## NOTICE

**NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMITS OF LIABILITY TO PAY INSURED LOSS SHALL BE REDUCED AND MAY BE EXHAUSTED BY PAYMENT OF DEFENSE COSTS AND DEFENSE COSTS SHALL BE APPLIED AGAINST ANY APPLICABLE RETENTION. IN NO EVENT SHALL THE INSURER BE LIABLE FOR DEFENSE COSTS OR INSURED LOSS IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

## INSTRUCTIONS

WHENEVER USED IN THIS **APPLICATION**, THE TERM "**APPLICANT**" SHALL MEAN THE **NAMED INSURED** AND ITS SUBSIDIARIES. ALL OTHER BOLDFACE TERMS IN THIS **APPLICATION** ARE DEFINED IN THE **POLICY** AND HAVE THE SAME MEANING IN THIS **APPLICATION** AS IN THE **POLICY**. PLEASE ANSWER ALL QUESTIONS FULLY AND TYPE OR PRINT CLEARLY. IF YOU DO NOT HAVE A COPY OF THE **POLICY**, PLEASE REQUEST IT FROM YOUR AGENT OR BROKER.

NOTE: For any questions that require a "☐Yes" or "☐No" response followed by an asterisk (*), please provide or attach a full explanation.

## I. General Information

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Legal Name of **Applicant** | | | | | |
| 2. | Address | Street | | | | |
| | | City | | State | | Zip |
| 3. | **Applicant's** Website | | | | | |
| 4. | State of Incorporation | | Date of Incorporation | | | |
| 5. | Individual authorized to receive notices and information regarding the proposed **Policy** and **Claims** | | | | | |
| | Name | | Title | | | |
| | Address | | | | | |
| | Telephone | | Email | | | |
| 6. | Individual designated to receive risk management information | | | | | |
| | Name | | Title | | Email | |

## II. Insurance Information

| | | | |
|---|---|---|---|
| 1. | Does the **Applicant** desire any changes to the expiring limit or retention of any currently purchased Coverage Section? If "Yes," indicate the desired changes in the table below: | ☐ Yes | ☐ No |

| | Coverage Requested | Expiring Limit | Requested Limit | Expiring Shared Limit | Expiring Retention | Requested Retention | Requested Shared Limit |
|---|---|---|---|---|---|---|---|
| ☐ | Directors & Officers Liability | $ | $ | ☐ | $ | $ | ☒ |
| ☐ | Employment Practices Liability | $ | $ | ☐ | $ | $ | ☐ |
| ☐ | Fiduciary Liability | $ | $ | ☐ | $ | $ | ☐ |
| ☐ | Crime | $ | $ | | $ | $ | ☐ |

*If any Requested Limit exceeds a corresponding Expiring Limit, please complete the Increased Limits Warranty Statement in Section VIII below.*

## III. General Risk Information

| | | | |
|---|---|---|---|
| 1. | NAICS Code that describes main operations (6 Digit) | | |
| 2. | Have the **Applicant's** main business operations have changed in the past twelve (12) months? If "Yes," please provide details in a separate attachment. | ☐ Yes* | ☐ No |
| 3. | List all states and countries in which the **Applicant** has started operations in the past twelve (12) months: | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4. | **Applicant** (as set forth in question I(1) above) is: | | | | | |
| (a) | Tax Status | | | | | |
| | ☐ | Not-For-Profit Tax Exempt 501(c)(3) | ☐ | For Profit - Private | | |
| | ☐ | Not-For-Profit Taxable | ☐ | For Profit – Public | | |
| (b) | Organizational Structure | | | | | |
| | ☐ | Not-For-Profit Corporation | ☐ | S-Corporation | | |
| | ☐ | Professional Corporation (PC, PA) | ☐ | C-Corporation | | |
| | ☐ | Partnership (GP, LLP) | ☐ | Joint Venture | | |
| | ☐ | Limited Partnership (LP) | ☐ | Other (describe) _____ | | |
| | ☐ | Limited Liability Corporation | _____ | | | |
| | If the **Applicant** is a General Partnership, Limited Partnership, Limited Liability Partnership or joint venture, please provide a copy of the partnership or joint venture agreement. | | | | | |
| (c) | If the **Applicant** is a Not-For-Profit Tax Exempt Corporation, is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? | | | | ☐ Yes* | ☐ No |
| 5. | If the **Applicant** is formed as a limited partnership, provide the name of all general partners and indicate the percentage ownership that each general partner has in the limited partnership. | | | | | |
| | _____ | | | | | |
| 6. | Do any of the **Applicant's** subsidiaries act as a general partner for another organization? | | | | ☐ Yes | ☐ No |
| | *Please note that unless specifically endorsed onto the **Policy**, the term **Subsidiary** will not include partnerships. | | | | | |
| | If "Yes," describe the nature of the other organization's business, if different than the **Applicant**: | | | | | |
| | _____ | | | | | |
| 7. | During the past twelve (12) months, has the **Applicant** had a change in any of the following (check all that apply): | | | | | |
| | (a) | Subsidiaries (greater than 50% ownership) | | | ☐ Yes | ☐ No |
| | (b) | Joint Ventures (50% or less ownership) | | | ☐ Yes | ☐ No |
| | (c) | Non-owned entities under its management control | | | ☐ Yes | ☐ No |
| | (d) | Managed care subsidiaries, joint ventures or entities under its management control | | | ☐ Yes | ☐ No |
| | Please attach an organizational chart reflecting organizational: name, structure, tax status, ownership percentage, description of operations for each entity. In addition, indicate whether coverage is requested for each such entity. | | | | | |
| 8. | **Applicant's** Accreditation (check all that apply): | ☐ JCAHO | ☐ NCQA | ☐ URAC | ☐ Other: _____ | |
| | (a) | During the past twelve (12) months, has any **Applicant's** license, certification or accreditation been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? | | | ☐ Yes* | ☐ No |
| | (b) | During the past twelve (12) months, has any certifying or accrediting body found any **Applicant** to be out of substantial compliance with its certifying or accrediting standards? | | | ☐ Yes* | ☐ No |
| 9. | During the past twelve (12) months or in the next twelve (12) months, has the **Applicant** completed, or proposed or contemplated any of the following: | | | | | |
| | (a) | Merger, acquisition or consolidation of any type? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (b) | Sale, Distribution or Divestiture of Assets or Stock? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (c) | A change in outside auditor? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (d) | Branch, location, facility, office, or subsidiary closings, layoffs or reductions in force? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (e) | Reorganization or arrangement with creditors under federal or state law? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (f) | Undertaking any new areas of business? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (g) | Entering into new governmental contracts? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | (h) | Conversion from Not-For-Profit to For-Profit status? | ☐ Past 12 | ☐ Next 12 | ☐ No | |
| | If the **Applicant** checked any of the "Past 12" or "Next 12" check boxes in response to question 9, please describe the material terms of each such transaction or event on a separate attachment. | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10. | Please provide the following financial information for the two most recent fiscal years (indicate month and year below): | | | | | | |
| | (a) | Financial Information | | | | | |
| | **Category** | | **MM/YY: ___/___** | | **MM/YY: ___/___** | | |
| | Annual Revenue | | $ | | $ | | |
| | Current Assets | | $ | | $ | | |
| | Total Assets | | $ | | $ | | |
| | Current Liabilities | | $ | | $ | | |
| | Long Term Debt | | $ | | $ | | |
| | Total Liabilities | | $ | | $ | | |
| | Equity or Net Assets | | $ | | $ | | |
| | Net Income (or Loss) | | $ | | $ | | |
| | Cash Flow From Operations | | $ | | $ | | |
| | (b) | Please provide revenue breakdown (by percentage) for Medicare, Medicaid and Private Pay: | | | | | |
| | Medicare | _____% | Medicaid | _____% | Private Pay | _____% | |
| | (c) | Does the **Applicant** have a defined benefit pension fund liability? | | | | ☐ Yes | ☐ No |
| | | If "Yes" to question 10(c), please indicate amount _____ | | | | | |
| | (d) | Does the **Applicant** have audited financial statements? | | | | ☐ Yes | ☐ No |
| | (e) | Has the **Applicant** ever received a qualified opinion from its auditors? | | | | ☐ Yes* | ☐ No |
| | (f) | Is the **Applicant** in compliance with all debt covenants it may have? | | | | ☐ Yes* | ☐ No |
| | Please attach a copy of the **Applicant's** financial statements for the last two (2) years (audited statements, if done). | | | | | | |
| 11. | Does the **Applicant** currently purchase medical professional liability coverage? | | | | | ☐ Yes | ☐ No* |
| 12. | During the past twelve (12) months have any of the **Applicant's** medical professional liability coverages been self-insured or insured by means of a self-insured trust, captive, risk sharing arrangement or pool? | | | | | ☐ Yes | ☐ No |
| | If "Yes" to the above, and attach a copy of the most recent actuarial study. | | | | | | |
| | (a) | Is the program funded in accordance with annually determined actuarial requirements? | | | | ☐ Yes | ☐ No* |
| | (b) | Does the program provide insurance to third parties? | | | | ☐ Yes* | ☐ No |
| 13. | Does the **Applicant** have coverage for peer review and credentialing activities under any insurance policy, self-insured trust, captive, risk sharing arrangement or pool? | | | | | ☐ Yes | ☐ No |

## IV. Directors & Officers Liability Information

| | | | | | |
|---|---|---|---|---|---|
| ☐ | If a renewal quote for **Directors & Officers Liability** coverage is desired, tick the check box and answer the questions in Section A. If optional coverages are desired, complete the corresponding Sections B-E as instructed below. | | | | |
| **A.** | **Ownership & Control** | | | | |
| 1. | Have there been any changes in the Board of Directors (or equivalent) or Senior Management of the **Applicant** within the past twelve (12) months for reasons other than death or retirement? | | | ☐ Yes* | ☐ No |
| 2. | During the past twelve (12) months have there been, or in the next twelve (12) months do you anticipate, any change in any of the following: | | | | |
| | a. | The number of shareholders? | | ☐ Yes* | ☐ No |
| | b. | Shareholders that own(ed) greater than 5% of any class of security or class of shares outstanding? | | ☐ Yes* | ☐ No |
| | c. | The number of shares outstanding? | | ☐ Yes* | ☐ No |
| 3. | Total number of outstanding shares or ownership instrument equivalents: _____ | | | | |
| ** Whenever used in this **Application**, the term shares or shareholders shall also include the equivalent ownership interest in organizations other than stock based corporations.* | | | | | |
| 4. | Does any shareholder of the **Applicant** own five percent (5%) or more of the voting shares directly or beneficially? If "Yes," please complete the table below. Attach additional pages if necessary. | | | ☐ Yes | ☐ No |

| Name of Shareholder | Ownership % | Director or Officer? | Family Relationship? |
|---|---|---|---|
| | % | ☐ Yes ☐ No | ☐ |
| | % | ☐ Yes ☐ No | ☐ |
| | % | ☐ Yes ☐ No | ☐ |
| | % | ☐ Yes ☐ No | ☐ |

If any individual listed above is related by family to another shareholder, director or officer of **Applicant**, please tick the corresponding check box.

| | | | |
|---|---|---|---|
| 5. | Has any shareholder changed their ownership percentage by more than five percent (5%) in the last twelve (12) months? | ☐ Yes* | ☐ No |

| | | | | |
|---|---|---|---|---|
| 6. | Recent, Pending or Potential Changes | | | |
| | (a) | Is the **Applicant** currently (or during the past twelve (12) months has the **Applicant** been) in breach or in violation of any debt covenant? | ☐ Yes | ☐ No |
| | (b) | In the past twelve (12) months has the **Applicant** had any change in executive officers? | ☐ Yes | ☐ No |
| | (c) | In the past twelve (12) months has the **Applicant** completed any: | | |
| | | (i) Public or private offering of securities? | ☐ Yes | ☐ No |
| | | (ii) Issuance of debt? | ☐ Yes | ☐ No |
| | (d) | Is the **Applicant** currently anticipating any of the above? | ☐ Yes | ☐ No |
| | If "Yes" to any of the questions above, please attach a full explanation, including any private placement memoranda or any documents filed with the Securities and Exchange Commission and a description including the type and amount of the offering, the method of solicitation or advertising, and the verification method of investor qualification, if applicable. | | | |
| 7. | Does the **Applicant** have a conflict of interest policy in place applicable to all directors, officers and trustees? | | ☐ Yes | ☐ No |
| 8. | Does the **Applicant** have a cybersecurity program in place that covers all aspects of cyber and data security, including Personal Health Information? | | ☐ Yes | ☐ No |
| 9. | Who in executive leadership has responsibility for the cybersecurity program, including investigating and responding to cybersecurity incidents? Provide the individual's name and title. | | | |
| | _____ | | | |
| 10. | Is there a particular board committee responsible for cybersecurity? | | ☐ Yes | ☐ No |
| 11. | How often is the committee, if any, and full board briefed on cybersecurity matters? | _____ | | |
| 12. | Does the **Applicant** currently purchase cyber/data security insurance? | | ☐ Yes | ☐ No |
| | If "Yes," please attach a description of the insurance program (carriers, limits, etc.). | | | |
| **B.** | **Antitrust** | | | |
| ☐ | If a renewal quote for **Antitrust Claim** coverage is desired, tick the check box and answer the questions in Section B. | | | |
| 1. | Does the **Applicant** have any exclusive contracts with any providers? | | ☐ Yes* | ☐ No |
| 2. | With respect to the following markets, does the **Applicant** control more than twenty percent (20%) of the market in any given geographical area? | | | |
| | (a) | Providers in any one field of medical practice. | ☐ Yes | ☐ No |
| | (b) | Health care services. | ☐ Yes | ☐ No |
| | If "Yes" to question 2(a) or (b) above, please attach market share percentage(s). | | | |
| 3. | Has the **Applicant** in the past twelve (12) months been involved with any actual, negotiated or attempted merger, acquisition or divestment or have any future plans for mergers, acquisitions or divestitures? If "Yes," please answer the following: | | | |
| | (a) | Has the **Applicant** consulted with legal counsel regarding any antitrust laws, regulations or actual or potential issues? | ☐ Yes | ☐ No |
| | (b) | Has the **Applicant** received an opinion from the Federal Trade Commission confirming that these activities will not violate antitrust Laws? | ☐ Yes | ☐ No |
| 4. | Does the **Applicant** have any provider agreements that contain non-compete clauses? | | ☐ Yes* | ☐ No |
| 5. | Does the **Applicant** have any provider agreements that contain "Most Favored" pricing clauses? | | ☐ Yes* | ☐ No |
| **C.** | **Provider Selection** | | | |
| ☐ | If a renewal quote for **Provider Selection Claim** coverage is desired, tick the check box and answer the questions in Section C. | | | |
| 1. | During the past twelve (12) months, has the **Applicant** made any changes to its Provider Selection policies or procedures for its health care staff, whether or not such staff is employed by the **Applicant**? | | ☐ Yes* | ☐ No |
| 2. | During the past twelve (12) months, has the **Applicant** closed or restricted staff admissions of a provider to any patient service department for reasons other than professional competence, including but not limited to a conflict of interest? | | ☐ Yes* | ☐ No |
| **D.** | **Healthcare Fraud & Abuse** | | | |
| ☐ | If a renewal quote for **Healthcare Fraud & Abuse Claim** coverage is desired, tick the check box and answer the questions in Section D. | | | |
| 1. | Is there a Compliance Program in effect? If "Yes,": | | ☐ Yes | ☐ No |
| | (a) | Date Program implemented: __/__/__ | (b) | Most recently revised date: __/__/__ |
| | (c) | How frequently does the Board receive reports about compliance issues? _____ | | |
| 2. | Compliance Officer Information | | | |
| | (a) | Name and title of the individual responsible for Compliance: _____ | | |
| | (b) | Does the individual have direct access to the CEO? | ☐ Yes | ☐ No |
| | (c) | Does this individual have direct access to the Board? | ☐ Yes | ☐ No |

| | | | | |
|---|---|---|---|---|
| 3. | Does the **Applicant** provide compliance training and education to all employees, **Independent Contractors** and independently practicing medical providers? | | ☐ Yes | ☐ No* |
| 4. | Does the **Applicant** provide annual training and education to employees, **Independent Contractors** and independently practicing medical providers who do billing and coding? | | ☐ Yes | ☐ No* |
| 5. | Does the **Applicant** conduct an annual, internal review of its billing and coding for compliance with applicable laws and regulations? | | ☐ Yes | ☐ No* |
| 6. | Does the **Applicant** have policies that address the protection of whistleblowers? | | ☐ Yes | ☐ No* |
| 7. | Does the **Applicant** utilize an external audit firm to monitor billing and coding compliance? | | ☐ Yes | ☐ No* |
| 8. | Does the **Applicant** utilize billing edit/checking software? | | ☐ Yes | ☐ No* |
| 9. | Does the **Applicant** centralize its billing and coding function? | | ☐ Yes | ☐ No* |
| 10. | Does the **Applicant** maintain a procedure, such as a hotline, to receive complaints and allegations of regulatory non-compliance or wrongdoing? | | ☐ Yes | ☐ No* |
| | (a) | If "Yes," what is the average number of complaints or allegations per month? _____ | | |
| | (b) | Are all complaints recorded and investigated? | ☐ Yes | ☐ No* |
| 11. | **Healthcare Fraud & Abuse Past Activities** | | | |
| | During the past twelve (12) months, has any **Applicant** proposed for this insurance: | | | |
| | (a) | Been subject to any regulatory inquiry, investigation, indictment or proceeding for any actual, alleged, or potential violations of the following, regardless of whether or not such inquiry was a result of voluntary self-disclosure: | | |
| | i. | Federal False Claims Act of 1863, or any similar federal, state or local statutory or common law? | ☐ Yes* | ☐ No |
| | ii. | Ethics in Patient Referrals Act of 1986 (Stark Law) or any similar federal, state, or local statutory or common law? | ☐ Yes* | ☐ No |
| | iii. | Any other similar federal, state, or local statutory or common law, rules or regulation? | ☐ Yes* | ☐ No |
| | iv. | Has the **Applicant** been subject to any type of federal or state mandate or regulatory compliance oversight (i.e. a corporate integrity agreement)? | ☐ Yes* | ☐ No |
| | (b) | Violated any healthcare fraud and abuse law? | ☐ Yes* | ☐ No |
| | (c) | Entered into a criminal or civil settlement with the United States, a state, or any party acting on behalf of the United States or a state by which claims against such **Applicant** were resolved? | ☐ Yes* | ☐ No |
| **E.** | **Additional Directors & Officers Optional Coverages** | | | |
| ☐ | If a renewal quote for **EMTALA Claim** coverage is desired, tick the check box and answer the question E(1). | | | |
| 1. | Does the **Applicant** conduct annual training pursuant to a formal training plan with respect to EMTALA? | | ☐ Yes | ☐ No* |
| ☐ | If a renewal quote for **HIPAA Claim** coverage is desired, tick the check box and answer the question E(2). | | | |
| 2. | Does the **Applicant** conduct annual training pursuant to a formal training plan with respect to HIPAA/HITECH and applicable state and federal privacy and data security laws? | | ☐ Yes | ☐ No* |
| ☐ | If a renewal quote for **IRC Claim** coverage is desired, tick the check box and answer the question E(3-4). | | | |
| 3. | Are all compensation arrangements and business transactions evaluated annually for compliance with Excess Benefits Transactions rules as defined in Section 4958 of the Internal Revenue Code of 1986, as amended? | | ☐ Yes | ☐ No* |
| 4. | Has the **Applicant** been subject to an investigation or paid a fine for an Excess Benefit Transaction violation? | | ☐ Yes* | ☐ No |
| **F.** | **Directors & Officers Past Activities (other than Healthcare Fraud & Abuse Past Activities)** | | | |
| 1. | Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following: | | | |
| | (a) | Anti-trust, copyright or patent litigation? | ☐ Yes* | ☐ No |
| | (b) | Civil, criminal or administrative proceeding alleging violation of any federal or state securities law? | ☐ Yes* | ☐ No |

## V. Employment Practices Liability

| | | | | |
|---|---|---|---|---|
| ☐ | If a renewal quote for **Employment Practices Liability** coverage is desired, tick the check box and answer the questions in Sections A, B, D & E. If optional **Third Party Liability** coverage is desired, complete Section C as instructed below. | | | |
| **A.** | **Employee Information** | | | |
| 1. | Total current worldwide employees | | Number of in-house counsel | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2. | Number of employees by category: | | | | | | |
| | | **Current Year (as of MM/YYYY)** | | | **Prior Year (as of MM/YYYY)** | | |
| | **Category** | **Total** | **California** | **Foreign** | **Total** | **California** | **Foreign** |
| | Full-time (not including employed physicians) | | | | | | |
| | Part-time (not including employed physicians) | | | | | | |
| | **Independent Contractors** (other than **Independent Medical Providers**) | | | | | | |
| | Volunteers | | | | | | |
| | Employed Physicians | | | | | | |
| | **Independent Medical Providers** | | | | | | |
| 3. | Terminations & Layoffs: | | | | | | |
| | Voluntary Terminations | | | | | | |
| | Involuntary Terminations | | | | | | |
| | Layoffs (5% or more of workforce or more than 50 employees) | | | | | | |
| 4. | For the past three (3) years, list the annual percentage turnover rate of employees at all locations: | | | | | | |
| | Current Year _____% | Prior Year _____% | | Two Years Ago ____% | | | |
| 5. | Salary Ranges (provide percentage of employees who fall into the following salary ranges; should total 100%): | | | | | | |
| | Salary Range | Current Year % | | Prior Year % | | | |
| | Up to $50,000 | | | | | | |
| | $50,000 -$150,000 | | | | | | |
| | $150,000 - $250,000 | | | | | | |
| | $250,000 - $500,000 | | | | | | |
| | Over $500,000 | | | | | | |
| | Adjust part time salaries to full time equivalent. | | | | | | |
| 6. | Are any providers required to maintain credentials at any other institution as a contingency of their employment with the **Applicant**? | | | | | ☐ Yes | ☐ No |
| **B.** | **Policies and Procedures** | | | | | | |
| 1. | Does the **Applicant** have an employee handbook? | | | | | ☐ Yes | ☐ No* |
| | If "Yes," is the employee required to sign and acknowledge receipt of the handbook? | | | | | ☐ Yes | ☐ No |
| 2. | Is there a written process, policy or procedure for: | | | | | **Yes** | **No** |
| | Equal Employment Opportunity | | | | | ☐ | ☐ |
| | Anti-Discrimination | | | | | ☐ | ☐ |
| | Anti-harassment (including sexual harassment) | | | | | ☐ | ☐ |
| | Employment at Will | | | | | ☐ | ☐ |
| | Progressive Discipline And Termination | | | | | ☐ | ☐ |
| | Reporting, Investigating and Resolving Employee Grievances and Complaints (Including Anti-Retaliation) | | | | | ☐ | ☐ |
| | Employee Evaluations (written performance appraisals/reviews) | | | | | ☐ | ☐ |
| | American with Disabilities Act (ADA) Accommodation | | | | | ☐ | ☐ |
| | Family and Medical Leave Act / Pregnancy | | | | | ☐ | ☐ |
| | Background Checks in Hiring Process | | | | | ☐ | ☐ |
| | Terminations and Layoffs | | | | | ☐ | ☐ |
| | Hiring/Interviewing | | | | | ☐ | ☐ |
| 3. | Does the **Applicant** distribute and document the receipt within the employment file of the above-listed procedures to all employees? | | | | | ☐ Yes | ☐ No |
| 4. | Is an application for employment used for all prospective employees? | | | | | ☐ Yes | ☐ No |
| 5. | Does the **Applicant** conduct training for all individuals for whom it is seeking coverage other than **Independent Contractors** or **Independent Medical Providers** regarding: | | | | | ☐ Yes | ☐ No |
| | (a) Anti-discrimination and anti-harassment (including sexual harassment) policies and procedures? | | | | | ☐ Yes | ☐ No |
| | (b) Internet and social media policies and procedures? | | | | | ☐ Yes | ☐ No |
| 6. | Does the **Applicant** conduct the training described in question 5(a-b) with **Independent Contractors** (non-**Independent Medical Providers**)? | | | | | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| 7. | Does the **Applicant** conduct the training described in question 5(a-b) with **Independent Medical Providers**? | ☐ Yes | ☐ No |
| 8. | Does the **Applicant** restrict employee access to employees' personal information such as social security numbers, account information and health care information? | ☐ Yes | ☐ No |
| 9. | Does the **Applicant** obtain and use consumer, credit or social media reports on employees or new applicants for employment? | ☐ Yes | ☐ No |
| 10. | Does the **Applicant** obtain each employee or applicant's written consent prior to obtaining any such report referred to in question 9? | ☐ Yes | ☐ No |
| **C.** | **Third Party Liability** | | |
| ☐ | If a renewal quote for **Third Party Claim** coverage is desired, tick the check box and answer the questions in Section C. | | |
| 1. | Does the **Applicant** have established policies and procedures outlining employee conduct when dealing with customers, vendors, service providers, business invitees or other third parties? | ☐ Yes | ☐ No |
| 2. | Does the **Applicant** conduct training for all individuals for whom it is seeking coverage regarding anti-discrimination and anti-harassment (including sexual harassment) policies and procedures with respect to third parties? | ☐ Yes | ☐ No |
| **D.** | **Federal Contractor Information (complete if Applicant is, or has been, a federal contractor)** | | |
| 1. | Does the **Applicant** currently have an Affirmative Action Plan in place? | ☐ Yes | ☐ No |
| 2. | Has the **Applicant** been subject to an OFCCP audit? | ☐ Yes* | ☐ No |
| **E.** | **Employment Practices Past Activities** | | |
| 1. | During the past twelve (12) months has any **Applicant**, in any capacity, been involved in any of the following matters: | | |
| | (a) EEOC or any similar administrative proceeding? | ☐ Yes* | ☐ No |
| | (b) Employment or labor-related litigation or disputes resulting in payment (including defense costs) greater than $10,000? | ☐ Yes* | ☐ No |
| | (c) Any action or civil suit brought against them by any customers, vendors, service providers, business invitees or other third parties alleging harassment, discrimination, or civil rights violations? | ☐ Yes* | ☐ No |
| | (d) Any violation of, or payment of any **Claims** related to, any law governing wage, hour or payroll policies and practices? | ☐ Yes* | ☐ No |

## VI. Fiduciary Liability Information

| | |
|---|---|
| ☐ | If a renewal quote for **Fiduciary Liability** coverage is desired, tick the check box and answer the questions in Sections A & C. For **Applicants** with Defined Benefit Plans, also complete Section B. |
| For each **Fiduciary Optional Coverage** renewal quote desired, tick the corresponding check box below. | |
| ☐ | **Voluntary Compliance Notice** |
| ☐ | **HIPAA Claim** |
| ☐ | **PPACA Claim** |
| ☐ | **IRC 4975 Claim** |
| ☐ | **ERISA 502(c) Claim** |
| ☐ | **PPA Claim** |
| **A.** | **Plan Information** |
| 1. | Provide the following information for each **Plan** to be covered: |

| Plan Names | Plan Assets (current year) | Type of Plan* | Number of Participants | Plan Status** | Funded Status (if DB Plan) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Defined Benefit (DB), Defined Contribution (DC), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP), Church Plan (CP), Other (O) – Attach Explanation | ** Active (A), Merged (M), Sold (S), Terminated (T), Frozen (F)

| | | | |
|---|---|---|---|
| 2. | Are any **Plan** assets invested in the **Applicant's** own securities? | ☐ Yes | ☐ No |
| 3. | Are any **Plan** assets managed by an independent investment manager? | ☐ Yes | ☐ No* |
| | (a) If "Yes," how often is the investment manager's performance reviewed? _____ | | |
| | (b) If "Yes," how often are requests for proposals issued? _____ | | |
| 4. | Does the **Applicant** handle any investment decisions in-house? | ☐ Yes* | ☐ No |
| 5. | Are any **Plans** managed by a third-party administrator? | ☐ Yes | ☐ No |
| | (a) If "Yes," how often is the third-party administrator's performance reviewed? _____ | | |

| | | | |
|---|---|---|---|
| | (b) If "Yes," how often are requests for proposals issued? _____ | | |
| 6. | Does the **Applicant** perform regular audits to assess whether investment, administrative and recordkeeping fees are not excessive and are comparable to benchmarking data? | ☐ Yes | ☐ No* |
| 7. | Is each **Plan** reviewed at least annually to ensure there are no violations of any **Plan** agreements or ERISA (e.g. prohibited transactions or party-in-interest rules)? | ☐ Yes | ☐ No* |
| 8. | Are any **Plans** currently not in compliance with **Plan** agreements or ERISA? | ☐ Yes* | ☐ No |
| 9. | During the past twelve (12) months, has the **Applicant** merged, terminated or frozen any **Plan**? | ☐ Yes | ☐ No |
| | If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance. | | |
| 10. | During the past twelve (12) months, has there been any amendment to any **Plan**, or has any amendment been contemplated, that resulted in or may result in any change or reduction of benefits, including but not limited to an increase in participants' share of costs? | ☐ Yes* | ☐ No |
| 11. | Are all **Plans** compliant with the Health Insurance Portability and Accountability Act (HIPAA)? | ☐ Yes | ☐ No* |
| **B.** | **Defined Benefit Plans** | | |
| | **Applicants** with Defined Benefit Plans please complete this Section. | | |
| 1. | Has an actuary certified that all Defined Benefit Plans are adequately funded in accordance with ERISA or any applicable similar law of the United States, or any state or other jurisdiction anywhere in the world? | ☐ Yes | ☐ No* |
| 2. | Has any Defined Benefit Plan received an adverse opinion as to its financial condition by an independent public accountant? | ☐ Yes* | ☐ No |
| 3. | Are there overdue employer contributions for any Defined Benefit Plan or has a waiver of contributions been requested? | ☐ Yes* | ☐ No |
| 4. | Does the **Applicant** have plans to convert any Defined Benefit Plan to a cash balance plan within the next twelve (12) months? | ☐ Yes* | ☐ No |
| 5. | Is there ERISA fidelity bond coverage currently in place with respect to any **Plan**? | ☐ Yes | ☐ No |
| 6. | Please attach audited pension financial statements for each Defined Benefit Plan. | | |
| **C.** | **Past Activities** | | |
| 1. | Has the **Applicant** or any **Plan** experienced an event reportable to the PBGC or been the subject of an investigation by the DOL, the IRS or any similar foreign agency in the last twelve (12) months? | ☐ Yes* | ☐ No |
| 2. | Has any fiduciary been accused, found guilty or held liable for a breach of trust? | ☐ Yes* | ☐ No |
| 3. | Has any fiduciary been convicted of criminal conduct? | ☐ Yes* | ☐ No |
| 4. | Have any **Claims** (other than for benefits) been made during the past twelve (12) months against any benefit program or any current or past fiduciaries? | ☐ Yes* | ☐ No |
| 5. | Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any **Plan**? | ☐ Yes* | ☐ No |

## VII. Crime Non-Liability Information

| | |
|---|---|
| ☐ | If a renewal quote for any **Crime Non-Liability** coverage is desired, tick the check box and answer the questions in Section A below. *Complete the "Social Engineering Fraud Supplemental Application" if a quote for **Social Engineering Fraud** coverage is desired. |

For each **Crime Optional Coverage** renewal quote desired, tick the corresponding check box below.

| | | | |
|---|---|---|---|
| ☐ | **Employee Theft** | ☐ | **Funds Transfer Fraud** |
| ☐ | **Premises** | ☐ | **Money Orders & Counterfeit Currency Fraud** |
| ☐ | **In Transit** | ☐ | **Credit Card Fraud** |
| ☐ | **Forgery** | ☐ | **Client** |
| ☐ | **Computer Fraud** | ☐ | **Social Engineering Fraud** |
| ☐ | **Expense** | | |

| | | | |
|---|---|---|---|
| **A.** | **Crime Information** | | |
| 1. | Are the **Applicant's** annual financial statements prepared by an independent CPA? | ☐ Yes | ☐ No |
| 2. | Has an outside audit identified any material weaknesses in the **Applicant's** (including any organization applying for coverage) system of internal controls? | ☐ Yes | ☐ No |
| | If "Yes," provide a copy of the audit and management's response. | | |
| 3. | Has the **Applicant** implemented all recommendations to correct such weaknesses? | ☐ Yes | ☐ No* |

| | | | | |
|---|---|---|---|---|
| 4. | Does someone other than the person responsible for reconciling bank accounts: | | | |
| | (a) | Make Deposits? | ☐ Yes | ☐ No* |
| | (b) | Make Withdrawals? | ☐ Yes | ☐ No* |
| | (c) | Sign Checks? | ☐ Yes | ☐ No* |
| 5. | What is the limit above which the **Applicant** requires countersignature for their checks? | | $_____ | |
| 6. | Do employees have access to resident's bank accounts? | | ☐ Yes* | ☐ No |
| 7. | Are funds established with resident's petty cash for incidental items? | | ☐ Yes | ☐ No |
| 8. | Is an itemized inventory of resident or patient property maintained and witnessed by at least two persons? | | ☐ Yes | ☐ No* |
| 9. | Are the **Applicant's** internal controls such that no employee can control a process from beginning to end (e.g. approve a voucher and request and sign a check or initiate a wire transfer)? | | ☐ Yes | ☐ No* |
| 10. | Does the **Applicant** have a process to detect fictitious employees in its payroll system? | | ☐ Yes | ☐ No* |
| 11. | Does the **Applicant** conduct background screening (including criminal, credit and prior employment checks) on all prospective employees? | | ☐ Yes | ☐ No* |
| 12. | Does the **Applicant** maintain an internal fraud hot-line for employees to report suspicious activity? | | ☐ Yes | ☐ No* |
| 13. | Does the **Applicant** use a Positive Pay System? | | ☐ Yes | ☐ No* |
| 14. | Are the **Applicant's** internal controls such that no one employee can add a vendor to the master vendor list or have the ability to edit or amend any information relating to a current vendor? | | ☐ Yes | ☐ No |
| | If "No," please explain the controls in place to prevent the authorization and/or billing to fictitious vendors in an attachment. | | | |
| 15. | Are background checks performed on vendors in order to determine ownership and financial capability prior to doing business with them? | | ☐ Yes | ☐ No* |
| 16. | Is an authorized vendor list utilized by the **Applicant** and updated annually for all purchases, with competitive bidding required over stated amounts? | | ☐ Yes | ☐ No* |
| 17. | Does the **Applicant** have inventory? If "Yes," please answer the following: | | | |
| | (a) | Does the **Applicant** have physical safeguards such as surveillance, security and lockup procedures? | ☐ Yes | ☐ No* |
| | (b) | How often, and by whom, are inventory (including but not limited to pharmaceuticals and other controlled substances) counts conducted? _____ | | |
| | (c) | Is inventory audited and counted by someone other than the person in charge of the daily management of the inventory? | ☐ Yes | ☐ No* |
| | (d) | Are pharmaceuticals and other controlled substances stored in locked spaces? | ☐ Yes | ☐ No* |
| 18. | Please provide a list of all **Applicant** employee welfare or retirement plans that are required to be bonded by ERISA. | | | |
| 19. | If applying for **Client** Coverage, please answer the following: | | | |
| | (a) | Please describe the services the **Applicant** provides for **Clients**: _____ | | |
| | (b) | Does the **Applicant** have custody or control over any funds, accounts, or materials of any of its **Clients**? If "Yes," please attach a description. | ☐ Yes | ☐ No |
| **B.** | **Crime Past Activities** | | | |
| | Has the **Applicant** or any proposed **Insured** sustained any crime-related losses in the past twelve (12) months? If "Yes," please provide a full explanation in a separate attachment. | | ☐ Yes | ☐ No |

## VIII. Increased Limits Representation Statement

Solely with respect to any increased limit requested or that ultimately may be issued for the proposed renewal, no **Insured** proposed for coverage has knowledge of any **Wrongful Act,** fact, circumstance, situation, transaction or event which could reasonably be expected to give rise to any future **Claim** or loss except as follows:

☐ None, or ☐ Yes, (If "Yes," provide full details on a separate sheet.)

Solely with respect to any increased limit requested or that ultimately may be issued for the proposed renewal, and without prejudice to any other rights and remedies of the **Insurer**, it is agreed by all concerned that if any such **Wrongful Act**, fact, circumstance, situation, transaction or event exists, whether or not disclosed above, any **Claim** or loss arising from such **Wrongful Act**, fact, circumstance, situation, transaction or event shall be excluded from coverage under the proposed **Policy**.

## IX. Applicant Representations, Fraud Warnings and Signatures

**THE SIGNING OF THIS APPLICATION DOES NOT BIND THE INSURER TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE INSURER SHALL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.**

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT ACKNOWLEDGES THAT ITS BROKER/PRODUCER IS NOT APPOINTED BY THE INSURER AND IS ACTING AS THE APPLICANT'S REPRESENTATIVE, AUTHORIZED TO PRESENT THIS APPLICATION ON THE APPLICANT'S BEHALF TO THE INSURER. IN THIS CAPACITY THE BROKER/PRODUCER HAS NO UNDERWRITING OR BINDING AUTHORITY WITH THE INSURER AND CANNOT BIND COVERAGE OR MODIFY THIS APPLICATION OR ANY INSURANCE POLICY. ANY BINDER OR POLICY MODIFICATION SHALL BE VALID ONLY IF ISSUED BY THE INSURER. APPLICANT FURTHER ACKNOWLEDGES THAT ANY FEES THAT IT PAYS TO THE BROKER/PRODUCER FOR THIS SERVICE IS AGREED TO IN WRITING BETWEEN APPLICANT AND THE BROKER/PRODUCER.**

### FRAUD WARNINGS

**Notice to Arkansas, Minnesota, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

**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 Kentucky Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Notice to Louisiana 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 fines and confinement in prison.

**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 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 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:** 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.

**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.

**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.

## SIGNATURES

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED APPLICATION FOR INSURANCE AND IN ANY MATERIALS SUBMITTED WITH THIS APPLICATION ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY THE INSURER. IF THE INFORMATION IN THE APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT SHALL NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE INSURER IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.**

**THE INFORMATION REQUESTED IN THIS APPLICATION IS FOR UNDERWRITING PURPOSES ONLY AND DOES NOT CONSTITUTE NOTICE TO THE INSURER UNDER ANY POLICY OF ANY ACTUAL OR POTENTIAL CLAIM OR LOSS.**

**THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER (OR THE FUNCTIONAL EQUIVALENT) OF THE APPLICANT. BY SIGNING THIS APPLICATION, THE UNDERSIGNED AUTHORIZED REPRESENTATIVE AGREES TO CONDUCT ELECTRONIC COMMERCE AND TO ACCEPT AN ELECTRONIC INSURANCE POLICY AND OTHER DOCUMENTS ISSUED BY THE INSURER. THE UNDERSIGNED AUTHORIZED REPRESENTATIVE ACKNOWLEDGES THAT HE OR SHE MAY REQUEST A WRITTEN (PAPER) POLICY.**

| SIGNATURE OF INSURED AUTHORIZED REPRESENTATIVE | |
|---|---|
| **SIGNATURE** | |
| **PRINTED NAME** | |
| **DATE** | |
| **TITLE** | |

| INSURED'S AUTHORIZED REPRESENTATIVE (AGENT/BROKER) | |
|---|---|
| **SIGNATURE** | |
| **STATE PRODUCER LICENSE NUMBER** | |
| **PRINTED NAME** | |
| **AGENCY NAME AND PHONE NUMBER** | |
| **DATE** | |

**UTAH APPLCANTS ONLY (NO SIGNATURE REQUIRED)**

**ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE INSURER. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES IF ALLOWED BY STATE LAW AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.**

**ARKANSAS, MISSOURI, NEW MEXICO, NORTH DAKOTA AND WYOMING APPLICANTS ONLY**

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT HEREBY ACKNOWLEDGES THAT HE/SHE IS AWARE THAT THE LIMIT OF LIABILITY CONTAINED IN THIS POLICY SHALL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED, BY THE COSTS OF LEGAL DEFENSE AND, IN SUCH EVENT, THE INSURER SHALL NOT BE LIABLE FOR THE COSTS OF LEGAL DEFENSE OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT SUCH EXCEEDS THE LIMIT OF LIABILITY OF THIS POLICY.**

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT HEREBY FURTHER ACKNOWLEDGES THAT HE/SHE IS AWARE THAT LEGAL DEFENSE COSTS THAT ARE INCURRED SHALL BE APPLIED AGAINST THE RETENTION AMOUNT.**

| SIGNATURE OF INSURED AUTHORIZED REPRESENTATIVE | |
|---|---|
| **SIGNATURE** | |
| **PRINTED NAME** | |
| **DATE** | |
| **TITLE** | |