

HEALTH CARE CONSULTANT PROFESSIONAL LIABILITY APPLICATION

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.

APPLICATION INSTRUCTIONS: Whenever used in this Application the term "you" means the entity or individual identified in response to Question 1 of PART I TELL US WHO YOU ARE ("Applicant") and all other entities and individuals proposed for this insurance.

PART I. TELL US WHO YOU ARE

1. Name of Applicant: _____
 2. Address: _____
City: _____ State: _____ ZIP: _____
Website: _____ Telephone: _____
 3. Risk Manager or Contact person and title: _____
Email address: _____ Telephone: _____
 4. Your corporate structure: For-Profit Private Company Publicly Traded
 Not-for-Profit Taxable Corp. Not-for-Profit Tax-Exempt Corp.
 Partnership Limited Liability Company
 Individual Joint Venture
 Other (describe): _____
 5. Year Established: _____
 6. Are you controlled, owned by, associated or affiliated with, or do you own, any other firm or business enterprise? Yes No
If "Yes," please explain. (If needed, use an attachment to this Application): _____

 7. Within the past 36 months, have you or do you expect to:
a. Change your name? Yes No
b. Merge, acquire, or consolidate with another entity? Yes No
c. Sell, distribute, or divest of any assets or stock? Yes No
d. Form any joint venture? Yes No
e. Enter into any new business activities or services? Yes No
- If "Yes" to any of the above, please explain and describe the essential terms of each such transaction.
(If needed, use an attachment to this Application): _____

PART II. GIVE US YOUR NUMBERS

A. PROFESSIONAL SERVICES:

Please identify the professional services for which coverage is desired (please check all that apply):

| ACTIVITY OR SERVICE | CHECK ALL THAT APPLY | REVENUE |
|--|--------------------------|---------|
| Advertising, marketing, or selling health care plans or services | <input type="checkbox"/> | |
| Billing, coding, reimbursement, repricing consulting | <input type="checkbox"/> | |
| Billing/submitting health care claims | <input type="checkbox"/> | |
| Care management | <input type="checkbox"/> | |
| Case management | <input type="checkbox"/> | |
| Compliance consulting | <input type="checkbox"/> | |
| Credentialing or peer review of health care providers | <input type="checkbox"/> | |
| Disease management | <input type="checkbox"/> | |
| EAP Services | <input type="checkbox"/> | |
| Educational programming or seminars | <input type="checkbox"/> | |
| Employee Benefit Consulting | <input type="checkbox"/> | |
| Ergonomic and workplace safety consulting | <input type="checkbox"/> | |
| Expert witness testimony services | <input type="checkbox"/> | |
| Health information exchange consulting | <input type="checkbox"/> | |
| Healthcare accreditation consulting | <input type="checkbox"/> | |
| Human Resource policy and procedure consulting | <input type="checkbox"/> | |
| Independent medical examinations | <input type="checkbox"/> | |
| Independent medical file review | <input type="checkbox"/> | |
| Marketing research | <input type="checkbox"/> | |
| Network development, physician contracting or managed care contracting | <input type="checkbox"/> | |
| Patient advocacy services | <input type="checkbox"/> | |
| Practice guidelines or critical pathway consulting | <input type="checkbox"/> | |
| Physician practice management | <input type="checkbox"/> | |
| Quality assurance or clinical improvement consulting | <input type="checkbox"/> | |
| Telephone triage consulting | <input type="checkbox"/> | |
| Transcription services | <input type="checkbox"/> | |
| Utilization review | <input type="checkbox"/> | |
| Other (describe in detail): | <input type="checkbox"/> | |
| | <input type="checkbox"/> | |
| | <input type="checkbox"/> | |
| | <input type="checkbox"/> | |

B. REVENUE:

| | LAST 12 MONTHS As of ___/___/___ | ESTIMATE NEXT 12 MONTHS As of ___/___/___ |
|--------------------------------|-------------------------------------|--|
| Total Revenue (all operations) | | |

C. CONTRACTS:

Please list your **five (5)** largest contracts and associated annual revenue:

| CONTRACTS | ANNUAL REVENUE |
|-----------|----------------|
| | |
| | |
| | |
| | |

D. CONSULTANTS AND EMPLOYEES:

| | LAST 12 MONTHS As of ___/___/___ | ESTIMATE NEXT 12 MONTHS As of ___/___/___ |
|-----------------------------|--|---|
| Total Number of Consultants | | |
| Total Number of Employees | | |

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Are you licensed by federal, state, or local government? Yes No NA
If "Yes," identify the licensing government: _____
2. Are you accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? Yes No NA
If "Yes", identify the accrediting/certifying organization: _____
3. Has your license, certification, or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? Yes No NA
If "Yes," please explain: _____
4. Have you ever acted, or will you act, in any capacity in which you have the ability to exercise decision-making authority for a client or an assignment? Yes No NA
If "Yes," please explain: _____
5. Do you assist in negotiating or have any authority to alter or enter into contractual relationships on any client's behalf? Yes No NA
If "Yes," please explain: _____
6. Do you enter into contracts with your clients? Yes No NA
7. Are any of your operations subcontracted? Yes No NA
 - a. Are written contracts used for all subcontracted work? Yes No NA
If "no", please explain: _____
 - b. Do you require all subcontractors to carry their own errors and omissions insurance? Yes No NA
If yes, what are required minimum limits? _____
If "no", please explain: _____
 - c. Are any of your operations subcontracted outside of the United States? Yes No NA
If "Yes," please describe: _____
8. If you provide Credentialing Services, do your written procedures comply with JCAHO or NCQA standards and all applicable laws? Yes No NA
9. If you provide Utilization Review Services, do you have written policies and procedures for utilization review, including for denials and appeals? Yes No NA
10. If you provide Claims Handling Services, do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters? Yes No NA
11. Do all contracts, sales literature, brochures and marketing materials go through legal counsel review and approval prior to their use? Yes No NA

PART IV. TELL US WHAT YOU HAVE

- Limits of Liability desired: \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
(Each Claim/Aggregate) \$3,000,000/\$3,000,000 \$5,000,000/\$5,000,000 Other: \$ _____
- Retention Desired: \$2,500 \$5,000 \$10,000 \$25,000 Other: \$ _____

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

| Type of Coverage | Insurance Carrier(s) | Limits | Deductible/ Retention | Premium | Policy Period | If Claims Made, Retroactive Date |
|----------------------------|----------------------|--------|-----------------------|---------|---------------|----------------------------------|
| Errors & Omissions | | | | | | |
| Medical Malpractice | | | | | | |
| D&O | | | | | | |
| EPL | | | | | | |
| Fiduciary | | | | | | |
| Crime | | | | | | |
| Network Security & Privacy | | | | | | |
| Other | | | | | | |

PART V. TELL US ABOUT YOUR CLAIM HISTORY

1. 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 dates of loss, claimant name, all defense and indemnity payments, and all defense and indemnity reserves (if claims are open) and claim status (open/closed): _____

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 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. 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 you 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 provide details: _____

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 2 AND ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

3. Are you or any entity or individual proposed for coverage, aware of any act, error or omission, or course of conduct which you have 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 provide details: _____

NOTE: WITHOUT PREJUDICE TO ANY OF OUR OTHER RIGHTS OR REMEDIES, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY ACT, ERROR OR OMISSION, OR COURSE OF CONDUCT REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VI. WHAT ELSE WE NEED

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

1. Currently valued loss runs (if you are currently insured elsewhere) including losses you may be handling within a self insured retention;
2. Your most current audited or accountant-prepared financial statements with notes;
3. If you are newly formed, Pro Forma financial statements;
4. Copies of all promotional or marketing materials that are not readily available on your website.
5. Sample copies of all types of client contracts, including sub-contractor contracts.
6. Resumes (including professional qualifications or designations) of all partners, principals, and key employees.
7. Description of your services, if not fully described in promotional or marketing materials.

PART VII. 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.

NOTICE TO 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.

NOTICE TO 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.

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 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 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.

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 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, 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.

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 may include imprisonment, fines, or a 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 OKLAHOMA APPLICANTS: 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 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.

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.

PART VIII. DECLARATIONS AND SIGNATURES

The undersigned, as 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. 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.

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.

| | | |
|-----------------------------------|-------|------|
| APPLICANT | | |
| BY <i>(CEO, CFO or President)</i> | TITLE | DATE |

NOTE: This Application must be signed by the CEO, CFO and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

| | |
|---|--|
| PRODUCED BY (<i>Insurance Agent</i>) | INSURANCE AGENCY |
| INSURANCE AGENCY TAXPAYER ID NO. | AGENT LICENSE NO. or SURPLUS LINES NO. |
| ADDRESS (<i>No., Street, City, State, and ZIP Code</i>) | |
| EMAIL ADDRESS | |

| | | |
|---|----------------------------------|--|
| SUBMITTED BY (<i>Insurance Agency</i>) | INSURANCE AGENCY TAXPAYER ID NO. | AGENT LICENSE NO. or SURPLUS LINES NO. |
| ADDRESS (<i>No., Street, City, State, and ZIP Code</i>) | | |

NOTE: For New Hampshire Applicants, producer's name and signature are required.