 - (4) Form any joint venture? Yes No NA
 - (5) Enter into any new business activities or services? Yes No NA

If "Yes" to any of the above, please explain and describe the essential terms of each such transaction. (If needed, use an attachment to this Application): _____

For an option containing Network Security and Privacy please fill out the following:

- 1. Do you employ a Chief Information/Security Officer? Yes No NA
- 2. Do you have a corporate-wide privacy policy? Yes No NA
- 3. Have your privacy policies been reviewed and approved by an attorney? Yes No NA
- 4. How often are your policies reviewed and updated? _____
- 5. Do you have restricted employee access to private information? Yes No NA
- 6. Do you have internal training for employees concerning the handling of data security and private, personal and sensitive information? Yes No NA
- 7. In the past twenty-four (24) months, have you undergone an internal or external privacy audit? Yes No NA
 If "Yes", have all recommendations been implemented? Yes No NA
 If "No", please explain: _____
- 8. Do you collect, receive, process, transmit, or maintain private, sensitive, or personal information as part of your business activities? Yes No NA
 - a. Is any of this information regulated by HIPAA, GLB, the Data Protection Act or any other law or regulation protecting private, sensitive, or personal information? Yes No NA
 - b. Do you have written procedures in place to comply with laws governing the handling or disclosure of such information, including any Red Flag Rules? Yes No NA
 - c. Do you share private, sensitive, or personal information gathered from customers with third parties? Yes No NA
- 9. Do you have a vendor approval process? Yes No NA
- 10. Do you require that contracts with outside companies and vendors require they defend and indemnify you in the event there is any loss arising out of the release or disclosure of private, sensitive, or personal information due to the outside company's or vendor's negligence? Yes No NA
- 11. Do you have a written and tested:
 - a. Disaster recovery plan? Yes No NA
 - b. Business continuity plan? Yes No NA
 - c. Computer security policy? Yes No NA
 - d. Procedure to change default credentials? Yes No NA
- 12. Do you store sensitive data on laptops or web servers? Yes No NA
 - a. If "Yes", is all data that is both "at-rest" and "in-transit" encrypted? Yes No
 - b. If "No", please describe any offsetting measures:

- 13. Do you use security and firewall technology? Yes No NA
- 14. Is it your policy to up-grade all security software as new releases/improvements become available? Yes No NA

15. Do you use anti-virus software? Yes No NA
 a. Is anti-virus software installed on all of your computer systems, including laptops, personal computers, and networks? Yes No NA
16. Do you use intrusion detection software to detect unauthorized access to internal networks and computer systems? Yes No NA
17. Do you have a formal documented user and password procedure in place? Yes No NA
18. Do you limit access to network servers and hardware? Yes No NA
19. Do you provide remote access to your network? Yes No NA
 a. Is remote access restricted to Virtual Private Networks (VPNs)? Yes No NA
20. How often is private/personal/sensitive/valuable information archived? _____
 a. How long is the information stored? _____
 b. Is the information stored in an off-premises secondary site? Yes No NA
21. Do you terminate all associated computer access and user accounts when an employee leaves the company? Yes No NA
22. Are your internal networks and computer systems subject to third party audit and monitoring? Yes No NA
 a. If "Yes", when was the last audit? _____
 b. Have all improvements and recommendations been implemented? Yes No NA
 c. If "No", please explain: _____

PART V. TELL US ABOUT YOUR CLAIM HISTORY

1. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against you or against any entity or individual proposed for coverage? Yes No
 If yes, please provide dates of loss, all defense and indemnity payments, and all defense and indemnity reserves (if claims are open): _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. During the past five (5) years, have you or any entity or individual proposed for coverage, submitted any claims or given notice of any act, error or omission, or course of conduct which you 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 of which the requested coverages would be a direct or indirect replacement? Yes No
 If yes, please provide details: _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 AND ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Are you or any entity or individual proposed for coverage, aware of any act, error or omission, or course of conduct which you 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? Yes No
 If yes, please provide details: _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION, OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VI. WHAT ELSE WE NEED

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application:

- 1. Currently valued loss runs (if you are currently insured elsewhere) including losses you may be handling within a self insured retention;
- 2. Your most current audited or accountant-prepared financial statements with notes;
- 3. If you are newly formed, Pro Forma financial statements;

If you want a D&O/EPL quote in addition to the above, please include these:

- 1. The names, occupations, and business affiliations of all your directors and officers.

PART VII. FRAUD WARNING

NOTICE TO RHODE ISLAND 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.

PART VIII. DECLARATIONS AND 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 us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us 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 us 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, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

APPLICANT		
BY <i>(CEO, CFO or President)</i>	TITLE	DATE

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

PRODUCED BY (<i>Insurance Agent</i>)	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS (<i>No., Street, City, State, and ZIP Code</i>)	
EMAIL ADDRESS	

SUBMITTED BY (<i>Insurance Agency</i>)	INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS (<i>No., Street, City, State, and ZIP Code</i>)		