ALLIED WORLD SURPLUS LINES INSURANCE COMPANY
1690 New Britain Avenue, Farmington, CT 06032 ·Tel. (860) 284-1300 · Fax (860) 284-1301

ALLIED WORLD MISCELLANEOUS MEDICAL SUITE
INSURANCE APPLICATION

THIS APPLICATION MUST BE COMPLETED IN FULL. PLEASE READ THE ENTIRE APPLICATION CAREFULLY, BEFORE SIGNING.

Note: If additional space is required for any response, please provide in a separate attachment, labeled with the question number.

NOTICE TO APPLICANT

Please include the following with this Application:

1. Loss History (supply the following):
   a. Claims listing of ten years currently valued, including current year, and detailed loss information (preferably in electronic form). Please see ADDENDUM A for the format.
   b. Carrier Loss Runs to support information in 1.a. above.
   c. Full details of all allegations for Claims on which there were losses paid in excess of $25,000, even if currently open or pending.
2. Most recent accrediting agency (JCAHO, CAP, CARF, etc.) and state licensure report, with recommendations and the institution's response to any contingencies, for each and every licensed and/or accredited facility. Please provide copy of original report from the agency (not the internet summary).

The information and documentation requested above is required before a firm quotation can be provided.

COVERAGE REQUESTED BY APPLICANT

ALL APPLICANTS MUST COMPLETE SECTIONS I., II., V., VI. AND VII. OF THIS APPLICATION. PLEASE COMPLETE ONLY THE ADDITIONAL SECTIONS OF THIS APPLICATION WHICH CORRESPOND TO THE COVERAGES YOU HAVE SELECTED BELOW.

Please indicate below which Coverage Sections the Applicant is applying for:

☐ **Section II.** **MEDICAL FACILITIES Coverage (includes Medical Malpractice, General Liability and Sexual Misconduct)**

☐ **Section III.** **MANAGEMENT LIABILIY Coverage**

☐ **Section IV.** **PRIVACY AND NETWORK RISK Coverage**

SECTION I. GENERAL APPLICANT INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION OF THE APPLICATION.

A. PRODUCER INFORMATION

1. Name of Producer:____
2. Business Address of Producer: ____

   City: __________________ State: _____________ Zip Code: __________
3. Agent Name:____
4. Business Address of Agent: ____

   City: __________________ State: _____________ Zip Code: __________
5. Surplus Lines Tax Filing State: _____________
6. Surplus Lines Licensing Number: _____________
7. Telephone Number of Agent: (______)__________________

B. GENERAL APPLICANT INFORMATION

1. Name of Applicant:____
2. DBA Name (if applicable):____
3. Website Address:____
4. Address of Applicant: ____

   City: __________________ State: _____________ Zip Code: __________
5. Telephone Number: (_____)__________________
6. Date/State of Incorporation or Organization: Date:_________________ State: ____________
7. Years in Operation:______________________________
8. States in which the Applicant operates: ____
9. Number of Locations: __________
10. Organization Type:
    - ☐ Not-For-Profit Tax Exempt
    - ☐ For-Profit Corporation
    - ☐ Joint Venture
    - ☐ General Partnership
    - ☐ Other (please specify):____

If the business type specified is a for-profit entity, please complete the following chart (or provide attachment):

Name of Owner	**Percentage of Ownership**	**Type of Organization**

If the business is for-profit, what percentage of shares is owned by Directors and Officers? __________

11. Name of Risk Manager:_________________________ Telephone Number:___________________
12. Mailing Address:____

City: ___________________ State: ______________ Zip Code: __________

13. Email Address:________________________________

C. FINANCIAL INFORMATION

1. Please provide the following information for the Applicant and all Subsidiaries.

Based on Financial Statements Dated:	____________________ (indicate Month & Year)
Total Assets	$
Total Liabilities	$
Total Annual Revenues/Contributions	$
☐ Net Income or ☐ Net Loss	$
Equity	$

C. ORGANIZATIONAL STRUCTURE

1. Please list all Subsidiaries or other Entities/Organizations for which coverage is desired: (Attach a separate sheet if necessary.)

Name of Entity/Organization	Nature of Business	Date Acquired or Created	Percentage of Ownership	Incorporated State or Country

If the Applicant is seeking coverage for other entities or organizations in addition to those listed above, please provide complete details in an attachment to the Application, indicating the relationship to the proposed Named Insured (either directly or through its subsidiaries).

2. Has the Applicant or any of the entities/organizations proposed for coverage completed any of the following in the past twenty four (24) months, or proposed or contemplated any of the following in next twelve (12) months:

   (a) Merger, Acquisition or Consolidation with another entity? ☐ Yes ☐ No
   (b) Sale, Distribution or Divestiture of assets or stock? ☐ Yes ☐ No
   (c) Registration for a Public Offering or a Private Placement of Securities? ☐ Yes ☐ No
   (d) Bankruptcy, Receivership, Liquidation or Reorganization? ☐ Yes ☐ No
   (e) Entering in any new Governmental Contracts? ☐ Yes ☐ No
   (f) Undertaking any new areas of business? ☐ Yes ☐ No

   (If "Yes" to any of the above, please provide details in an attachment.)

3. Does the Applicant contract with any third party to manage, operate or administer any of its facilities or operations? ☐ Yes ☐ No

4. Licenses/Accreditations:

   (a) Accredited by CAP ☐ Yes ☐ No
   (b) Accredited by JCAHO ☐ Yes ☐ No
   (c) Member of ACHC ☐ Yes ☐ No
   (d) Medicare Approved ☐ Yes ☐ No
   (e) Licensed by the following states: ____
   (f) Other (please specify):____

SECTION II. MEDICAL FACILITIES COVERAGE

ALL APPLICANTS MUST COMPLETE THIS SECTION OF THE APPLICATION.

A. PROFESSIONAL LIABILITY EXPOSURES

Healthcare Professional Services Provided: Check each box that applies and provide projected exposure information for the next 12 months. If you have multiple locations, provide exposure information for each location separately. An Asterisk next to a specific facility type indicates that there is a Supplemental Application that needs to be completed.

Facility Type	Visits	Beds	Facility Type	Receipts	Visits
Residential Care/Group Homes*			**Treatment Centers**		
☐ Adolescent/ Child Residential Care			☐ Student/Community Health Center*		
☐ Adult Group Home			☐ Cancer Treatment – Outpatient Center*		
☐ Developmental Disability /Residential Care			☐ Dialysis*		
Outpatient/Behavioral Care*			☐ Lithotripsy		
☐ Behavioral/ Mental Health/ Counseling Center			☐ Medi Spa*		
☐ Substance Abuse Facility			☐ Sleep Center		
☐ Counseling Center			☐ Crisis Stabilization		
☐ Methadone Clinic			☐ Radiation Therapy		
☐ Weight Loss Center			☐ Urgicenter		
☐ Other Counseling ________________			☐ Other Treatment ____________________		
☐ Weight Loss Center				**Preliminary/Final Reads**	**Visits**
Outpatient/Behavioral Care*			☐ Telemedicine		
☐ Behavioral/Mental Health/ Counseling Center			☐ Teleradioligy		
☐ Substance Abuse Facility				**Receipts**	**FTE's**
☐ Counseling Center			☐ Disease Management		

☐ Methadone Clinic			**Facility Type**	**Receipts**	
☐ Weight Loss Center			**Laboratory***		
☐ Other Counseling ______________			☐ Organ/Tissue Bank*		
Outpatient Rehabilitation*			☐ Pathology Lab		
☐ Cardiac Rehabilitation			☐ Blood/Plasma Banks*		
☐ Trauma Rehabilitation			☐ Dental Lab		
☐ Physical/ Occupational Rehabilitation/Outpatient Center			☐ Medical Lab		
☐ Other Rehabilitation			☐ Ocular Lab		
	Visits	**FTE's**	☐ Optical Establishment		
Home Health/Hospice*			☐ Quality Control/Reference Lab		
☐ Home Health Care			☐ X-ray/Imaging Center		
☐ Hospice Care-Outpatient			☐ Other Lab __________		
☐ Hospice Care-Inpatient		FTE's: Beds:		**Receipts**	**Other**
☐ Respite Care			**Misc. Services:**		
☐ Other Hospice ___________			☐ DME*		
	Visits	**Receipts**	☐ Medical Registry Services/Staffing*		FTE's
Imaging/Radiation			☐ Pharmacy*		
☐ Imaging Center*			☐ Other Services ____________		
	Visits	**Beds**		**Receipts**	**FTE's**
Surgical			**Transport***		
☐ Abortion Clinic			☐ Air Ambulance Service		
☐ Birthing Center			☐ Ground Ambulance Service:		
☐ Optical Surgery Center			☐ Non-Emergency		
☐ Surgicenter			☐ Emergency		
☐ Other Surgical: ____________			☐ Other Transport: ____________		

Visits: Count each patient each time they enter your facility, regardless of the number of departments visited or the number of procedures/treatments performed within each

department. For home care, count each patient each time you visit for health related services.

Beds: Use the total number of occupied beds.

Receipts: Use gross annual receipts.

B. GENERAL LIABILITY EXPOSURES

1. Physical Exposures:

Please complete the following table for each building or facility. Attach a separate sheet, if necessary.

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					

2. Motor Vehicle Exposures (Attach a separate sheet, if necessary):

Type of Vehicle	# Owned/Operated by Applicant
Private Passenger	
Service	
Patient Transport Emergent	
Non Emergent	
Other (please describe)	

C. ADMINISTRATION AND STAFF

1. **Medical Directors, Physicians and Surgeons**

   a. Does the Medical Director of any facility provide direct patient care?

   ☐ YES ☐ NO ☐ N/A

b. List all Medical Directors, Physicians and Surgeons in the chart below:

Names	Specialty	Insurance Carrier/Policy Number/Policy Period	Check One:	Hours per month:	Financial Interest:
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐Employee ☐ Contractor		
			☐ Employee ☐ Contractor		

2. **Health Care Professionals:**

	Employees			**Contractors**		
	Full-Time	**Part-Time**	**Annual Hours**	**Full-Time**	**Part-Time**	**Annual Hours**
Aides						
Chiropractors						
Counselors						
Dentists/Oral Surgeons						
Dieticians/Nutritionists						
EMT's/Paramedics						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Physician Assistants						
Occupational Therapists						
Pharmacists						
Physical Therapists						
Podiatrists						
Psychologists/Mental Health Counselors						
RNs/LPNs/LVNs						

Respiratory Therapists						
Social Workers						
Speech/Hearing Therapists						
Students/Interns						
Technicians (X-ray, Lab, etc)						
Other (Describe):						
Total:						
	Provide Total Number of: Students: ________ Volunteers: ___________					

C. PEER REVIEW AND CREDENTIALING

1. Does the Applicant perform any peer review or credentialing activities? ☐ Yes ☐ No

   If "Yes," please complete the following questions. If "No," skip to Subsection D.

   (a) Who does the credentialing of contracted health providers? ___________________________

   (b) Does the credentialing process include querying the National Practitioner Data Bank? ☐ Yes ☐ No

   (c) Are there written policies and procedures in place for such activities? ☐ Yes ☐ No

   (d) Do the procedures follow NCQA or JCAHO standards? ☐ Yes ☐ No

   (e) Does the Applicant audit and track utilization statistics to identify potential issues relating to medical necessity? ☐ Yes ☐ No

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

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

   If "Yes," please indicate:
   How many (total number)? _______
   How many for reasons of professional incompetence? _________
   How many for reasons other than professional incompetence? _________

D. INSURANCE REQUIREMENTS

1. Indicate if employed or contracted by healthcare professionals are required to carry Professional Liability Insurance:

(If "No," please explain why not.)

a. Physicians or surgeons?

☐ Yes ☐ No Explain: ____

b. Dentists, nurse anesthetists, nurse practitioners, physician's assistants, and nurse midwives?

☐ Yes ☐ No Explain: ____

c. Allied health care professionals?

☐ Yes ☐ No Explain: ____

2. Will any of the above be included as Additional Insureds on this policy?

(If "Yes," attach schedule or list.)

☐ Yes ☐ No Explain: ____

a. Indicate the minimum Professional Liability Insurance Limits required for employed or contracted:

Physicians or surgeons?

$ __________________ Each Occurrence/ $ ___________________ Aggregate

Dentist, nurse anesthetist, nurse practitioners, physician's assistants, and nurse midwives?

$ __________________ Each Occurrence/ $ ___________________ Aggregate

Allied health care professionals?

$ __________________ Each Occurrence/ $ ___________________ Aggregate

3. How often does the Applicant verify Professional Liability Insurance limits?

____

____

E. HIRING, SCREENING AND TRAINING PROCEDURES FOR EMPLOYEES AND CONTRACTORS AND PROVIDER CREDENTIALS

1. Do screening/hiring procedures include the following?

a.	Educational background	☐ Yes	☐ No
b.	Previous employers/employment history	☐ Yes	☐ No
c.	Personal references	☐ Yes	☐ No
d.	Hospital privileges for physicians and dentists	☐ Yes	☐ No
e.	Criminal background check: ☐ County ☐ State ☐ Federal	☐ Yes	☐ No
f.	Medical professional claims history	☐ Yes	☐ No
g.	Drug/alcohol abuse screening	☐ Yes	☐ No

2. Are each of the above procedures followed and documented?

☐ Yes ☐ No If "No," explain: ____

3. How often does the Applicant update its list of specific privileges? ______________

4. Does **any** proposed Insured have a pending license suspension or revocation, or any pending disciplinary action? ☐ Yes ☐ No
   If "Yes," explain: ____

5. Has any facility proposed for coverage been required to notify the National Practitioner Data Bank of any license suspension, peer review action or professional liability payment involving any member of the medical or dental staff? ☐ Yes ☐ No

6. Are written job descriptions established for all employees? ☐ Yes ☐ No

7. Is a competency-based checklist used to assess and document staff skills?
   ☐ Yes ☐ No If "No," explain: ____

F. CONTRACTUAL AGREEMENTS

1. Does Legal Counsel review all contractual agreements for the proposed Insureds?
   ☐ Yes ☐ No

2. Has any proposed Insured agreed to hold harmless and indemnify a third party under contract?
   ☐ Yes ☐ No

   If "Yes," please attach a copy of every such contract.

3. Please describe any services provided by the proposed Insureds to other entities pursuant to contract:
   ____
   ____

   Indicate the Limits of Liability the Insured is required to carry pursuant to any such service contract:
   ____

4. Does the proposed Insured entity or facility lend or lease equipment from others?
   ☐ Yes ☐ No

5. If "Yes," to question e., are there hold harmless and indemnity agreements in place with these lessors? ☐ Yes ☐ No

   Indicate the Limits of Liability the Insured is required to carry pursuant to any such lease agreement:
   ____
   ____

G. RISK MANAGEMENT/QUALITY MANAGEMENT

1. Does the Applicant have a written Risk Management/Quality Management program?

☐ Yes ☐ No

2. If "Yes," does it include Peer Review? ☐ Yes ☐ No

3. If "Yes," does the governing body of the Applicant periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No

4. Who coordinates the Risk Management/Quality Program (i.e., Risk Manager)?

Name: ___________________________

Title: ___________________________

Phone Number: ___________________________

Email Address: ___________________________

5. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

H. CLAIMS HISTORY

* Losses – Please include Loss Runs and attach a detailed explanation to any "Yes" answers, or complete a Supplemental Claim Form.

1. Is any proposed Insured aware of any event, transaction, accident, circumstance or loss that has occurred that might give rise to a claim or suit in the future? ☐ Yes ☐ No

2. Have all such incidents been reported to the Applicant's current insurance carrier?

☐ Yes ☐ No

3. Has any proposed Insured had any professional liability claim or suit brought against them during the last five years? ☐ Yes ☐ No

4. Has any proposed Insured, including any individual, entity or facility, been the subject of a disciplinary investigation or proceeding, or reprimanded by any governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

5. Have any proposed Insured been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No

PLEASE NOTE THAT, WITHOUT PREJUDICE TO ANY OTHER RIGHTS OF THE INSURER, IT IS AGREED THAT ANY CLAIM OR RELATED CLAIM, THAT ARISES OUT OF ANY CLAIM, INCIDENT, CIRCUMSTANCE OR LOSS THAT IS OR REASONABLY SHOULD HAVE BEEN DISCLOSED IS EXCLUDED FROM THE PROPOSED COVERAGE.

SECTION III. MANAGEMENT LIABILITY COVERAGE

ONLY COMPLETE THIS SECTION IF YOU ARE APPLYING FOR MANAGEMENT LIABILITY COVERAGE.

A. DIRECTORS AND OFFICERS LIABILITY INFORMATION

1. Has the Applicant experienced changes to its Board of Directors or to its Key Executives over the past year? ☐ Yes ☐ No

   (If "Yes," please provide complete details in an attachment.)

2. Do the Applicant's By-Laws limit or eliminate by indemnification, the personal liability of the directors, officers, trustees, employees, volunteers, staff and committee members, to the broadest extent permitted by law? ☐ Yes ☐ No
3. Has the Applicant obtained advice from antitrust legal counsel (particularly related to mergers and acquisitions)? ☐ Yes ☐ No
4. Has the Applicant received an opinion from the Federal Trade Commission (FTC) confirming that these activities will not violate antitrust laws? ☐ Yes ☐ No
5. Does the Applicant have any provider agreements that contain "Most Favored" pricing clauses?

   ☐ Yes ☐ No
6. Does the Applicant have exclusive contracts with any hospitals or other healthcare providers? ☐ Yes ☐ No

B. REGULATORY COMPLIANCE

1. Name of Applicant's Chief Compliance Officer:____
2. Does the Insured Entity have a Regulatory Compliance Plan in effect? ☐ Yes ☐ No

   If "Yes", what date was it originally put into effect? ____________________
3. Does training of new employees include training on compliance issues? ☐ Yes ☐ No
4. Does the Applicant maintain a procedure, such as a hotline, to receive complaints and allegations of regulatory non-compliance or wrongdoing? ☐ Yes ☐ No

   If "Yes", what is the average number of complaints or allegations per month? _____________

Are all complaints recorded and investigated? ☐ Yes ☐ No

5. Does the Applicant have medical billing and coding software in place to discover errors?
☐ Yes ☐ No

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

7. Has the Applicant been subjected to any type of audit investigating overpayments received for services provided? ☐ Yes ☐ No
If "Yes," please provide details in an attachment.

C. EMPLOYMENT PRACTICES LIABILITY INFORMATION

(Please provide the following information for the Applicant and all Subsidiaries for which coverage is being requested.)

1. Enter the **TOTAL** (**Inclusive of California**) number of employees in the boxes below.
Note: Seasonal, Temporary and Leased Employees to be included as Part-Time employees
Number of Employees in ALL STATES/JURISDICTIONS:

Full Time:	
Part Time:	

2. Please provide a breakdown of employees located in the states in which the Applicant operates:

State	**Percentage of Employees**

3. For the past 3 years, what has been the annual percentage turnover rate of employees (all locations)?
Year _____, _____% Year _____, _____% Year _____, _____%

4. What percentage of employees currently have an annual salary, including projected bonus amounts, of:

Salary Amount	**Percentage**
Less than $50,000	
$50,000 - $100,000	
$100,000 - $250,000	
Greater than $250,000	

5. Does the Applicant have a full-time Human Resources manager or the equivalent? ☐ Yes ☐ No

6. Does the Applicant have written procedures in place for the following:
Hiring / interviewing? ☐ Yes ☐ No

Employment at-will statement? ☐ Yes ☐ No
Discrimination? ☐ Yes ☐ No
Progressive discipline policies and procedures? ☐ Yes ☐ No
Employment evaluations? ☐ Yes ☐ No
Accommodating the disabled? ☐ Yes ☐ No
Employee grievances or complaints? ☐ Yes ☐ No
Sexual harassment? ☐ Yes ☐ No
Workplace harassment? ☐ Yes ☐ No
Employee terminations? ☐ Yes ☐ No
Orientation of all new employees? ☐ Yes ☐ No

7. Does the Applicant distribute the above-listed procedures to all employees at all locations?
☐ Yes ☐ No

8. Is the Applicant or any of its Subsidiaries currently undergoing or does the Applicant or any of its Subsidiaries contemplate undergoing during the next twelve (12) months, any employee layoff or early retirements programs (including ones resulting from any type of company restructuring, or office, plant or store closing)?
(If "Yes", please provide details in an attachment.) ☐ Yes ☐ No

D. FIDUCIARY LIABILITY INFORMATION

1. Please provide the following information for each Plan to be covered:

Plan Name and Plan Number	Type of Plan *	Number of Participants	Percent of Participants that are currently employees	Plan Assets	Plan Status**

* Welfare (W), Defined Benefit (DB), Defined Contribution (DC), ESOP (ESOP), Other (O)

** Active (A), Merged (M), Sold (S), Terminated (T), Frozen (F)

2. Are any of the Plans assets invested in the Applicant's own securities? ☐ Yes ☐ No
If "Yes", are the investments 'Company Directed' or invested at the discretion of the employee?
☐ Yes ☐ No

3. Have any Plan benefits been modified within the last two years? ☐ Yes ☐ No

4. Are any Plans managed by an independent third-party administrator? ☐ Yes ☐ No
If "Yes," how often is the third-party administrator's performance reviewed? :____________

5. Does the Applicant plan on terminating, suspending, merging or dissolving any Plans within the next twelve (12) months? ☐ Yes ☐ No
(If "Yes," please provide complete details in an attachment.)

E. CLAIMS HISTORY

1. Does any person or entity for whom coverage is sought under the proposed insurance have any knowledge of any fact, circumstance, situation, or information of any error, misstatement, misleading statement, act, omission, neglect, breach of duty or other matter that may give rise to a Claim which may fall within the scope of coverage under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

2. Has any Claim been made or legal proceeding been brought against any person or entity for whom coverage is sought under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

3. Does any person or entity for whom coverage is sought under the proposed insurance have knowledge of any inquiry, investigation or communication that he/she/it has reason to believe might give rise to a Claim that might fall within the scope of the coverage under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

4. Has the Applicant or any of its Subsidiaries, or any director or officer thereof:
   a. Been named as a party in, or otherwise involved in any antitrust, copyright or patent litigation? ☐ Yes ☐ No
   b. Been charged in any civil or criminal action or administrative proceeding, with a violation of any federal or state antitrust or unfair trade practices law? ☐ Yes ☐ No
   c. Been charged in any civil or criminal action or administrative proceeding, with a violation of any federal or state securities law or regulation? ☐ Yes ☐ No
   d. Been named as a party in, or otherwise involved in any representative actions, class actions, or derivative suits? ☐ Yes ☐ No
   e. Been charged in any civil or criminal action or administrative proceeding with

a violation of any federal or state anti-harassment or anti-discrimination law? ☐ Yes ☐ No

If "Yes," please provide complete details in an attachment.

IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS WITH REGARD TO ANY QUESTIONS IN THIS SECTION XVI., REGARDLESS OF WHETHER IT IS DISCLOSED IN THIS APPLICATION, ANY CLAIM BASED ON, ARISING FROM, OR IN ANY WAY RELATING TO SUCH MATTER OF WHICH THERE IS KNOWLEDGE OR INFORMATION SHALL BE EXCLUDED FROM COVERAGE UNDER THE INSURANCE BEING APPLIED FOR, AND THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS OR DEFENSE EXPENSES OR OTHER COSTS RESULTING THEREFROM, AND TO THE EXTENT THIS POLICY PROVIDES DUTY TO DEFEND COVERAGE, THE INSURER SHALL HAVE NO DUTY TO DEFEND ANY CLAIM, SUIT OR OTHER LEGAL PROCEEDING ARISING OUT OF SUCH MATTER.

IV. PRIVACY & NETWORK SECURITY LIABILITY COVERAGE

ONLY COMPLETE THIS SECTION IF YOU ARE APPLYING FOR PRIVACY AND NETWORK SECURITY COVERAGE.

1. Please provide an estimate of the total number of records maintained by your organization.

   ____

   Definition of "record": For purposes of providing an estimate, consider the number of patients for which you maintain information, the number of employees you have (or had, if you continue to maintain a terminated employee's information), the number of individuals you may have on marketing lists, or generally, the presence and number of any other non-public information relating to an individual.

   Note: DO NOT count different pieces of information (or different locations for that information) on the same individual more than once. Six different instances of information on a single person only counts as ONE record.

2. If you are required to comply with the Payment Card Industry Data Security Standard (PCI-DSS) because you accept payments by credit card, what tier/level do you fall into? For more information on PCI-DSS tiers, refer to:
   https://www.pcisecuritystandards.org/merchants/how_to_be_compliant.php

   Check one of the following – check N/A only if you do not accept credit cards as a form of payment for your services:

   ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ N/A

3. Laptops: Have you implemented whole disk encryption on all laptop computers? ☐ Yes ☐ No

4. Wireless Networks: If you have a wireless network, what is the current security protocol? If you do not have a wireless network, select N/A? ☐ WPA ☐ WPA2 ☐ N/A

5. Does the Applicant always use encryption to protect information stored on backup tapes? If an alternative method of storage, other than backup tapes of is used, select N/A and describe the method? ☐ Yes ☐ No ☐ N/A

   Description of alternative method of storage: ______________________________

6. Do the responses to the Section IV., Questions 1 thru 5, apply to all operations of the name insured and all subsidiary operations? ☐ Yes ☐ No

V. INSURANCE INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION OF THE APPLICATION.

Please provide the following details regarding the Applicant's current Insurance programs:

Coverage	Carrier	Limit of Liability	Retention	Premium	Policy Period	Retroactive Date
Medical Malpractice						
General Liability						
Sexual Misconduct						
Directors and Officers						
Employment Practices						
Fiduciary						
Privacy and Network Security						

If Applicant does not currently have such coverage in place, please indicate “N/A.”

MISSOURI APPLICANTS, DO NOT ANSWER QUESTION 1.

1. Have any of the Applicant’s prior carriers cancelled coverage or indicated an intent to not offer renewal terms?
   (If “Yes,” please provide complete details in an attachment.) ☐ Yes ☐ No

VI. REPRESENTATIONS OF AND NOTICES TO THE APPLICANT

ALL APPLICANTS MUST COMPLETE THIS SECTION OF THE APPLICATION.

The undersigned authorized representative of the Applicant declares that the statements set forth herein are true, and reasonable effort has been made to obtain sufficient information from all persons proposed for this insurance to facilitate the accurate completion of the Application.

The undersigned authorized representative agrees that if the information supplied on this Application changes between the date of this Application and the effective date of the insurance, he/she will, in order for the information to be accurate on the effective date of the insurance, immediately notify the Insurer of such changes, and the Insurer may withdraw or modify any outstanding quotations or agreement to bind insurance.

The submission of this Application by the Applicant to the Insurer or signing of this Application by or on behalf of the Applicant does not obligate the Insurer to issue the insurance requested. It is agreed that this Application shall be the basis of the contract if a policy is issued and shall be deemed to be attached to, incorporated into and become a part of, the policy.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF. NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE.

NOTICE TO ALABAMA 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 RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

NOTICE TO ARKANSAS 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 FINES AND CONFINEMENT IN PRISON."

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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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 INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

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 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."

NOTICE TO LOUISIANA 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 FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE 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 KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

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 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 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, 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 OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: 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 (365:15-1-10, 36 §3613.1)."

NOTICE TO OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE 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."

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 OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO TENNESSEE 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO TEXAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

NOTICE TO VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

NOTICE TO 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

NOTICE TO WEST VIRGINIA: "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 FINES AND CONFINEMENT IN PRISON."

NOTICE TO ALL OTHER 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."

VII. DECLARATION AND SIGNATURE

ALL APPLICANTS MUST COMPLETE THIS SECTION OF THE APPLICATION.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE HEREBY ACKNOWEDGES THAT HE OR SHE IS MAKING THE REPRESENTATIONS IN THIS APPLICATION ON BEHALF OF THE APPLICANT AND ALL ENTITIES OR PERSONS PROPOSED FOR COVERAGE UNDER THE POLICY.

Signed: ________________________________

Print Name: ________________________________

Title: ________________________________
***See Note Below**

Date: ________________________________

***This form must be completed, dated and signed by the President, CEO, CFO, Senior Administrator, Executive Director or Senior Risk Manager of the Applicant**