

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.

Renewal Submission Attachments

- In addition to any attachments that are requested throughout this **Application**, please submit the following:
- Please attach a copy of the **Applicant's** financial statements for the last two (2) years (audited statements, if done).

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," please provide details in a separate attachment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If any Requested Limit exceeds a corresponding Expiring Limit, a separate Increased Limits Warranty Statement is required. Please contact the company for the current Increased Limits Warranty Statement.</i>			

III. General Risk Information

1.	Have the Applicant's main business operations changed in the past twelve (12) months? If "Yes," please provide details in a separate attachment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Applicant's Accreditation (check all that apply):	<input type="checkbox"/> JCAHO	<input type="checkbox"/> NCQA
	(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"/> URAC	<input type="checkbox"/> Other:
3.	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:	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

(a)	Merger, acquisition or consolidation of any type?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(b)	Sale, distribution or divestiture of assets or stock?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(c)	Public or private offerings of security or debt?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(d)	Breach or violation of any debt covenants?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(e)	A change in outside auditor?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(f)	Reorganization or arrangement with creditors under federal or state law?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(g)	Undertaking any new areas of business?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(h)	Entering into new governmental contracts?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(i)	Conversion from not-for-profit to for-profit status?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(j)	Branch, location, facility, office, or subsidiary closings, layoffs or reductions in force?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
(k)	Change in senior executive officers for reasons other than illness?	<input type="checkbox"/> Past 12	<input type="checkbox"/> Next 12	<input type="checkbox"/> No
If the Applicant checked any of the "Past 12" or "Next 12" check boxes in response to question 12, please describe the material terms of each such transaction or event in a separate attachment.				
4.	Does the Applicant currently purchase medical professional liability coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*	
5.	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	

IV. Directors & Officers and Entity Liability Information

If a renewal quote for **Directors & Officers and Entity Liability** Coverage Section is desired, tick the check box and answer the questions in Section A-E.

A. Ownership & Control

1. Have there been any changes in the board of directors (or equivalent) of the **Applicant** within the past twelve (12) months for reasons other than death or retirement? Yes* No

2. Has any shareholder changed their ownership percentage by more than five percent (5%) in the last year? Yes* No

3. 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?	
	%	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	%	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	%	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	%	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. Does the **Applicant** have a cybersecurity risk management plan in place that covers all aspects of cyber data privacy and security, including Personal Health Information (PHI)? Yes No*

5. Does the **Applicant** currently purchase cyber/data security insurance? Yes No

If "Yes," please provide a description of the insurance program:

Carrier	Limit Purchased	Effective Date	Expiration Date

B. Antitrust

1. Has the **Applicant** made any changes to existing exclusive contracts with any providers or entered into any new such contracts? 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. Does the **Applicant** have any provider agreements that contain non-compete clauses? Yes* No

4. Does the **Applicant** have any provider agreements that contain "Most Favored" pricing clauses? Yes* No

C. Provider Selection

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?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
D. Healthcare Fraud & Abuse			
1.	During the past twelve (12) months, have there been any changes to the formal compliance program? Most recently revised date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*
(d)	How frequently does the board receive reports about compliance issues?		
E. Additional Directors & Officers Optional Coverages			
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"/> N/A
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"/> N/A
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* <input type="checkbox"/> N/A
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 <input type="checkbox"/> N/A

V. Employment Practices Liability Information										
If a renewal quote for Employment Practices Liability Coverage Section is desired, tick the check box and answer the questions in Sections A-C.										
A. Employee Information										
1.	Total current worldwide employees		Number of in-house counsel							
2.	Number of employees by category:		Current Year (as of MM/YY)			Prior Year (as of MM/YY)				
	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 Prior	%				
5.	Annual Compensation Range*† (provide percentage of employees who fall into the following annual compensation ranges; should total 100%):									
	Annual Compensation Range		Current Year %			Prior Year %				
	Up to \$50,000									
	\$50,000 - \$150,000									
	\$150,000 - \$250,000									
	\$250,000 - \$500,000									
	Over \$500,000									
	*Annual compensation means: (a) the most current annual base salary, or annualized compensation pursuant to written agreement; plus (b) the annualized amount of any performance-based cash commissions or bonuses.									
	†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, Procedures and Risk Management			
1.	During the past twelve (12) months, has the Applicant made amendments to any human resources policies or procedures or employee handbook?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
2.	Were any employment practices risk management resources used, including <i>Script curated for Berkley Healthcare</i> , to improve or update the Applicant's risk management program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For more information regarding <i>Script curated for Berkley Healthcare</i> , visit www.bhcscrip.com			
C. Third Party Liability			
1.	During the past twelve (12) months, has the Applicant made amendments to any 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

VI. Fiduciary Liability Information

If a renewal quote for Fiduciary Liability Coverage Section is desired, tick the check box and answer the questions in Section A.						
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 twelve (12) months, 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*
6.	Is there ERISA fidelity bond coverage currently in place with respect to any Plan ?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Defined Benefit Plans (For Applicants with defined benefit plans, 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.	Please attach audited pension financial statements for each defined benefit plan.					

VII. Crime Non-Liability Information

If a renewal quote for any Crime Non-Liability Coverage Section is desired, tick the check box and answer the questions in Section A.						
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.	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*
4.	Does the Applicant have pharmaceutical 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 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*
5.	Does the Applicant allow employees to make changes to vendor or supplier details (including routing numbers, account numbers, telephone numbers, and contact information) without confirming those changes with a direct call using only the contact number previously provided by the vendor or supplier before the request was received?				<input type="checkbox"/> Yes*	<input type="checkbox"/> No
6.	Does the Applicant require that all outgoing payments or funds transfers be subject to dual authorization by at least one executive after being initiated by a third employee?				<input type="checkbox"/> Yes	<input type="checkbox"/> No*
7.	Does the Applicant have custody or control over any funds, accounts, or materials of any of its Clients ? If "Yes," please provide a description.				<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 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 (in Alabama, additionally restitution).

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 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, CHIEF FINANCIAL OFFICER, GENERAL COUNSEL (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 APPLICANTS 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.