# 365Complete Application –
## Health Care Service Organizations

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

- **This Application must be completed in full, including all required attachments.**
- **If additional space is required for a response, include such response in an attachment to this Application, clearly identifying the Application question for which the response is being provided.**
- **We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.**
- **Whenever used in this Application, the terms "Applicant," "You," or "Your Company" shall mean the organization proposed as the Named Insured and any Subsidiaries thereof, and their respective directors, officers, trustees, governors and employees.**

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**1. GENERAL INFORMATION**

(a) Applicant's Name (proposed Named Insured):

_____

(b) Principal Address:

Street: _____ City: _____ State: _____

Zip Code: _____

(c) Date of Incorporation (proposed Named Insured): _____

(d) State(s) in which the Applicant operates: _____

(e) Total Number of Employees of Applicant: _____

(f) Website Addresses: _____

(g) Contact Person for Applicant (Named and Title): _____
Email Address: _____
(Contact Person will receive all risk management and other required notifications.)

(h) Total Gross Revenues of Applicant (Please provide on a Fiscal Year basis):

| Prior Year | Current Year | Next Year (estimated) |
|---|---|---|
| | | |

(i) Is the Applicant or any of its Subsidiaries, or other entities proposed for coverage, publicly-traded?
☐ Yes ☐ No

(j) Type of Organization (Choose all that accurately describe the Applicant):
☐ Health Plan ☐ Medical Group or Clinic ☐ PHO ☐ IPA ☐ MSO
☐ TPA ☐ Peer Review Organization ☐ Utilization Review Organization
☐ Other (describe):_____

(k) Insured Entities:

If coverage is desired for entities other than Subsidiaries of the Applicant (Subsidiaries being entities in which the proposed Named Insured has more than a 50% ownership of the outstanding securities), please list each such entity below. If required, list such entities on a separate attachment. Please note that coverage for such entities is not automatically available; the terms and conditions of the Policy, if issued, will determined actual coverage.

| Name of Entity | Relationship to Applicant | Description of Operations | Tax Status (For-Profit, Not-for-Profit, etc.) | Percent of Ownership by Applicant |
|---|---|---|---|---|
| | | | | |
| | | | | |

**2. PROFESSIONAL SERVICES LIABILITY**

(a) Please indicate the services performed by Applicant, or outsourced/subcontracted by Applicant to a third party, by checking all that apply.

| | Performed by Applicant | Outsourced by Applicant to a Third Party |
|---|---|---|
| Credentialing or peer review of health care providers | ☐ | ☐ |
| Utilization review | ☐ | ☐ |
| Handling, adjusting or paying claims | ☐ | ☐ |
| Case management | ☐ | ☐ |
| Disease Management | ☐ | ☐ |
| Enrollment processing | ☐ | ☐ |
| Third Party Administration | ☐ | ☐ |
| Actuarial services | ☐ | ☐ |
| Billing/submitting/coding/reimbursement of claims | ☐ | ☐ |
| Advertising, marketing, selling health care plans/products/services | ☐ | ☐ |
| Secure stop-loss placements | ☐ | ☐ |
| Services for automobile or disability plans | ☐ | ☐ |
| Nurse call line | ☐ | ☐ |
| Employee Assistance Programs | ☐ | ☐ |

(b) Please list any other services performed by or on behalf of the Applicant for others, that are not listed above:

| Service Provided or Activities Performed | % of Applicant's Total Annual Revenue | Are services or activities outsourced or subcontracted? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

(c) If any of the above services or activities described in Questions 2(a) or 2(b) are outsourced or subcontracted to a third party by the Applicant, does the Applicant:

(i) audit the third party on a regular basis? ☐ Yes ☐ No

(ii) require the third party to maintain and show proof of Errors and Omissions Liability Insurance at least annually? ☐ Yes ☐ No

(iii) require the third party to indemnify the Applicant by contract? ☐ Yes ☐ No

(d) Are any of the Applicant's services provided to or for Medicare/Medicaid plans or enrollees? ☐ Yes ☐ No

If "Yes," what percentage of the Applicant's Total Annual Revenue is derived from such services? _____%

**3. DIRECTORS AND OFFICERS LIABILITY**

(a) Does any individual with an ownership interest in the Applicant, excluding directors or officers of the Applicant, directly or beneficially own ten percent (10%) or more of the ownership units? ☐ Yes ☐ No

(b) Is the Applicant currently, or has the Applicant at any time during the past 12 months been, involved in any of the following:

(i) A merger, acquisition or divestiture;

(ii) A bankruptcy, reorganization, liquidation or similar action;

(iii) A private placement or registering any securities under the Securities Act of 1933;

(iv) a breach of any debt covenant or loan agreement? ☐ Yes ☐ No

If "Yes" to question 3(a) or 3(b), please describe in detail on separate attachment.

**4. EMPLOYMENT PRACTICES LIABILITY**

(a) Does the Applicant have written procedures for handling employee complaints of discrimination, harassment, or other improper conduct? ☐ Yes ☐ No

(b) Has the Applicant had a downsizing or layoff in the past 18 months or anticipate such event in the next 12 months? ☐ Yes ☐ No

(c) What percent of Applicant's employees are employed in the State of California? _____ %

(d) How many physicians does the Applicant employ? _____

**5. FIDUCIARY LIABILITY**

Please complete the following chart for all Employee Benefit Plans or other Plans for which the Applicant is requesting Fiduciary Liability Coverage. List additional Plans on a separate attachment.

| **Full Plan Name** | **Plan Type** * | **Sponsorship** ** | **Total Assets of Plan ($)** | **Current Number of Plan Participants** | **Plan Status** *** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

* **Plan Types**: Defined Benefit (DB); Defined Contributions (DC); ESOP (E); Self-Funded Welfare Benefit Plan (W); Health & Welfare Plan (HW); Cash Balance (CB); Other (O)

** **Sponsorship:** Multiple Employer (ME); Government (G); Church (C), Other (O)

*** **Plan Status**: Active (A); Frozen (F); Sold (S); Terminated (T) If any Plan has been terminated, indicate date of termination.

(a) Is the Applicant delinquent in making any contributions under any Plan? □ Yes □ No
If "Yes," please explain:

_____

_____

(b) Is the Applicant planning any action which, over the next 12 months, would result in a reduction of benefits for any Plan participants, or in any Plan being terminated, frozen, sold or merged into another Plan? □ Yes □ No

If "Yes," please provide details, including the approximate value of assets affected and the proposed date of action.

_____

_____

(c) Are all Plans in compliance with Employee Retirement Income Security Act ("ERISA"), or similar foreign laws if applicable? □ Yes □ No

**6. PRIVACY & NETWORK SECURITY LIABILITY**-

(a) Please quantify (number of individual records) the Personally Identifiable Information ("PII") the Applicant currently stores in its Network?
(If unable to provide an exact number, please provide a best estimate, and describe the methodology for arriving at this estimate.)

_____#

Methodology:

_____

_____

*Personally Identifiable Information is information from which an individual may be uniquely and reliably identified, including, but not limited to an individual's name, address, telephone number, in combination with their social security number, account relationships, account numbers, passwords, PIN numbers, credit or debit card numbers, biometric information, Nonpublic Personal Information as defined by the Gramm-Leach Bliley Act of 1999, or Protected Health Information ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").*

(b) Do You transmit, receive, store, handle or have access to any of the following information:

□ Credit Card numbers (If checked, please answer question (c) below.)
□ Medical Records □ Social Security Numbers □ Drivers License Numbers
□ Other :(describe) _____

(c) If Credit Card information is transmitted, received, stored, handled or access by You, indicate Your Payment Card Industry (PCI) Compliance Level.
□ Level 1 □ Level 2 □ Level 3 □ Level 4 □ Level 5

(d) Please indicate where PII may be stored by You?
□ Desktop drive □ Laptop □ Offsite facility
□ PDA □ Network drive □ Software Application
□ Other (describe): _____

(e) Is Your PII encrypted during transmission, receipt or storage? □ Yes □ No

(f) Please indicate which encryption method is used by You (check all that apply):
□ File based encryption □ Secure email
□ Encrypted VPN Tunnel □ Secure Wide Area Network
□ Other (describe): _____

(g) Is anyone permitted to connect to the Applicant's Network through a wireless network?
□ Yes □ No

(h) Complete the following table with respect to encryption of technology assets within the Applicant's Network:

| Technology Assets | Encrypted? |
|---|---|
| Laptops | Yes ☐ No ☐ |
| Mobile Devices | Yes ☐ No ☐ |
| Backups | Yes ☐ No ☐ |
| Wireless Network | Yes ☐ No ☐ |
| Other: _____ | Yes ☐ No ☐ |

(i) Are any persons or entities permitted to connect to Your network from an off-site location?
□ Yes □ No

If "Yes," please complete the chart below.

| **Name of Person or Entity** | **Services provided to You** | **Type of remote connection that is permitted** |
|---|---|---|
| | | |
| | | |

(j) Does Applicant have any data leakage controls and/or information security software packages in place? Please check all that apply.
□ Firewall □ Intrusion Detection System or Intrusion Prevention System
□ Network Admission Control □ Secure Tokens □ Biometrics Devices
□ Other (describe): _____

(k) Does Applicant have an Incident Response Plan in place for dealing with a data breach?
□ Yes □ No

**7. MEDIA LIABILITY**

(a) Do any promotional or advertising materials, publications, or other matter created or disseminated by the Applicant contain any of the following types of content or information?

| | | | | | |
|---|---|---|---|---|---|
| Medical Diagnostics | ☐ | Physician content | ☐ | Controversial | ☐ |
| Social Commentary | ☐ | Religious content | ☐ | None of the Above | ☐ |

If none of the above, please describe the types of materials or matter created or disseminated by the Applicant and their content:
_____
_____

(b) Does the Applicant have a formal and active review process to screen matter and content, including any content provided by a third party, for the following, prior to any dissemination, publication, broadcast or distribution:

(i) Privacy Violations;
(ii) Defamation, Libel, Slander;
(iii) Trademark Infringement; or
(iv) Copyright Infringement? ☐ Yes ☐ No

**8. CLAIMS/POTENTIAL CLAIMS INFORMATION**

**During the last five years has any party proposed for coverage had any claims, suits, or regulatory proceedings brought against them, or been given notice of any fact or circumstance, or is currently aware of any fact or circumstance, that could give rise to a claim, suit or regulatory proceeding, for which coverage may be provided under the proposed policy? ☐ Yes ☐ No**

**If "Yes," please explain in detail in a separate attachment, including the claimant's name, allegations made, status of claim, suit or proceeding, incurred defense amounts and total amounts paid in judgment or settlement.**

**WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE INSURER, IT IS AGREED THAT ANY MATTER REQUIRED TO BE DISCLOSED IN RESPONSE TO THE ABOVE QUESTIONS, AND ANY CLAIM ARISING FROM OR RELATED TO SUCH MATTER, IS EXCLUDED FROM ALL PROPOSED INSURANCE.**

**9. ADDITIONAL APPLICATION MATERIALS**

At the discretion of the Insurer, and as is relevant to the requested coverage(s), the following materials may be required of the Applicant.

- Any specific Claim or Potential Claim information;
- Summary and status of any suit or regulator proceeding filed within the last five (5) years by or against any person(s) or entity(ies) proposed for coverage under this insurance, including any suit that has been resolved;
- Applicant's last 2 audited or accountant-prepared financial statement with notes;
- Any registration statements filed with the SEC or any private placement memorandums within the last twelve (12) months; and
- The latest edition of the Applicant's Privacy Policy.

**10. NOTICES TO APPLICANT**

**The Undersigned warrants that to the best of his or her knowledge and belief, the statements set forth herein are true. The Insurer will have relied upon this Application in issuing any policy. The Insurer is hereby authorized to make any investigations and inquiry in connection with the information, statements and disclosures provided in this Application.**

**The signing of the Application does not bind the Undersigned to purchase the insurance, nor does review of this Application bind the Insurer to issue a policy. It is agreed that this Application shall be the basis of the contract should a policy be issued. This Application shall be attached and will become 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.**

**The Undersigned declares that the person(s) and entity (ies) proposed for this insurance understand that:**

- **The Policy shall apply only to Claims made during the Policy Period or Extended Reporting Period (if applicable);**

- **The limit of liability contained in the Policy shall be reduced, and may be completely exhausted by, the payment of Defense Expenses, and, in such event, the Insurer shall not be liable for Defense Expenses or for the amount of any judgment or settlement to the extent that such cost exceeds the limit of liability in the Policy; and**
- **Defense Expenses that are incurred shall be applied against the retention amount.**

**11. MATERIAL CHANGE**

**The Undersigned further declares that if any occurrence or event that takes place prior to the effective date of the insurance for which application is being made which may render inaccurate, untrue, or incomplete any statement made, such occurrence or event will immediately be reported in writing to the Insurer. The Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.**

**12. FRAUD WARNINGS**

**NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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 ACT, WHICH IS A CRIME ANY MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**NOTICE TO ARKANSAS AND WEST VIRGINIA 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMING 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 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 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 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.**

**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 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.**

**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 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.**

NAME OF AUTHORIZED REPRESENTATIVE: _____

TITLE: _____

SIGNATURE: _____ DATE: _____