NAS Insurance Services, inc.

Application For: Managed Care Errors and Omissions, Directors and Officers, including Corporate Entity Coverage, and Employment Practices Liability Coverage (Claims Made)

Notice: The Policy for which this application is made, subject to its terms, applies only to any Claim (as applicable in the Coverage Section for which application is made) made against any of the Insureds during the Policy Period. The Limit of Liability available to pay damages or settlements shall be reduced and may be exhausted by amounts incurred as Costs, Charges and Expenses (as defined in the Coverage Section for which application is made), and Costs, Charges and Expenses shall be applied to the retentions. Submission of this application does not guarantee coverage.

General Instructions for completing this Application

1. **Please type or print in ink.**
2. **Please read carefully and answer all questions. If a question is not applicable, so state by writing "Not Applicable".**
3. **The Application must be signed by an executive officer.**
4. **This Application and all exhibits shall be used for purposes of this coverage only.**
5. **Please read the Policy for which application is made (the "Policy") prior to completing this Application.**
6. **The terms as used herein shall have the meanings as defined in the Policy.**

SECTION I. GENERAL INFORMATION

1. Name of proposed Named Insured ("Applicant"): _____

   Address: _____
   (Street)

   _____
   (City) (State) (Zip Code)

2. Does Applicant have subsidiaries? ☐ Yes ☐ No

   If "Yes", please list on a separate page.

3. Structure: ☐ Sole Proprietor ☐ Corporation ☐ LLC ☐ Partnership ☐ Not for Profit

4. Type of Organization: ☐ PHO ☐ IPA ☐ Medical Group ☐ MSO ☐ HMO ☐ TPA ☐ Other

   If "TPA" or "Other", then please provide a description of services offered on a separate page.

5. Date Applicant began operations: _____

6. Is the Applicant publicly-held or a public reporting company under the Securities Exchange Act of 1934? **If "Yes", coverage is not available.** ☐ Yes ☐ No

For questions 7 through 12, if the answer is "Yes" then please provide details on a separate page.

7. Within the last 18 months, has the Applicant transacted or attempted a private debt or equity offering of securities? ☐ Yes ☐ No

8. Within the next 18 months does the Applicant anticipate any:

a) private debt equity offering of securities? ☐ Yes ☐ No
b) public offering of securities? ☐ Yes ☐ No

9. Has the Applicant in the past 18 months been involved with any actual, negotiated or attempted merger, acquisition or divestment? ☐ Yes ☐ No

10. Does the Applicant contemplate transacting any mergers or acquisitions in the next 12 months? ☐ Yes ☐ No

11. Is the Applicant owned, managed or controlled by any other entity? ☐ Yes ☐ No

12. Is the Applicant involved in any joint ventures? ☐ Yes ☐ No

SECTION II. FINANCIAL INFORMATION

13. Describe the following financial information of the Applicant for the most recent fiscal year-end.

a) Total Assets: $ _____

b) Net Income: _____ or Net Loss: _____ $ _____
(check one)

c) Equity: $ _____

d) Fiscal year ending: 200 ____

14. Has any auditor in the last two fiscal years rendered a "going concern" opinion for the financial statements of the Applicant? **If "Yes", coverage is not available.** ☐ Yes ☐ No

Please attach the latest years' full financial statements, and a current profit/loss statement including a balance sheet if the audit is not available.

SECTION III. MANAGED CARE PROFESSIONAL ERRORS AND OMISSIONS INFORMATION

15. Is the Applicant seeking Managed Care Errors and Omissions coverage? ☐ Yes ☐ No

If "No", skip to Section IV.

16. Does the Applicant assume capitated or a percentage of premium risk on behalf of itself or any of its contracted providers? ☐ Yes ☐ No

If "No," is the assumption of such risk contemplated within the next 12 months? ☐ Yes ☐ No

17. List all Payer organizations with which the Applicant contracts and check the appropriate box which best describes the type of Payer organization. **(Please use an additional page if required).**

Name of Payer	HMO	Indemnity Insurer	Self Funded Employer	TPA	Other (Explain)
A) _____	☐	☐	☐	☐	☐ _____
B) _____	☐	☐	☐	☐	☐ _____
C) _____	☐	☐	☐	☐	☐ _____
D) _____	☐	☐	☐	☐	☐ _____

18. Number of Providers:	Employed/Owned		Under Contract	
	Last 12 Months	Next 12 Months	Last 12 Months	Next 12 Months
a) Physicians (not including Psychiatrists)	_____	_____	_____	_____
b) Psychiatrists/Psychologists	_____	_____	_____	_____
c) Other Practitioners	_____	_____	_____	_____
d) Hospitals	_____	_____	_____	_____
e) Other Institutions (e.g. clinics or outpatient facilities)	_____	_____	_____	_____

19. If an MSO, provide number of clients: _____

20. Are all medical services provided under written contracts between the Applicant and health care providers? ☐ Yes ☐ No

If the answer is "Yes", please attach a sample copy of such contracts.

21. Does Applicant require its providers to maintain Medical Malpractice Insurance? ☐ Yes ☐ No

a) Minimum limits of liability $ _____ Deductible: _____

b) Describe procedure to ensure that such coverage is maintained/renewed : _____

_____

For questions 22 through 24, if the answer is "Yes", then please provide details on a separate page.

22. Does the Applicant employ physicians, psychologists, dentists, or any other health care professional in any medical capacity, other than in peer review, utilization or administrative duties? ☐ Yes ☐ No

23. Excluding General and Internal medicine, is there any medical specialty in which more than 20% of your contracted providers specialize? ☐ Yes ☐ No

24. In any of the Applicant's marketing regions:

a) Do Applicant's exclusive participating providers constitute greater than 20% of the market for such providers? ☐ Yes ☐ No

b) Do Applicant's non-exclusive participating providers constitute greater than 30% of the market for such providers? ☐ Yes ☐ No

CREDENTIALING

25. Does the Applicant perform credentialing of health care providers? ☐ Yes ☐ No

If "No", skip to question 32.

26. a) Is the Applicant delegated to perform credentialing activities on behalf of any health plans that Applicant contracts with? ☐ Yes ☐ No

b) Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No

If "Yes", then please provide details of circumstances and corrected plan of action on a separate page.

27. a) Is credentialing performed in accordance with NCQA standards? ☐ Yes ☐ No
b) Are written protocols maintained for credentialing and recredentialing? ☐ Yes ☐ No

If "No", then please provide details of credentialing process on a separate page.

28. Does the Applicant sub-delegate credentialing to any third party, (i.e. primary source verification)? ☐ Yes ☐ No

If answer is "Yes", then please identify such third parties and describe oversight process to audit the third party.

29. Are insufficient patient encounters, excessive utilization or any other economic factors grounds to disqualify or remove a provider from the Applicant's panel? ☐ Yes ☐ No

a) Have any providers been terminated from the Applicant's provider panel in the past 12 months? ☐ Yes ☐ No

If answer is "Yes", then please indicate how many were terminated and for what reasons on a separate page.

b) Were the terminated providers notified of their due process rights, as applicable? ☐ Yes ☐ No

30. Have any applicant providers been denied membership to the panel in the last 12 months? ☐ Yes ☐ No

If "Yes", then please indicate how many were denied, and for what reasons on a separate page.

31. How are complaints against providers handled?_____

_____

UTILIZATION MANAGEMENT

32. Is the Applicant delegated to perform utilization management activities on behalf of any health plans that you contract with? ☐ Yes ☐ No

If "No", skip to question 41.

33. Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No

If "Yes", then please provide details on a separate page.

34. Does the Applicant utilize guidelines such as Milliman and Robertson and/or InterQual for its utilization decisions? ☐ Yes ☐ No

35. What activities is the Applicant delegated to perform:

Prospective utilization review	☐ Yes	☐ No
Concurrent utilization review	☐ Yes	☐ No
Retrospective utilization review	☐ Yes	☐ No
Case management	☐ Yes	☐ No
Referrals to specialists	☐ Yes	☐ No

36. Does the Applicant follow a written prescribed process for appeals to the Payer(s)? ☐ Yes ☐ No

37. Does the Applicant sub-delegate utilization management to any third party? ☐ Yes ☐ No

If the answer is "Yes", then please identify such third parties and describe oversight process to audit the third party on a separate page.

38. Does the Applicant provide utilization management services to any third party for a fee? ☐ Yes ☐ No

If the answer is "Yes", then please indicate the percentage of total revenues for this year and anticipated for next year:

This year: _____ Next year: _____

39. In any of the Applicant's contracts, does the Applicant have the responsibility to make the final determination as to whether or not a procedure is covered? ☐ Yes ☐ No

40. What are the credentials of the personnel who draft and/or issue denial(s) of benefits:

_____

_____

CLAIMS ADJUDICATION

41. Is the Applicant delegated to perform claims adjudication activities on behalf of any health plans that you contract with? ☐ Yes ☐ No

If "No", skip to question 45.

42. Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No

If "Yes", then please provide details on a separate page.

43. If Applicant is delegated to perform claims adjudication activities, what activities is the Applicant delegated to perform:

Review of claims	☐ Yes	☐ No
Processing of reimbursement	☐ Yes	☐ No
Issuance of denial of claims	☐ Yes	☐ No
Claims appeals	☐ Yes	☐ No

If "Yes" to Claims appeals, please submit a copy of the delegation agreement.

44. Does the Applicant have an information system(s) to manage the claims processing? ☐ Yes ☐ No

OTHER SERVICES

45. If Applicant provides any of the following services to third parties for a fee, please indicate all that apply:

Actuarial consulting	☐ Yes	☐ No	Staffing	☐ Yes	☐ No
Collections of accounts receivable	☐ Yes	☐ No	Insurance placement	☐ Yes	☐ No
Billings	☐ Yes	☐ No	Enrollment processing	☐ Yes	☐ No
Accounting	☐ Yes	☐ No	Design of employee benefit plans	☐ Yes	☐ No
Other: _____					

MARKETING/SALES

46. Is any sales or promotional material bearing the name or identify of the Applicant distributed to:
    a) Enrollees/beneficiaries? ☐ Yes ☐ No
    b) Providers? ☐ Yes ☐ No
    c) Payers? ☐ Yes ☐ No

47. Does such material always refer to contracted providers as Independent Contractors? ☐ Yes ☐ No

48. Are any warranties or representations as to quality of health care made in any sales or promotional materials? ☐ Yes ☐ No

    If "Yes", then please submit copies of materials with statements.

49. Does the Applicant have such material reviewed by legal counsel prior to publication? ☐ Yes ☐ No

    If "No", then please submit copies of all sales and promotional materials.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SECTION INFORMATION

50. Do you have a Compliance program in place for HIPAA? ☐ Yes ☐ No

    i) If "Yes", when was it implemented? _____. Please provide a copy.

    ii) If "No", please explain what measures you are taking to enforce HIPAA regulations:

    (Use separate sheet if necessary): _____

    _____

    _____

    a) Are you willing to implement a compliance plan for HIPAA? ☐ Yes ☐ No

    If "Yes", within what time frame?: _____

    b) Do you give patients and other persons protected under HIPAA notification of their privacy rights? ☐ Yes ☐ No

51. Is there a Board policy on HIPAA compliance? ☐ Yes ☐ No

    If "Yes", please provide a copy.

52. Do you have a HIPAA compliance officer/manager? ☐ Yes ☐ No

    a) If "Yes", who is it, how are they qualified, and to whom do they report? _____

    _____

    _____

    b) If "No", who ensures compliance? _____

53. Do you use an outside HIPAA compliance consultant? ☐ Yes ☐ No

    If "Yes", who? _____

SECTION IV. DIRECTORS & OFFICERS AND INSURED ORGANIZATION INFORMATION

Is the Applicant seeking Directors & Officers and Insured Organization coverage? ☐ Yes ☐ No

If "No", skip to Section V.

54. Do the Directors and Officers as a whole, directly or indirectly, own or control the voting rights of more than 5% of the outstanding securities of the Applicant? ☐ Yes ☐ No

If "Yes", please list each name and their ownership amount.

For questions 55 through 57, if the answer is "Yes", then please provide details on a separate page.

55. Does the Applicant act as a general partner in any partnership? ☐ Yes ☐ No

56. Does the Applicant have any direct or indirect insurance operations? ☐ Yes ☐ No

57. Is coverage requested for Outside Service positions on any for profit or public corporate boards or other joint venture? ☐ Yes ☐ No

If "Yes", please submit the following for the outside company: name, audited financial statement, schedule of primary D&O, and schedule of proposed Insured Persons and their capacity.

SECTION V. EMPLOYMENT PRACTICES INFORMATION

Is the Applicant seeking Employment Practices coverage? ☐ Yes ☐ No

If "No", skip to Section VI.

58. Total number of employees: Full time _____ Part time _____ Temporary _____

59. NAS Helpline Contact #1:

_____
(Name) (Title) (Phone) (Fax) (Email)

NAS Helpline Contact #2:

_____
(Name) (Title) (Phone) (Fax) (Email)

60. Have any officers or senior management voluntarily or involuntarily left the employ of the Applicant within the last 18 months? ☐ Yes ☐ No

If "Yes", provide details on a separate page.

61. Does the Applicant anticipate in the next 12 months, or transacted in the last 12 months, any plant, facility, branch or office closing, consolidations or layoffs affecting 20% or more of the total employees or affecting an entire division, location or business unit? ☐ Yes ☐ No

If "Yes", please provide details on a separate page.

62. Describe the internal controls maintained for Employment Practices.

a) Have all supervisors and officers attended training on sexual harassment and discrimination within the last 18 months? ☐ Yes ☐ No

b) Does labor relations counsel review the employment policies/procedures at least annually? ☐ Yes ☐ No

c) Is there a separate Human Resources Department? ☐ Yes ☐ No

d) Publish and distribute an employee handbook? ☐ Yes ☐ No

If "Yes", does it include policies for:

i) anti-harassment? ☐ Yes ☐ No

ii) EEO? ☐ Yes ☐ No

iii) at-will provision? ☐ Yes ☐ No

iv) Americans with Disabilities Act? ☐ Yes ☐ No

v) Family and Medical Leave Act ? ☐ Yes ☐ No

vi) all employees receive a copy and sign for receipt? ☐ Yes ☐ No

e) Are all mandatory federal and state posting requirements met? ☐ Yes ☐ No

f) Are there written procedures for handling employee grievances or complaints? ☐ Yes ☐ No

g) Does the Applicant use an application for employment? ☐ Yes ☐ No

If "Yes", does it include:

i) "At will" statement ☐ Yes ☐ No

ii) EEO statement ☐ Yes ☐ No

h) Are terminations reviewed by either Human Resources, Senior Management or outside labor relations counsel? ☐ Yes ☐ No

63. Annual percentage turnover rate for employees: Previous Year: 200__ _____% Current Year: 200__ _____%

64. Are stock options offered to employees, officers or directors as part of their compensation? ☐ Yes ☐ No

If "Yes", please provide details on a separate page.

65. Third Party Claims Exposure **(Please respond if coverage for third party claims is desired).**

a) Does the Applicant have written procedures for the handling of customer/client/third party relations? ☐ Yes ☐ No

i) Are these procedures included in the Employee Handbook? ☐ Yes ☐ No

ii) Do they include anti-discrimination and anti-sexual harassment policies? ☐ Yes ☐ No

iii) Do they include procedures for handling complaints of discrimination and sexual harassment by a customer/client/other third party? ☐ Yes ☐ No

SECTION VI. PRIOR INSURANCE INFORMATION.

Please provide details of insurance/reinsurance currently in force **(If "None", so state):**

Type of Coverage	Insurance Carrier(s)	Policy Period	Limits	Deductible	Premium
Managed Care E&O					
D&O					
EPLI					
Medical Malpractice					
Stop Loss					

66. Has any insurance carrier canceled or non-renewed any of the above? ☐ Yes ☐ No

SECTION VII. PRIOR ACTIVITIES INFORMATION

For questions 67 through 71 if the answer is "Yes", then please provide details on a separate page.

67. Has any insurer made payments to or on behalf of any person or entity proposed for this insurance at any time in the last five years? ☐ Yes ☐ No

68. Has the applicant given written notice under the provisions of any current or prior policy providing similar insurance of any specific facts or circumstances which might give rise to a claim under such insurance? ☐ Yes ☐ No

69. Has the Applicant ever been cited for any violation of federal, state or local licensing requirements for operation? ☐ Yes ☐ No

70. Has the Health Care Financing Administration, Department of Health and Human Services, or similar federal, state or local agency ever sanctioned the Applicant? ☐ Yes ☐ No

71. Has the Applicant ever had Medicare participation status revoked or restricted in any manner? ☐ Yes ☐ No

a) Within the last five years, has any person or entity proposed for this insurance been the subject of or involved in any: litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry, including any investigation by the Department of Labor or the Equal Employment Opportunity Commission? ☐ Yes ☐ No

If "Yes", then please complete the Supplemental Claim/Wrongful Act Incident Form for each such matter.

b) Is any person or entity proposed for this insurance aware of any wrongful act, facts, incidents, or any circumstance which may result in claims being made against you? ☐ Yes ☐ No

SECTION VIII. THE APPLICANT REQUESTS QUOTATIONS FOR (check that all apply):

	Limits of Liability (in Millions)					
	$1.0	$1.0/3.0	$2.0	$5.0	Other	Retention
☐ Managed Care Errors & Omissions	☐	☐	☐	☐	☐	_____
☐ Directors & Officers	☐	☐	☐	☐	☐	_____
☐ Employment Practices Liability	☐	☐	☐	☐	☐	_____

SECTION IX. OTHER INFORMATION

1. The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

2. It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

3. It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

Signed: _____ Title: _____
Must be Signed by an Executive — Title

Name: _____
Please Print or Type

Capacity: _____

Applicant Organization: _____

Date: _____
(Month) (Day) (Year)

For purposes of creating a binding contract of insurance by this application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed on and the same document.

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