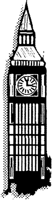

NAS Insurance Services, inc.

Application For Managed Care Errors and Omissions, Directors and Officers, Including Corporate Entity Coverage, and Employment Practices Liability Coverage

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.**

I. General Information

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

   ____

   a) Are there subsidiaries to be covered? ☐ Yes ☐ No
   If Yes, please list on a separate page.

   b) Address: ____
   (Number) (Street)

   ____
   (City) (State) (Zip Code)

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

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3. Type of Organization: ☐ PHO ☐ IPA ☐ Medical Group ☐ MSO ☐ HMO ☐ TPA ☐ Other
If "TPA" or "Other" then please provide details of services offered on a separate page.

4. Has the Applicant been in business longer than five (5) years? ☐ Yes ☐ No

For questions 5 through 10, if the answer is Yes then please provide details on a separate page.

5. 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

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

7. 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

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

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

10. Does the Applicant have a currently implemented billing compliance plan? ☐ Yes ☐ No

II. Financial Information

1. 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: $____________________

2. Fiscal year ending: 200 ___

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

For questions 4 through 7, if the answer is Yes then please provide details on a separate page.

4. Do the current liabilities exceed current assets? ☐ Yes ☐ No

5. Do long-term liabilities exceed 45% of total assets? ☐ Yes ☐ No

6. Will more than 50% of the total long-term liabilities mature within the next 18 months? ☐ Yes ☐ No

7. Has any auditor in the last 2 fiscal years rendered a "going concern" opinion for the financial statements of the Applicant? ☐ Yes ☐ No

III. The Applicant requests quotations for (check that all apply):

			Limits of Liability (in Millions)				
			$1.0	$1.0/3.0	$2.0	$5.0	Retention
☐ Managed Care Errors & Omissions	☐ Yes	☐ No	☐	☐	☐	☐	______
☐ Directors & Officers	☐ Yes	☐ No	☐	☐	☐	☐	______
☐ Employment Practices Liability	☐ Yes	☐ No	☐	☐	☐	☐	______

IV. **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.

Submitted by: ______________________
(Agent)

Date: ______________________
(Month) (Day) (Year)

Signed: ______________________
Must be Signed by an Executive

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.

Please fully complete and attach the Information for the Coverage Section(s) desired.

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Managed Care Professional Errors and Omissions Coverage Section Information

Is the Applicant seeking Managed Care Errors and Omissions coverage? ☐ Yes ☐ No
If Yes, please answer the following questions.

For questions 1 and 3, if the answer is Yes please provide details on a separate page.

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

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

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

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

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

4. 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

5. 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)__________	☐	☐	☐	☐	☐ __________

For questions 6 through 10, if the answer is Yes then please provide details on a separate page.

6. Total number of patients under contract of healthcare plans, Medicare and Medicaid:

__________ Last 12 months __________ Next 12 months

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

8. 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

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

10. Is the Applicant licensed by any entity for insurance or managed care professional services? ☐ Yes ☐ No

11. Name of firm acting as legal counsel to the Applicant: ______________________________

12. Number of Providers:

	Employed/Owned Last 12 Months	Employed/Owned Next 12 Months	Under Contract Last 12 Months	Under Contract 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)	________	________	________	________

13. If an MSO, provide number of clients: ______________

For questions 14 through 16, if the answer is Yes, then please provide details on a separate page.

14. 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

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

16. 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

17. 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.

18. 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 : ______________
____

19. a) Does Applicant give/require Hold Harmless Agreement to/with contracted providers? ☐ Yes ☐ No

b) Does Applicant give/require Hold Harmless Agreement to/with payers? ☐ Yes ☐ No

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

CREDENTIALING

20. Does the Applicant perform credentialing of health care providers which it:

    a) Employs? ☐ Yes ☐ No
    b) Contracts with or on behalf of? ☐ Yes ☐ No
    c) Refers enrollees/patients to? ☐ Yes ☐ No

    If answer is Yes to any of the above, then please answer all questions in this Section.

21. 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 answer is Yes to 20, then please provide details of circumstances and corrected plan of action on a separate page.

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

    If answer is No to 21, then please provide details of credentialing process on a separate page.

23. 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.

24. a) Does the Applicant contract with any specialty provider organizations ☐ Yes ☐ No
    b) If "Yes", does the Applicant credential each provider in the contracted organization or is credentialing sub-delegated? ☐ Yes ☐ No

    If credentialing is sub-delegated, please describe oversight process to audit the 3rd party on a separate page.

25. 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 the answer is Yes to 25.a, 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

26. Have any providers, who applied, been denied membership to the panel in the last 12 months? ☐ Yes ☐ No

    If the answer is Yes to 26, then please indicate how many were denied, and for what reasons on a separate page.

27. How are complaints against the providers handled? ____

    ____

UTILIZATION MANAGEMENT

28. a) Is the Applicant delegated to perform utilization management activities on behalf of any health plans that you contract with? ☐ Yes ☐ No
    b) Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No
    If the answer is Yes to 27, then please provide details on a separate page.

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

30. 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

31. Is the Applicant delegated to process requests for:
    Organ transplants ☐ Yes ☐ No
    Experimental procedures ☐ Yes ☐ No

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

33. 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.

34. 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 ______________

35. 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

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

CLAIMS ADJUDICATION

37. a) Is the Applicant delegated to perform claims adjudication activities on behalf of any health plans that you contract with? ☐ Yes ☐ No
    b) Has any health plan ever revoked previously delegated activities? ☐ Yes ☐ No
    If the answer to 36 is Yes, then please provide details on a separate page.

38. 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.

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

OTHER SERVICES

40. 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

41. a) Is any sales or promotional material bearing the name or identify of the Applicant distributed to:
(i) Enrollees/beneficiaries ☐ Yes ☐ No
(ii) Providers ☐ Yes ☐ No
(iii) Payers ☐ Yes ☐ No

b) Does such material always refer to contracted providers as Independent Contractors? ☐ Yes ☐ No

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

If the answer is Yes, then please submit copies of materials with statements.

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

If the answer is No, then please submit copies of all sales and promotional materials.

PRIOR INSURANCE

42. a) Describe any current insurance maintained.

Coverage	Yes	No	Limits	Expiring Premium
Managed Care E&O	____	____	__________	____________

For questions b) through d) if the answer is Yes, then please provide details on a separate page.

b) 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

c) 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

d) Has any insurer ever cancelled or non-renewed any similar insurance? ☐ Yes ☐ No

PRIOR ACTIVITIES INFORMATION

43. 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? ☐ Yes ☐ No
If Yes, then please complete the Supplemental Claim/Wrongful Act Incident form for each 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
If the answer is Yes, then please provide details on a separate page.

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