Homeland Insurance Company of New York **Homeland Insurance Company of Delaware** *(Stock companies owned by the **OneBeacon Insurance Group**)* One Beacon Lane Canton, MA 02021	OneBeacon PROFESSIONAL INSURANCE®

PLAN PURCHASER PROTECTION 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 ☐ For-Profit Publicly Traded
   ☐ Not-for-Profit Taxable Corp. ☐ Not-for-Profit Tax-Exempt Corp.
   ☐ Partnership ☐ Limited Liability Company
   ☐ Joint Venture ☐ Other(describe):

5. State(s) where you operate:

6. Your type of business:
   ☐ Consumer Products ☐ Education
   ☐ Manufacturing ☐ Media
   ☐ Municipal ☐ Retail
   ☐ Transportation ☐ Union
   ☐ Other (describe):

7. Do you own, operate or supervise an on-site clinic or sickroom, a hospital, inpatient or outpatient clinic, pharmacy, dispensary or other medical facility? ☐ Yes ☐ No
   If "Yes," please provide particulars:

8. Do you employ physicians, surgeons, dentists or other health care professionals, in any medical capacity except to perform administrative duties, peer review or utilization review functions? ☐ Yes ☐ No
   If "Yes," please provide particulars:

9. If you are seeking coverage for any other entities (e.g., subsidiaries, joint ventures, or partnerships), list each entity below and **include all exposure data**. If needed, list additional entities on a separate attachment. (Please note that coverage for these entities is not automatically included. The policy, if issued, will determine actual coverage.)

Name & Address	Relationship	Description of Operations	Tax Status	Percent Owned

PART II. GIVE US YOUR NUMBERS

A. List all of your available health plans:

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

Name of Insurer, Plan Administrator or Vendor	Type of Benefit (Health Care, Dental, Vision, etc.)	Type of Plan (HMO, PPO, etc.)	Average Number of Enrollees Per Year (including dependents)

B. If you contract directly with providers (e.g., doctors, hospitals, etc.), please provide the number of:

Hospitals/Clinics under direct contract to you	Providers under direct contract to you	Providers available to you through Network Vendor

PART III. TELL US HOW YOU DO IT

A. GENERAL OPERATIONS:

1. Are your health plans fully insured or self-insured? ☐ Fully insured ☐ Self-insured
2. Do you use a consultant for choosing health care plans or benefits? ☐ Yes ☐ No ☐ NA
   If "Yes," please provide the firm's name:
3. Who on your staff makes the final selection of insurer(s), plan(s), network(s) or vendor(s)?
4. Are all contracted insurers, plans, networks or vendors required to maintain professional liability or errors and omissions insurance? ☐ Yes ☐ No ☐ NA
   If "No," please explain:
5. Do you purchase group health insurance for any other entity, union, etc. other than those named in this application? ☐ Yes ☐ No ☐ NA

6. Is the administration of your health plans sub-contracted? ☐ Yes ☐ No ☐ NA
   a. Are written contracts used for all subcontracted work? ☐ Yes ☐ No ☐ NA
   b. Do you require all subcontractors to carry their own errors and omissions insurance? ☐ Yes ☐ No ☐ NA
   c. Do you indemnify the subcontractor? ☐ Yes ☐ No ☐ NA
   d. Does the subcontractor indemnify you? ☐ Yes ☐ No ☐ NA
   e. Are any of your operations subcontracted outside of the United States? ☐ Yes ☐ No ☐ NA
   If "Yes," please describe:

7. Do you contract for performance of health care services outside of the United States? ☐ Yes ☐ No ☐ NA
   If "Yes", please describe:

B. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS:

1. Who does the credentialing of contracted health care providers?
   You: ☐ Yes ☐ No
   Subcontractor: ☐ Yes ☐ No Name:
2. If credentialing is subcontracted:
   a. Do you review or audit the process? ☐ Yes ☐ No ☐ NA
   b. Is the subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No ☐ NA
3. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? ☐ Yes ☐ No ☐ NA
4. Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials? ☐ Yes ☐ No ☐ NA
5. Are providers allowed a hearing or appeal prior to termination? ☐ Yes ☐ No ☐ NA
6. 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?
7. How often do you re-credential contracted health care providers?

C. UTILIZATION REVIEW/ COST CONTAINMENT:

1. Who performs utilization review?
   You: ☐ Yes ☐ No
   Subcontractor: ☐ Yes ☐ No Name:
2. If utilization review is subcontracted:
   a. Do you review or audit the utilization review process? ☐ Yes ☐ No ☐ NA
   b. Is the subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No ☐ NA
   c. Does the subcontractor make the final benefit determination? ☐ Yes ☐ No ☐ NA
3. Do you have written policies and procedures for utilization review, including for denials and appeals? ☐ Yes ☐ No ☐ NA
   If "Yes," do the procedures:
   a. Follow NCQA or URAC standards and comply with all applicable laws? ☐ Yes ☐ No ☐ NA
   b. 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
   c. Require consultation with legal counsel when considering appeals? ☐ Yes ☐ No ☐ NA
   d. Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers? ☐ Yes ☐ No ☐ NA
4. Do you have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? ☐ Yes ☐ No ☐ NA
5. Do you utilize independent external review for appeals? ☐ Yes ☐ No ☐ NA

D. ADVERTISING/MARKETING/SALES/EMPLOYEE COMMUNICATIONS:

1. Who prepares the description of benefits and communications to enrollees?
   You: ☐ Yes ☐ No
   Subcontractor: ☐ Yes ☐ No Name:
2. Do all contracts, sales literature, brochures, summary plan descriptions and marketing materials:
   a. Expressly identify covered and non-covered procedures? ☐ Yes ☐ No ☐ NA
   b. Make statements or warranties as to the quality of health care, breadth of plan? ☐ Yes ☐ No ☐ NA
   c. Go through legal counsel review and approval prior to their use? ☐ Yes ☐ No ☐ NA
   d. Define the term(s) "investigative" or "experimental" procedures? ☐ Yes ☐ No ☐ NA
   e. Clearly state that you have discretionary authority in the interpretation and administration of the plan's provisions? ☐ Yes ☐ No ☐ NA

PART IV. TELL US WHAT YOU HAVE

Limits of Liability desired: (Each Claim/Aggregate)
☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000
☐ $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
Plan Purchaser Errors & Omissions						
Medical Malpractice						
D&O						
EPL						
Fiduciary						
Stop Loss						
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 names, all defense and indemnity payments, all defense ad 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 forseen 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. Most recent health plan financials including actuarial report, if applicable.

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 *(CEO, CFO or President)*	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 *(Insurance Agent)*	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*	
EMAIL ADDRESS	

SUBMITTED BY *(Insurance Agency)*	INSURANCE AGENCY TAXPAYER ID NO.	AGENT LICENSE NO. or SURPLUS LINES NO.
ADDRESS *(No., Street, City, State, and ZIP Code)*		

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