



# Application for Health Care Directors & Officers Liability Insurance

**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES.**

- This application must be completed in full, including all required attachments.
- Attach a separate sheet of paper if more space is needed to answer any question.
- "Insured Entity" means the Parent Company proposed for insurance and any subsidiaries.
- We treat all applications as confidential. If additional assurances of confidentiality are required, we are willing to address the applicant's needs.

## **I. GENERAL INFORMATION:**

1. a) Name of Insured Entity: \_\_\_\_\_  
 b) Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 c) Website address: \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_  
 d) Date of Incorporation: \_\_\_\_\_ Date operations began: \_\_\_\_\_  
 e) States where Insured Entity operates: \_\_\_\_\_  
 f) Name of Risk Manager: \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

2. a) Insured Entity is (check all that apply):
- |   |  |  |                         |
|---|--|--|-------------------------|
| <input type="checkbox"/> Hospital       | <input type="checkbox"/> Third Party Administrator | <input type="checkbox"/> HMO                 | If so, please indicate: |
| <input type="checkbox"/> Health System  | <input type="checkbox"/> Peer Review Organization  | <input type="checkbox"/> Staff Model         |                         |
| <input type="checkbox"/> Medical Group  | <input type="checkbox"/> Managed Behavioral Health | <input type="checkbox"/> Network/Panel Model |                         |
| <input type="checkbox"/> Surgery Center | <input type="checkbox"/> MSO                       | <input type="checkbox"/> Combined            |                         |
| <input type="checkbox"/> Nursing Home   | <input type="checkbox"/> PHO                       | <input type="checkbox"/> PPO                 |                         |
| <input type="checkbox"/> URO            | <input type="checkbox"/> CVO                       | <input type="checkbox"/> PBM                 |                         |
| <input type="checkbox"/> IPA            | <input type="checkbox"/> Other (describe): _____   |  |                         |

- b)  Not-For-Profit Tax Exempt                       Limited Liability Company  
 Not-For-Profit Taxable                         Partnership  
 For-Profit     Joint Venture  
 Other (describe): \_\_\_\_\_

c) List all subsidiary companies:

Name	Description of Operations	Date Acquired/ Created	Tax Status	Percent Owned

**II. ADDITIONAL INFORMATION:**

1. Current Coverage:

Type of Coverage	Insurance Carrier	Limits	Retention/ Deductible	Premium	Policy Period
Directors & Officers					
Errors & Omissions					
Medical Malpractice					
Stop Loss/ Provider XS					
Fiduciary					
Crime					

2. What is the retroactive date of the current Directors and Officers Liability policy? \_\_\_\_\_

3. Have any of the Insured Entity's current Insurance carriers indicated an intent to not offer renewal terms?  Yes  No  
If "Yes", please provide details as an attachment.

4. Has any carrier ever cancelled, rescinded, or declined to renew a Directors and Officers Liability policy?  Yes  No  
If "Yes", please explain: \_\_\_\_\_  
\_\_\_\_\_

5. Coverage desired? Limit \_\_\_\_\_ Retention \_\_\_\_\_

6. Is any of the Insured Entity's medical malpractice/HPL exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk sharing arrangement?  Yes  No

7. Is the Insured Entity owned or operated by a state, city, town, authority, or other governmental entity?  Yes  No  
If "Yes", please identify: \_\_\_\_\_

8. Does the Insured Entity contract with any third party to manage, operate, or administer its facilities or operations?  Yes  No  
If "Yes", please identify: \_\_\_\_\_

9. Stock or equity ownership: **(If Not-For-Profit, proceed to #10)**

- a) Total number of voting securities outstanding: \_\_\_\_\_  
b) Total number of voting security holders: \_\_\_\_\_

c) Total number of voting securities owned by the Insured Entity's directors and officers:

d) Does any security holder own five percent (5%) or more of the voting securities directly or beneficially?  Yes  No

If "Yes", list names and percentages of holdings.

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10. Have there been any changes in the Board of Directors or Senior Management within the past three (3) years?  Yes  No

If "Yes", please explain:

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11. a) Total Gross Revenue last 12 months: \_\_\_\_\_ Next 12 months: \_\_\_\_\_

b) Total number of enrollees last 12 months: \_\_\_\_\_ Next 12 months: \_\_\_\_\_

12. Do the Insured Entity's By-Laws limit or eliminate, by indemnification the personal liability of the directors, officers, trustees, employees, volunteers and staff, faculty and committee members to the broadest extent permitted by law?  Yes  No

13. During the last three (3) years, have the outside auditors identified any material weaknesses in the system of internal controls?  Yes  No

14. Has the Insured Entity in the past thirty-six (36) months completed, or agreed to, or within the next twelve (12) months contemplate, any of the following:

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

b) Sale, distribution or divestiture of any any assets or stock?  Yes  No

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

d) Bankruptcy, receivership, liquidation or reorganization?  Yes  No

e) Enter into any new governmental contracts?  Yes  No

f) Undertake any new areas of business?  Yes  No

Please explain \_\_\_\_\_

If the answer to any of the questions above is "Yes",

a) Has it been approved by the Board of Directors?  Yes  No

b) Has it been submitted to the shareholders for approval?  Yes  No

15. Antitrust Market Position:

a) Do you contract with more than 25% of the physicians in any given field of practice within its geographical service area?  Yes  No

If "Yes", please explain: \_\_\_\_\_

b) Do you control more than 25% of the hospital beds or specialty services within your geographic service area?  Yes  No

If "Yes", please explain: \_\_\_\_\_

c) Do you have exclusive contracts with any hospitals or providers?  Yes  No

- d) Have you obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)?  Yes  No
- e) Have you received an opinion from the Federal Trade Commission (FTC) confirming that these activities will not violate antitrust laws?  Yes  No
- f) Do you have any provider agreements that contain "Most Favored" pricing clauses?  Yes  No
- g) Do you have any provider agreements that contain non-compete clauses?  Yes  No

16. Peer Review/Credentialing:

Does the Insured Entity perform any peer review or credentialing?  Yes  No

If "Yes", please complete the following questions.

- a) Who does the credentialing of contracted health providers?  Yes  No
- b) Does the credentialing process include querying the National Practitioner Data Bank?  Yes  No
- c) Are there written policies and procedures in place?  Yes  No
- d) Do the procedures follow NCQA or JCAHO standards?  Yes  No
- e) Does the Insured Entity perform on-site visits?  Yes  No

If "Yes", how often? \_\_\_\_\_

- f) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials become final?  Yes  No

- g) Have any providers been removed or disqualified from the Insured Entity's Panel in the last twelve (12) months?  Yes  No

If "Yes":

(1) How many? \_\_\_\_\_

(2) How many for reasons other than professional competence? \_\_\_\_\_

**III. EMPLOYMENT PRACTICES INFORMATION:**

1. Total number of employees:

Currently: Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

1 year ago: Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

Independent Contractors/

Leased Employees Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

Employed Physicians Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

2. Please provide a breakdown of employees in the states in which you operate:

\_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_ % \_\_\_\_\_ %

3. How many employees or officers have been involuntarily terminated in the past:

12 months? \_\_\_\_\_

24 months? \_\_\_\_\_

4. What percentage of employees has turned over in the past:

12 months? \_\_\_\_\_ %

24 months? \_\_\_\_\_ %

5. What percentage of employees have an annual salary, including bonuses, of:

Less than \$50,000 \_\_\_\_\_ %  
 \$50,000-\$100,000 \_\_\_\_\_ %  
 \$100,000-\$250,000 \_\_\_\_\_ %  
 Greater than \$250,000 \_\_\_\_\_ %

6. What percentage of employees are:

Union \_\_\_\_\_ %  
 Non-union \_\_\_\_\_ %

7. How many employees have a written contract? \_\_\_\_\_

8. Has the Insured Entity undergone within the last 12 months or plan on undergoing during the next 12 months any of the following:

- a) Restructuring that may lead to employee layoffs, early retirements or reassignment of duties?  Yes  No
- b) Sale of any business division, subsidiary or unit?  Yes  No
- c) Closure of any business division, subsidiary or unit?  Yes  No

If "Yes", what is the percentage of total employees effected? \_\_\_\_\_  
 Name of outside labor counsel, if applicable, that is involved? \_\_\_\_\_

9. Does the Insured Entity currently have:

a) Human Resources/Personnel department, or a full-time Human Resource/ Personnel Director?  Yes  No

If "No", who handles this function? \_\_\_\_\_

b) An employee handbook?  Yes  No

If "Yes":

(1) Does the handbook have an "At-will" statement?  Yes  No

(2) Is it distributed to all employees?  Yes  No

(3) When was this last updated? \_\_\_\_\_

c) Written Human Resources Manual or equivalent guideline?  Yes  No

Please provide the last month/year this was last reviewed and updated with outside labor counsel: \_\_\_\_\_

d) Written policy with respect to sexual harassment?  Yes  No

e) Written policy for Family Medical Leave?  Yes  No

f) Policies and procedures to respond to grievances?  Yes  No

g) Standard performance appraisal, review or similar forms for all employees?  Yes  No

h) Outside counsel for legal advice?  Yes  No

10. Are all of the procedures listed above implemented and followed at all locations?  Yes  No

If "No", please provide details \_\_\_\_\_

11. Do you track, monitor and react to pay equity studies and promotional practice studies?  Yes  No

12. Do you review terminations to look at trends which might indicate discrimination?  Yes  No

13. Do you perform self-critical analysis of workforce diversity?  Yes  No

**IV. REGULATORY INFORMATION**

a) Name of Compliance Officer and title: \_\_\_\_\_

b) Does the Insured Entity have a Compliance Plan in effect?  Yes  No  
If "Yes", what date was it effected? \_\_\_\_\_

3. Does new employee orientation include training on compliance?  Yes  No

4. Does the Insured Entity maintain a process, such as a hotline, to receive complaints and allegations of wrongdoing?  Yes  No  
If "Yes", what is the average number of hotline complaints or allegations per month? \_\_\_\_\_  
Are all hotline complaints investigated?  Yes  No

5. Has the Insured Entity invested in billing edit-checking software?  Yes  No

6. Does the Insured Entity utilize an external audit firm to monitor billing and coding compliance?  Yes  No

7. Has the Insured Entity proposed for this insurance been subjected to any type of audit investigating overpayments received for services provided?  Yes  No  
If "Yes", please explain: \_\_\_\_\_

8. Has the Insured Entity proposed for this insurance voluntarily disclosed to any Governmental entity any violations or potential violations of the Civil False Claims Act or the Physician Ownership & Referral Law (Stark Self-Referral Law)?  Yes  No

9. Has the Insured 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 or the Physician Ownership & Referral Law?  Yes  No  
If "Yes", please explain: \_\_\_\_\_

**V. CLAIMS AND WARRANTY INFORMATION**

1. During the past five (5) years, no claims of a type which might fall within the scope of the proposed insurance have been made against the Insured Entity or any individual 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 1 OR CLAIM RELATED THERETO IS EXCLUDED FROM THE PROPOSED INSURANCE.**

2. During the past five (5) years, neither the Insured Entity nor any individual proposed for coverage, has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they 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, 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 REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 OR CLAIM RELATED THERETO 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 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.**

3. Neither the Insured Entity nor any individual proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they 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, 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 3 OR CLAIM RELATED THERETO IS EXCLUDED FROM THE PROPOSED INSURANCE.**

## **VI. ATTACHMENTS**

1. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:
  - a) Most current CPA-audited financial statements with notes and Management letters and Interim financials if the audit is more than six (6) months old;
  - b) List of current Board of Directors;
  - c) Current organizational chart listing each subsidiary, including the current ownership percentage and tax status of each;
  - d) Copies of the Insured Entities current Bylaws and Articles of Incorporation;
  - e) Employee Handbook;
  - f) Summary and status of any litigation filed within the last five (5) years by or against any person(s) or entity(ies) proposed for this insurance (including any litigation that has been resolved);
  - g) Copy of the Insured Entities current primary D&O policy, if applicable;
  - h) Copy of the Insured Entities Compliance Program and/or Code of Conduct;

- i) Any registration statements filed with the SEC or any private placement memorandums within the last twelve (12) months.

## **VII. SIGNATURES AND WARRANTY**

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 diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Underwriter in connection 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 the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract. The Application is on file with the Underwriter, and will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Insured Entity or the Underwriter to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Insured Entity will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

**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, TENNESSEE, 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 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 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.**

**A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.**

Signature of Applicant: \_\_\_\_\_  
(MUST be signed by President, CEO, Owner, or Partner.  
It is agreed the signer has authority to act on behalf of all Insureds.)

Printed Name of Applicant: \_\_\_\_\_ Title \_\_\_\_\_

Date: \_\_\_\_\_