OneBeacon HEALTHCARE GROUP

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Atlantic Specialty Insurance Company
(Stock company owned by the OneBeacon Insurance Group)

Application
(New Business)

MANAGED CARE ERRORS AND OMISSIONS LIABILITY INSURANCE

THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS AND CONDITIONS, ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. CLAIM EXPENSES ARE PART OF AND NOT IN ADDITION TO THE LIMIT OF LIABILITY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES WILL BE REDUCED AND MAY BE EXHAUSTED BY CLAIM EXPENSES, AND CLAIM EXPENSES WILL BE APPLIED AGAINST THE RETENTION. WE WILL HAVE NO OBLIGATION TO PAY JUDGMENTS, SETTLEMENTS OR CLAIM EXPENSES ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED.

Instructions:
Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1. Applicant Name and all other entities and individuals proposed for this insurance.

A. ACCOUNT INFORMATION

1. Applicant Name	
Doing Business As	
Federal Employee I.D. # (FEIN)	
State of Domicile	
2. Mailing Address	Street:
	City: State: Zip:
	County: Website Address:
3. Risk Manager or Contact Person	Name/Title:
	Email Address:
	Telephone Number:
4. Applicant's Legal Structure	☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other:_____
5. Tax Status	☐ For Profit Private Company ☐ Publicly Traded ☐ Not For Profit Taxable Corp. ☐ Not For Profit Exempt Corp.
6. Date incorporated:_____	Date operations began:_____
7. List all states where you operate and provide services:	

8. Within the past 36 months or within the next 12 months, have you or do you expect to:

a. Merge, acquire or consolidate with another entity? ☐ Yes ☐ No ☐ NA

b. Enter into any new business activities or services? ☐ Yes ☐ No ☐ NA

If "Yes," to either of the above, please explain and describe the essential terms of each such transaction: (If needed, use an attachment to the Application):

9. List below all entities (e.g., subsidiaries, joint ventures, or partnerships) requested to be included for coverage under the proposed insurance and include all exposure data. If needed, list additional entities on a separate attachment.

Name & Address	Relationship	Description of Operations	Tax Status	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

10. Are you::

☐ HMO (If so, please indicate): ☐ Staff Model ☐ Network/IPA Model ☐ Combined [both]

☐ PPO ☐ PHO ☐ IPA ☐ Peer Review

☐ Third Party Administrator ☐ Utilization Review Organization ☐ MSO

☐ Medical Group or Clinic ☐ Accountable Care Organization ☐ Medical Home

☐ Other (describe): _____

B. CURRENT AND REQUESTED COVERAGE -

Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

11. Limits of liability requested: (Each Claim/Aggregate)

☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$2,000,000

☐ $3,000,000/$3,000,000 ☐ $5,000,000/$5,000,000 ☐ $10,000,000/$10,000,000

☐ $15,000,000/$15,000,000 ☐ $20,000,000/$20,000,000 ☐ Other: $_____

Retention Desired:

☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000

☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $500,000

☐ $1,000,000 ☐ $2,500,000 ☐ Other: $_____

12. Please provide details of insurance/self-insurance/reinsurance currently in force (if none, please state):

Type of Coverage	Carrier	Limits	Deductible/ Retention	Premium	Policy Period MM/DD/YY – MM/DD/YY	If Claims Made, Retroactive Date
Managed Care Errors & Omissions						
Medical Malpractice*						
D&O*						
EPL*						
Fiduciary*						
Stop Loss*						
Insolvency*						
Crime*						
Network Security & Privacy *						
Other (describe): _____						

C. EXPOSURE DETAILS

13. Enrollment:

Note: Wherever used, "enrollees" means covered lives, not just covered employees and not member months

Enrollment Type	Enrollees Last (12) Months As of MM/DD/YYYY	Enrollees Next (12) Months As of MM/DD/YYYY
HMO		
PPO		
Indemnity		
POS		
ASO		
IPA		
Medicaid		
Medicare		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other (please describe): _____		
Total Enrollment		

14. Revenue:

	Last (12) Months As of MM/DD/YYYY	Estimated Next (12) Months As of MM/DD/YYYY
Total Revenue (all operations)		
PPO Revenue		
Utilization Review/Case Management Revenue		
MSO Revenue		
PHO Revenue		
IPA Revenue		
Carve-Out-Revenue		
TPA/Claims Administration Revenue		

15. Number of Health Care Providers:

Provider Type	Last (12) Months As of MM/DD/YYYY	Estimated Next (12) Months As of MM/DD/YYYY
Contracted Physicians		
Employed Physicians		

16. Managed Care Activities:

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. Please check all that apply. (Note: not all checked services may be covered):

Activity or Service	Applicant Performs or Subcontracts	Applicant Performs for Other for a Fee
Credentialing or peer review of health care providers	☐	☐
Utilization review	☐	☐
Drafting practice guidelines/Critical Pathways	☐	☐
Case management	☐	☐
Disease management	☐	☐
Handling and adjusting of enrollees' health care benefit claims	☐	☐
Application or enrollment processing for enrollees of health care plans	☐	☐
Billing/other processing of enrollees' claims under health care plans	☐	☐
Advertising, marketing, or selling health care plans/products	☐	☐
Establishing health care provider networks to provide managed care	☐	☐
Actuarial services for health care plans	☐	☐
Assisting customers in securing reinsurance	☐	☐
Services for automobile liability or disability	☐	☐
Third party administration (TPA) services	☐	☐
Employee Assistance Program (EAP)	☐	☐
Nurse call line	☐	☐
OTHER (DESCRIBE):	☐	☐
	☐	☐
	☐	☐

D. OPERATIONS AND ADMINISTRATION	NOTE: If you are an IPA, PHO or Medical Group or Clinic and DO NOT have claim handling or utilization review responsibilities skip questions (46) through (49)	
GENERAL OPERATIONS:		
17. Are you licensed by federal, state, or local government? If "Yes," identify the licensing government: _____		☐ Yes ☐ No ☐ NA
18. Are you accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? If "Yes," identify the accrediting/certifying organization: _____		☐ Yes ☐ No ☐ NA
19. Has you license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? If "Yes," please explain:		☐ Yes ☐ No ☐ NA
20. Do you have a formal risk management program?		☐ Yes ☐ No ☐ NA
21. Are any of your operations subcontracted?		☐ Yes ☐ No ☐ NA
a. Credentialing		☐ Yes ☐ No ☐ NA
b. Utilization Review		☐ Yes ☐ No ☐ NA
c. Claim Handling		☐ Yes ☐ No ☐ NA
d. Other		☐ Yes ☐ No ☐ NA
22. Are written contracts used for all subcontracted work? If "No," please explain:		☐ Yes ☐ No ☐ NA
23. Do you require all subcontractors to carry their own errors and omissions insurance? If "Yes," what are required minimum limits? _____ If "No," please explain:		☐ Yes ☐ No ☐ NA
24. Do you indemnify the subcontractor?		☐ Yes ☐ No ☐ NA
25. Does the subcontractor indemnify you?		☐ Yes ☐ No ☐ NA
26. Are any of your operations subcontracted outside of the United States?		☐ Yes ☐ No ☐ NA
HEALTHCARE REFORM:		
27. Have you ever provided customer rebates based on Medical Loss Ratio obligations? If "Yes," how often? _____		☐ Yes ☐ No ☐ NA
28. Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio rebates?		☐ Yes ☐ No ☐ NA
29. Do you publish their Medical Loss Ratio calculation process?		☐ Yes ☐ No ☐ NA

30. Have you ever been sanctioned, fined, investigated or sued for non-compliance related to their Medical Loss Ratio requirements? ☐ Yes ☐ No ☐ NA

31. Do you have an individual that is responsible for compliance with healthcare reform? ☐ Yes ☐ No ☐ NA

32. Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? ☐ Yes ☐ No ☐ NA

If "Yes," please explain:

33. Have you made changes to your policies and procedures to comply with all healthcare reform acts? ☐ Yes ☐ No ☐ NA

34. Do you offer quality incentives to providers? ☐ Yes ☐ No ☐ NA

35. Do you disclose and explain the provider incentives to members? ☐ Yes ☐ No ☐ NA

If "Yes," please provide details re: how and where the information is disclosed:

36. Do you have or plan to form a Medical Home facility? ☐ Yes ☐ No ☐ NA

If "Yes," please provide details:

CREDENTIALING:

37. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? ☐ Yes ☐ No ☐ NA

38. Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials? ☐ Yes ☐ No ☐ NA

39. Are providers allowed a hearing or appeal prior to termination? ☐ Yes ☐ No ☐ NA

40. Do you clearly express grounds for termination of providers in their contracts? ☐ Yes ☐ No ☐ NA

41. Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? ☐ Yes ☐ No ☐ NA

If "No," what minimum limits are required? _____

42. Do you perform on-site visits of contracted healthcare providers? ☐ Yes ☐ No ☐ NA

If "Yes," how often? _____

43. Do you disclose your reimbursement policies for non-par providers on your website? ☐ Yes ☐ No ☐ NA

If "No," please explain:

44. Do your subscribers have access to non-par provider rates? ☐ Yes ☐ No ☐ NA

If "No," please explain:

45. Do you have a provider tiering program? ☐ Yes ☐ No ☐ NA

If "Yes," please provide details on tiering criteria and appeal process:

UTILIZATION REVIEW: SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

46. Do you have written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☐ No ☐ NA

47. Do your written Utilization Review Procedures:

a. Follow NCQA or URAC standards and comply with all applicable laws? ☐ Yes ☐ No ☐ NA

b. Require physician review of all proposed denials? ☐ Yes ☐ No ☐ NA

c. State that enrollees must be notified of all denials and appeals in writing including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No ☐ NA

d. Require consultation with legal counsel when considering appeals? ☐ Yes ☐ No ☐ NA

e. Allow for a physician to override a practice guideline? ☐ Yes ☐ No ☐ NA

f. Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? ☐ Yes ☐ No ☐ NA

g. Utilize same specialty reviewers for benefit/coverage denials? ☐ Yes ☐ No ☐ NA

h. Adhere to government mandated external review requirements in the states where the Applicant operates? ☐ Yes ☐ No ☐ NA

i. Utilize the external review process in states where it is not mandated? ☐ Yes ☐ No ☐ NA

CLAIM HANDLING SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

48. Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? ☐ Yes ☐ No ☐ NA

ADVERTISING/MARKETING/SALES SKIP THIS SECTION if you are an IPA, PHO or Medical Group/Clinic and do not provide this service.

49. Do all contracts, sales literature, brochures and marketing materials:

a. Expressly identify covered and non-covered procedures? ☐ Yes ☐ No ☐ NA

b. Expressly refer to all contracted providers as independent contractors? ☐ Yes ☐ No ☐ NA

c. Make statements or warranties as to the quality of healthcare, breadth of plan? ☐ Yes ☐ No ☐ NA

d. Go through legal counsel review and approval prior to their use? ☐ Yes ☐ No ☐ NA

E. CLAIMS HISTORY

50. During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against you or against any entity or individual proposed for coverage? ☐ Yes ☐ No

If "Yes," please provide the following information for all such claims as an attachment to this Application: dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed).

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS, DEFENSES OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION (50) IS EXCLUDED FROM THE PROPOSED INSURANCE.

51. During the past five (5) years, have you or any entity or individual proposed for coverage, submitted any claims or given notice of any act, error or omission, or course of conduct which the Applicant had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement? ☐ Yes ☐ No

If "Yes," please attach details to this Application.

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION (51) AND ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION (51) IS EXCLUDED FROM THE PROPOSED INSURANCE.

52. Are you or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details to this Application.

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS, DEFENSES OR REMEDIES, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION (52) IS EXCLUDED FROM THE PROPOSED INSURANCE

F. ATTACHMENTS

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application:

- Currently valued loss runs (if you are currently insured elsewhere) including losses you may be handling within a self-insured retention
- Your most current audited or accountant-prepared financial statements with notes
- If you are newly formed, Pro Forma financial statements
- Copies of all promotional or marketing materials that are not readily available on your website
- If operation is a start-up, business plans and resumes (including professional qualifications/designations) of all partners, principals and key employees

If you want a D&O/EPL quote in addition to the above, please include these:

- The names, occupations, and business affiliations of all your directors and officers.

G. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND 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.

ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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.

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.

KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO AND 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 crime and may be subject to civil fines and criminal penalties.

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 may include imprisonment, fines, or a denial of insurance benefits.

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.

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.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

H. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)			
Insurance Agency			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip: