*(Stock company owned by the **OneBeacon Insurance Group**)* One Beacon Lane Canton, MA 02021	

MANAGED CARE ERRORS AND OMISSIONS LIABILITY RENEWAL 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. Have you changed tax status? ☐ Yes ☐ No
   Please explain: ______________________________

5. Are there any **new** State(s) where you operate: ______________________________

6. Are there any **new** operations that should be considered for coverage? ☐ Yes ☐ No
   If so, describe: ______________________________

If you are seeking coverage for any ***new*** 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

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 xx/xx/xxxx
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. Over the past 12 months, 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:____
2. Are any of your operations subcontracted outside of the United States? ☐ Yes ☐ No ☐ NA
   If "Yes," please describe:

B. HEALTHCARE REFORM:

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

If yes, please provide details:

C. CREDENTIALING:

1. Have there been any changes to your written credentialing procedures ? ☐ Yes ☐ No ☐ NA
2. 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? ☐ Yes ☐ No ☐ NA
   If "No," what minimum limits are required? ______
3. Do you perform on-site visits of contracted health care providers? ☐ Yes ☐ No ☐ NA
   If "Yes," how often? ______
4. Do you disclose your reimbursement policies for non-par providers on your website? ☐ Yes ☐ No ☐ NA
   If "No," please explain: ______
5. Do your subscribers have access to non-par provider rates? ☐ Yes ☐ No ☐ NA
   If "No," please explain: ______
6. 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/Clinic and do not provide this service.

1. Have there been any changes to your written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☐ No ☐ NA
2. Do your written Utilization Review Procedures:
   a) Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? ☐ Yes ☐ No ☐ NA
   b) Utilize same specialty reviewers for benefit/coverage denials? ☐ Yes ☐ No ☐ NA
   c) Adhere to government mandated external review requirements in the states where you operate? ☐ Yes ☐ No ☐ NA
   d) 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/Clinic and 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

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. 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 for years you may have been insured elsewhere and including losses you may be handling within a self insured retention;

2. Your most current audited or accountant-prepared financial statements with notes.

If you want a D&O/EPL quote, in addition to 1 & 2 above, please include the names, occupations, and business affiliations of all your directors and officers.

PART VI. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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 APPLICANTS: WARNING: It is a crime to provide false or misleading information 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, NEW MEXICO AND 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.

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 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 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.

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.

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.

APPLICANT		
BY *(CEO, CFO or President)*	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 *(Insurance Agent)*	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS:	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID #.	AGENT LICENSE # or SURPLUS LINES #.
ADDRESS *(No., Street, City, State, and ZIP Code)*		

NOTE: For New Hampshire Applicants, producer's name and signature are required.