

Name and Address	Relationship to Applicant	Description of Operations	Types of Health Plans	Tax Status	Percent Owned

b) Is the **Applicant** currently, or has the **Applicant** ever been insured for managed care professional liability? Yes No

If "Yes," for each such policy provide information on policy period, carrier, limits, retroactive date, deductible, retention and annual premium.

3. List all health plans available through the **Applicant**:

Name of Insurer, Plan, Network or Vendor	Type of Benefit (Health Care, Dental, Vision)	Type of Plan (HMO, POS, PPO, Indemnity, TPA, etc.)	Average Number of Enrollees, Covered Lives, Dependents Per Year

4. a) Does the **Applicant** use a consultant for choosing health care plans or benefits?

If "Yes," provide the consultant's name and address: _____

b) Describe the process for selecting insurer(s), plan(s), network(s) or vendor(s): _____

c) Who on the **Applicant's** staff makes the final selection of insurer(s), plan(s), network(s) or vendor(s)?

d) Are all contracted insurers, plans, networks or vendors required to maintain professional liability or errors and omissions insurance?

If "No," please explain: _____

e) Provide details of the **Applicant's** indemnification arrangements with contracted insurers, plans, networks or vendors or attach copies of sample contracts.

PART II. UTILIZATION REVIEW / COST CONTAINMENT

5. a) Who performs utilization review?
Applicant: Yes No
Subcontractor: Yes No Name: _____
Other: Name: _____
- b) Number of benefits denied/avoided (e.g., denial rate): _____
- c) Number of cases reviewed in last year: _____
- d) Number of full-time equivalent (FTE) reviewers: _____
Number of part-time equivalent (PTE) reviewers: _____
- e) If utilization review is subcontracted:
(i) Does the **Applicant** review or audit the utilization review process? Yes No
(ii) Is the subcontractor required to maintain errors and omissions insurance? Yes No
If "Yes," what minimum limits are required? _____
Is the **Applicant** named as an additional insured? Yes No
- f) Does the **Applicant** have written policies and procedures for utilization review, including for denials and appeals? Yes No
If "Yes," do such policies and procedures follow NCQA or URAC standards and comply with any applicable law? Yes No
- g) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals?
- h) Does a physician review all proposed denials of benefits prior to issuance of the denial? Yes No
- i) Does the **Applicant** have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? Yes No
- j) Does the **Applicant** use practice guidelines as part of its utilization review procedures? Yes No
If "Yes," do guidelines state in writing that the physician's judgment may override a guideline? Yes No
- k) Does the **Applicant** utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? Yes No
- l) Does the **Applicant** utilize specialty reviews for benefit/coverage denials? Yes No

**PART III. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS
(ANSWER ONLY IF APPLICANT CONTRACTS DIRECTLY WITH PROVIDERS)**

6. a) If the **Applicant** contracts directly with providers (e.g., doctors, hospitals, etc.), please provide the number of:
(i) Providers under direct contract to **Applicant**: _____
(ii) Hospitals/Clinics under direct contract to **Applicant**: _____
(iii) Providers available to **Applicant** through Network Vendor: _____
- b) Are all medical services provided under a written contract or agreement between the health care provider and the **Applicant** or **Applicant's** vendor? Yes No

- c) Who does the credentialing of contracted health care providers?
Applicant: Yes No
 Subcontractor: Yes No Name: _____
 Other: Name: _____
- d) If credentialing is subcontracted:
 (i) Does the **Applicant** review or audit the process? Yes No
 (ii) Is the subcontractor required to maintain errors and omissions insurance? Yes No
 If "Yes," what minimum limits are required? _____
 Is the **Applicant** an additional insured on the policy? Yes No
- e) Does the **Applicant** have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials? Yes No
- f) Do the written credentialing procedures follow JCAHO or NCQA standards and comply with any applicable law? Yes No
 (i) Are the procedures given to health care providers? Yes No
 (ii) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final? Yes No
- g) Does the **Applicant** or its vendor query any data source as part of the credentialing process? Yes No
 If "Yes," which one(s)? _____
- h) How often does the **Applicant** re-credential contracted health care providers?

- i) Does the **Applicant** perform on-site visits of contracted health care providers? Yes No
 If "Yes," how often? _____
- j) Does the **Applicant** restrict the practice of any health care provider who has a mental or physical disorder which may impair his/her ability to practice? Yes No
 If "Yes," please explain: _____

- k) Have any providers been removed or disqualified from the **Applicant's** panel in the last twelve (12) months? Yes No
 If "Yes," how many for credentialing or professional conduct reasons? _____
 How many for reasons other than professional competence? _____

PART IV. ADVERTISING/MARKETING/SALES/EMPLOYEE COMMUNICATIONS

7. a) Who prepares plan booklet / communications to enrollees?
Applicant Yes No
 Other Yes No Name: _____
- b) Do all plan booklets, brochures or summary plan descriptions expressly identify covered and non-covered procedures? Yes No
- c) Do any plan booklets, brochures or summary plan descriptions use the term(s) "investigative" or "experimental" procedures?
 If "Yes," do all such materials define what is considered "investigative" or "experimental"? Yes No
 Do all such materials clearly state that the **Applicant** has discretionary authority in the interpretation and administration of the plan's provisions? Yes No

- d) Do plan booklets, brochures or summary plan descriptions expressly refer to all contracted health care providers as independent contractors? Yes No
- e) Do any plan booklets, brochures or summary plan descriptions make statements or warranties as to the quality of health care, breadth of plan, "providing all necessary care" or being the "best" plan, etc.?
- f) Does the **Applicant's** legal counsel review and approve all plan booklets, brochures or summary plan descriptions prior to their use? Yes No
- g) Are enrollee satisfaction surveys conducted?
If "Yes," how often? _____

PART V. MEDICAL SERVICES PROVIDED BY APPLICANT

- 8. a) Does the **Applicant** own, operate, or supervise an on-site clinic or sickroom, a hospital, inpatient or outpatient clinic, pharmacy, dispensary, or other medical facility?
If "Yes," please give particulars: _____
- b) Does the **Applicant** employ physicians, surgeons, dentists, or other health care professionals, in any medical capacity except to perform administrative duties, peer review or utilization review functions? Yes No
If "Yes," please give particulars: _____

PART VI. CLAIMS INFORMATION

- 9. 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 9 IS EXCLUDED FROM THE PROPOSED INSURANCE.

- 10. 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 as would fall within the scope of the proposed insurance to any insurer providing errors & omissions, fiduciary or directors & officers coverage, 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 10 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 10 IS EXCLUDED FROM THE PROPOSED INSURANCE.

11. 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 result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is none, so state:
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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 11 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

12. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:
- a) **Applicant's** last two (2) audited or accountant-prepared financial statements with notes.
 - b) Most recent actuarial report, if applicable.
 - c) Written utilization review procedures, including procedures for denials of benefits and appeals.
 - d) Written credentialing and peer review procedures, if applicable.
 - e) Sample contract(s) with health care providers (physicians, hospitals, and others), if applicable.
 - f) Sample enrollee(s) plan booklets and summary plan descriptions, if applicable.
 - g) Sample copy of a utilization review denial letter (with the identity of the enrollee removed).

PART VIII. SIGNATURES

NOTICE TO APPLICANT — PLEASE READ CAREFULLY.

FOR THE PURPOSES OF THIS 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 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.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND ALONG WITH THE APPLICATION IS CONSIDERED PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME A PART OF IT. THE UNDERWRITER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING ANY POLICY. THE APPLICATION WILL BECOME A PART OF SUCH POLICY IF ISSUED.

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 OUTSTANDING QUOTATION OR AGREEMENT TO BIND INSURANCE.

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

- (I) THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE DURING THE "POLICY PERIOD" AND ARE REPORTED TO THE UNDERWRITER IN WRITING DURING THE "POLICY PERIOD" OR WITHIN NINETY (90) DAYS AFTER THE EXPIRATION OF THE POLICY OR, DURING 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 THE 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, 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 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 (<i>President, Chairman, or CEO</i>):	TITLE:	DATE:

NOTE: This Application must be signed by the President, Chairman, 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 (<i>Insurance Agent or Broker</i>): Please print and sign name _____	
FIRM NAME:	
TAXPAYER ID OR SOCIAL SECURITY NO.:	PRODUCER LICENSE NO.:
ADDRESS (<i>No., Street, City, State, and ZIP</i>):	
EMAIL ADDRESS:	

SUBMITTED BY (<i>Firm</i>):	TAXPAYER ID OR SOCIAL SECURITY NO.:	PRODUCER LICENSE NO.:
ADDRESS (<i>No., Street, City, State, and ZIP</i>):		