

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 INSURED 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							
Coverage Requested	Limit Requested	Retention Requested	Shared Limit Requested	Current Limit	Current Retention	Current Premium	Current Carrier
<input type="checkbox"/> Directors & Officers Liability	\$	\$	<input type="checkbox"/>	\$	\$	\$	
<input type="checkbox"/> Employment Practices Liability	\$	\$	<input type="checkbox"/>	\$	\$	\$	
<input type="checkbox"/> Fiduciary Liability	\$	\$	<input type="checkbox"/>	\$	\$	\$	
<input type="checkbox"/> Crime	\$	\$		\$	\$	\$	

MISSOURI APPLICANTS: DO NOT ANSWER QUESTIONS II(1) AND II(2):

1.	Has the Applicant been canceled or non-renewed for any of the insurance coverages listed above?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
2.	Has any insurer for any coverages listed above indicated an intent not to offer renewal terms to the Applicant ?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

III. General Risk Information					
1.	NAICS Code that describes main operations (6 Digit)				
2.	Applicant's business and operations include the following (check all that apply):				
	<input type="checkbox"/> Home Healthcare	<input type="checkbox"/> Hospital	<input type="checkbox"/> Long Term Care		
	<input type="checkbox"/> Managed Care	<input type="checkbox"/> Other Ambulatory Healthcare	<input type="checkbox"/> Physician Group or Clinic		
	<input type="checkbox"/> Social Services	<input type="checkbox"/> Surgery Center	<input type="checkbox"/> Other (describe below)		
3.	Provide description of the Applicant's business, including any explanation if "Other" was checked above: _____ _____ _____				
4.	List all states and countries in which the Applicant operates: _____				
5.	Applicant (as set forth in question I(1)) is:				
(a)	Tax Status				
	<input type="checkbox"/> Not-For-Profit Tax Exempt 501(c)(3)	<input type="checkbox"/> For Profit - Private			
	<input type="checkbox"/> Not-For-Profit Taxable	<input type="checkbox"/> For Profit - Public			
(b)	Organizational Structure				
	<input type="checkbox"/> Not-For-Profit Corporation	<input type="checkbox"/> S-Corporation			
	<input type="checkbox"/> Professional Corporation (PC, PA)	<input type="checkbox"/> C-Corporation			
	<input type="checkbox"/> Partnership (GP, LLP)	<input type="checkbox"/> Joint Venture			
	<input type="checkbox"/> Limited Partnership (LP)	<input type="checkbox"/> Other (describe) _____			
	<input type="checkbox"/> 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.					
6.	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?			<input type="checkbox"/> Yes*	<input type="checkbox"/> No
7.	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. _____				
8.	Do any of the Applicant's subsidiaries act as a general partner for another organization? *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 : _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Does the Applicant have any subsidiaries, joint ventures or non-owned entities under management control? If "Yes," please attach an organizational chart reflecting ownership, a description of operations, and the tax status of each such entity. Indicate whether coverage is requested for each such entity.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Applicant's Accreditation (check all that apply):		<input type="checkbox"/> JCAHO	<input type="checkbox"/> NCQA	<input type="checkbox"/> URAC
	(a) Has any Applicant's license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No	
11.	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(d)	Has the Applicant ever received a qualified opinion from its auditors?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
Please attach a copy of the Applicant's financial statements for the last two (2) years (audited statements, if done).				
12.	Has the Applicant completed in the past eighteen (18) months, or proposed or contemplated in the next twelve (12) months, any of the following:			
	(a)	Merger, acquisition or consolidation of any type?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(b)	Sale, Distribution or Divestiture of Assets or Stock?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(c)	A change in outside auditor?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(d)	Branch, location, facility, office, or subsidiary closings, layoffs or reductions in force?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(e)	Reorganization or arrangement with creditors under federal or state law?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(f)	Undertaking any new areas of business?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(g)	Entering into new governmental contracts?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
	(h)	Conversion from Not-For-Profit to For-Profit status?	<input type="checkbox"/> Past 18	<input type="checkbox"/> Next 12 <input type="checkbox"/> No
If the Applicant checked any of the "Past 18" or "Next 12" check boxes in response to question 12, please describe the material terms of each such transaction or event on a separate attachment.				
13.	Does the Applicant currently purchase medical professional liability coverage?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
14.	Does the Applicant have coverage for peer review and credentialing activities under any insurance policy, self-insured trust, captive, risk sharing arrangement or pool?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Submission Attachments	
In addition to any attachments that are requested throughout this Application , please submit the following:	
<ul style="list-style-type: none"> Loss runs for the past five (5) years from any carrier for which coverage is requested and is a direct or indirect replacement; and Summary and status report of any litigation filed in the last five (5) years against any person or entity proposed for insurance including any litigation that is resolved, which is not included in the loss runs but may be covered under any of the coverage section(s) requested. 	

IV. Directors & Officers Liability Information				
<input type="checkbox"/>	If a 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.	Do you have a board of directors or equivalent?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
2.	Please indicate the number of authorized _____ and currently filled _____ board seats (or equivalent).			
3.	Are these positions <input type="checkbox"/> elected or <input type="checkbox"/> appointed? If "appointed," please attach an explanation.			
4.	In the past twenty-four (24) months has the Applicant completed any change in directors other than due to term expiration or death?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
5.	Total number of outstanding shares or ownership instrument equivalents: _____			
* Whenever used in the Application , the term <i>shares</i> or <i>shareholders</i> shall also include the equivalent ownership interest in organizations other than stock based corporations.				
6.	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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Name of Shareholder	Ownership %	Director or Officer?	Family Relationship?
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
		%	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
If any individual listed above is related by family to another shareholder, director or officer of the Applicant , please tick the corresponding check box.				
7.	Has any shareholder changed their ownership percentage by more than five percent (5%) in the last year?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No

8.	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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b)	In the past twenty-four (24) months has the Applicant had any change in executive officers?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c)	In the past twenty-four (24) months has the Applicant completed any:			
	(i) Public or private offering of securities?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(ii) Issuance of debt?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d)	Is the Applicant currently anticipating any of the above?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.			
9.	Does the Applicant have a conflict of interest policy in place applicable to all directors, officers and trustees?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Does the Applicant have a cybersecurity program in place that covers all aspects of cyber and data security, including Personal Health Information?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
11.	Does the Applicant currently purchase cyber/data security insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If "Yes," please attach a description of the insurance program (carriers, limits, etc.).			
B.	Antitrust			
<input type="checkbox"/>	If a 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?		<input type="checkbox"/> Yes*	<input type="checkbox"/> 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.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b)	Health care services.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If "Yes" to question 2(a) or (b) above, please attach market share percentage(s).			
3.	Does the Applicant have any provider agreements that contain non-compete clauses?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
4.	Does the Applicant have any provider agreements that contain "Most Favored" pricing clauses?		<input type="checkbox"/> Yes*	<input type="checkbox"/> No
C.	Provider Selection			
<input type="checkbox"/>	If a quote for Provider Selection Claim coverage is desired, tick the check box and answer the questions in Section C.			
1.	Does the Applicant perform Provider Selection (i.e. peer review and credentialing) for its health care staff, whether or not such staff is employed by the Applicant ?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(a)	Does the Applicant have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and decisions that could adversely affect health care staff membership, privileges or licensing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b)	Does the Provider Selection process include querying the National Practitioner Data Bank?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c)	Is legal counsel consulted before any recommendation or decision is finalized that could adversely affect health care staff membership, privileges or licensing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	(a) Within the last two (2) years 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? If "Yes," please attach details including the number of providers impacted.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(b) Are there any formal plans for future closings or restrictions, as described in C(2)(a) above?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(c) If the answer to any part of question C(2) is "Yes," has the Applicant consulted with legal counsel regarding proper procedures and safeguards prior to any such instance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
D.	Healthcare Fraud & Abuse			
<input type="checkbox"/>	If a 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,":		<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
(c)	Does this individual have direct access to the Board?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*
3.	Does the Applicant provide compliance training and education to all employees, Independent Contractors and independently practicing medical providers?		<input type="checkbox"/> Yes	<input type="checkbox"/> No*

4.	Does the Applicant provide annual training and education to employees, Independent Contractors and independently practicing medical providers who do billing and coding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
5.	Does the Applicant conduct an annual, internal review of its billing and coding for compliance with applicable laws and regulations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
6.	Does the Applicant have policies that address the protection of whistleblowers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
7.	Does the Applicant utilize an external audit firm to monitor billing and coding compliance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
8.	Does the Applicant utilize billing edit/checking software?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
9.	Does the Applicant centralize its billing and coding function?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
10.	Does the Applicant maintain a procedure, such as a hotline, to receive complaints and allegations of regulatory non-compliance or wrongdoing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
	(a) If "Yes," what is the average number of complaints or allegations per month? _____		
	(b) Are all complaints recorded and investigated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
11.	Healthcare Fraud & Abuse Past Activities		
	In the past five (5) years, 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?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	ii. Ethics in Patient Referrals Act of 1986 (Stark Law) or any similar federal, state, or local statutory or common law?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	iii. Any other similar federal, state, or local statutory or common law, rules or regulation?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	(b) Violated any healthcare fraud and abuse law?	<input type="checkbox"/> Yes*	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
E. Additional Directors & Officers Optional Coverages			
<input type="checkbox"/>	If a 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
<input type="checkbox"/>	If a 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
<input type="checkbox"/>	If a quote for IRC Claim coverage is desired, tick the check box and answer the questions 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
4.	Has the Applicant been subject to an investigation or paid a fine for an Excess Benefit Transaction violation?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
F. Directors & Officers Past Activities (other than Healthcare Fraud and 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 in the past five (5) years:		
	(a) Anti-trust, copyright or patent litigation?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	(b) Deceptive or unfair trade practices or consumer fraud?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	(c) Civil, criminal or administrative proceeding alleging violation of any federal or state securities law?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
	(d) Any other criminal action?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
2.	Other than those identified in your response to question F(1), has any Claim that might be covered by this Policy been brought at any time during the last five (5) years against, (i) any Applicant or (ii) any proposed Insured Person in his or her capacity as a director or officer of any entity?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

V. Employment Practices Liability Information							
<input type="checkbox"/>	If a 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:						
	Category	Current Year (as of MM/YYYY)			Prior Year (as of MM/YYYY)		
		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 ?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Policies and Procedures							
1.	Does the Applicant have an employee handbook?					<input type="checkbox"/> Yes	<input type="checkbox"/> No*
	If "Yes," is the employee required to sign and acknowledge receipt of the handbook?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Is there a written process, policy or procedure for:					Yes	No
	Equal Employment Opportunity					<input type="checkbox"/>	<input type="checkbox"/>
	Anti-Discrimination					<input type="checkbox"/>	<input type="checkbox"/>
	Anti-Harassment (including sexual harassment)					<input type="checkbox"/>	<input type="checkbox"/>
3.	Does the Applicant conduct anti-discrimination and anti-harassment (including sexual harassment) training for all individuals for whom it is seeking coverage including Independent Contractors or Independent Medical Providers ?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Does the Applicant restrict employee access to employees' personal information such as social security numbers, account information and health care information?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Third Party Liability							
<input type="checkbox"/>	If a 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?					<input type="checkbox"/> Yes	<input type="checkbox"/> 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?					<input type="checkbox"/> Yes	<input type="checkbox"/> No

D.	Employment Practices Past Activities		
1.	During the past three (3) years has any Applicant , in any capacity, been involved in any of the following matters:		
(a)	EEOC or any similar administrative proceeding?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
(b)	Employment or labor-related litigation or disputes resulting in payment (including defense costs) greater than \$10,000 during the last five (5) years?	<input type="checkbox"/> Yes*	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
(d)	Any violation of, or payment of any Claims related to, any law governing wage, hour or payroll policies and practices?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

VI. Fiduciary Liability Information					
<input type="checkbox"/> If a 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 quote desired, tick the corresponding check box below.					
<input type="checkbox"/>	Voluntary Compliance Notice	<input type="checkbox"/>	IRC 4975 Claim		
<input type="checkbox"/>	HIPAA Claim	<input type="checkbox"/>	ERISA 502(c) Claim		
<input type="checkbox"/>	PPACA Claim	<input type="checkbox"/>	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.	Does the Applicant handle any investment decisions in-house?				<input type="checkbox"/> Yes* <input type="checkbox"/> No
3.	Are any Plans currently not in compliance with Plan agreements or ERISA?				<input type="checkbox"/> Yes* <input type="checkbox"/> No
4.	In the past three (3) years, has the Applicant merged, terminated or frozen any Plan ?				<input type="checkbox"/> Yes <input type="checkbox"/> 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.				
5.	Are all Plans compliant with the Health Insurance Portability and Accountability Act (HIPAA)?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No*
2.	Is there ERISA fidelity bond coverage currently in place with respect to any Plan ?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Please attach audited pension financial statements for each Defined Benefit Plan.				
C. Fiduciary 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 three (3) years?				<input type="checkbox"/> Yes* <input type="checkbox"/> No
2.	Has any fiduciary been accused, found guilty or held liable for a breach of trust?				<input type="checkbox"/> Yes* <input type="checkbox"/> No
3.	Has any fiduciary been convicted of criminal conduct?				<input type="checkbox"/> Yes* <input type="checkbox"/> No
4.	Have any Claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries?				<input type="checkbox"/> Yes* <input type="checkbox"/> 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 ?				<input type="checkbox"/> Yes* <input type="checkbox"/> No

VII. Crime Non-Liability Information			
<input type="checkbox"/>	If a 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 is desired.		
For each Crime Optional Coverage quote desired, tick the corresponding check box below.			
<input type="checkbox"/>	Employee Theft	<input type="checkbox"/>	Funds Transfer Fraud
<input type="checkbox"/>	Premises	<input type="checkbox"/>	Money Orders & Counterfeit Currency Fraud
<input type="checkbox"/>	In Transit	<input type="checkbox"/>	Credit Card Fraud
<input type="checkbox"/>	Forgery	<input type="checkbox"/>	Client
<input type="checkbox"/>	Computer Fraud	<input type="checkbox"/>	Social Engineering Fraud*
<input type="checkbox"/>	Expense		
A. Crime Information			
1.	Does someone other than the person responsible for reconciling bank accounts make deposits, withdrawals or sign checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
2.	What is the limit above which the Applicant requires countersignature for their checks?	\$ _____	
3.	Do employees have access to resident's bank accounts?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
4.	Does the Applicant conduct background screening (including criminal, credit and prior employment checks) on all prospective employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
5.	Does the Applicant use a Positive Pay System?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
6.	Does the Applicant have inventory? If "Yes," please answer the following:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	(a) Does the Applicant have physical safeguards such as surveillance, security and lockup procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
	(d) Are pharmaceuticals and other controlled substances stored in locked spaces?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*
7.	If applying for Client Coverage, please answer the following:		
	(a) 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Crime Past Activities			
	Has the Applicant or any proposed Insured sustained any crime-related losses in the past three (3) years? If "Yes," please provide a full explanation in a separate attachment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VIII. Warranty Statement	
	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:
<input type="checkbox"/> None, or	<input type="checkbox"/> Yes, (If "Yes," provide full details on a separate sheet.)
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	
<p>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.</p>	
<p>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</p>	

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	
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
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)	
<p>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.</p>	
ARKANSAS, MISSOURI, NEW MEXICO, NORTH DAKOTA AND WYOMING APPLICANTS ONLY	
<p>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.</p>	
<p>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.</p>	
SIGNATURE OF INSURED AUTHORIZED REPRESENTATIVE	
SIGNATURE	
PRINTED NAME	
DATE	
TITLE	