Application for:
MISCELLANEOUS ERRORS AND OMISSIONS FOR HEALTHCARE PROFESSIONALS LIABILITY

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

Return Applications to:
Rockwood Programs, Inc.
3001 PhiladelphiaPike,
Claymont, DE 19703
Tel: 800-365-0816
Fax: 302-764-9125
www.rockwoodinsurance.com

Notice: The Policy for which this Application is made, subject to its terms, applies only to any Claim (as applicable in the Coverage Section for which application is made) made against any of the Insureds during the Policy Period. The Limit of Liability available to pay damages or settlements shall be reduced and may be exhausted by amounts incurred as Costs, Charges and Expenses (as defined in the Coverage Section for which application is made), and Costs, Charges and Expenses shall be applied to the retentions. Submission of this Application does not guarantee coverage.

1. Name of Applicant: _____
(as it should appear on the policy)

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Website: _____

2. Is firm: ☐ Corporation ☐ Partnership ☐ Individual ☐ LLC ☐ Publicly traded
☐ For Profit ☐ Not for Profit ☐ Other _____

3. Date the Applicant's firm was established: _____/_____/_____

4. If coverage is desired for any other entities (subsidiaries, common ownership, joint ventures), please specify below. Please use an additional page, if necessary.

Name and Address	Relationship to Applicant	Description of Operations	Percent Owned

5. Total Expected Revenue for the upcoming policy period: $ _____

Current Year: $ _____ Last Year: $ _____

6. Describe the following financial information of the Applicant for the most recent fiscal year end.

a) Total Assets: $ _____

b) Net Income: ☐ or Net Loss: ☐ $ _____
(check one)

c) Equity: $ _____

d) Fiscal year ending: 20_____

7. Services to be Covered:

Services	Yes	No	% of Revenue
Actuarial analysis	☐	☐	%
Advertising/marketing of healthcare plans/products	☐	☐	%
Billing/Coding/Reimbursement consulting	☐	☐	%
Case management	☐	☐	%
Claims handling/adjustment of benefits	☐	☐	%
Credentialing/peer review	☐	☐	%
Development/implementation of clinical guidelines	☐	☐	%
Disease management	☐	☐	%
Expert Witness services	☐	☐	%
Healthcare, wellness education	☐	☐	%
Independent medical exams	☐	☐	%
Medical billing	☐	☐	%
Physician practice/office management (please describe):	☐	☐	%
Utilization review	☐	☐	%
☐ Other (please describe):			%

8. Are other services provided for which coverage is not desired? ☐ Yes ☐ No
   If "Yes", please describe services and indicate percent of the Applicant's total revenue:

   _____ _____%

9. Does the Applicant have any direct patient contact? ☐ Yes ☐ No

10. Does the Applicant entity or any persons proposed for coverage provide medical services? ☐ Yes ☐ No

11. Does the Applicant maintain all licenses as required by any federal, state or local government? ☐ Yes ☐ No

12. Within the next 18 months, does the Applicant anticipate any:
    a) private debt equity offering of securities? ☐ Yes ☐ No
    b) public offering of securities? ☐ Yes ☐ No

13. Is the Applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company? ☐ Yes ☐ No
    If "Yes", please list all affiliations:

    _____

14. Has the name of the firm ever changed, or has any merger or consolidation ever taken place? ☐ Yes ☐ No
    If "Yes", please provide details including dates and any liabilities assumed:

    _____

    _____

15. Does anyone affiliated with the Applicant firm provide services to any client in which any partner, director, officer or equity owner or spouse of the Applicant firm serves as partner, director, officer or equity owner of the client firm? ☐ Yes ☐ No
    If "Yes", please provide explanation: _____

    _____

16. Does the Applicant firm use a written contract with clients describing the services provided?
☐ Always ☐ Most of the Time ☐ Some of the Time ☐ Never

17. Does the Applicant ever enter into contracts where the fees for services are contingent upon the client achieving cost reductions or improved operating results? ☐ Yes ☐ No
If "Yes", please attach a detailed description of such arrangements.

18. Staff Information:
(Please include with application all principal and key employee resumes)

Name of all Principals, Partners, Owners and Key Employees	Professional Qualifications	Years with Applicant Firm	Years providing service	Continuing Education (Yes or No)	Position with Firm

19. Number of consultants to be covered: _____

20. Total Number of employees: Full Time: _____ Part Time: _____

21. Has the Applicant provided services to any governmental entities or plan to do so? ☐ Yes ☐ No
If "Yes", please attach an explanation.

22. If the Applicant handles patient data, is there a compliance program in place for HIPAA? ☐ Yes ☐ No

23. a) Total annual billings: $_____
b) Percentage of annual projected billings attributable to Medicare patients: _____%
c) Percentage of annual projected billings attributable to Medicaid patients: _____%

24. Does the Applicant have a compliance program in place? ☐ Yes ☐ No

Insurance History

25. a) Please list the Applicant's Professional Liability Insurance Coverage carried during the past three (3) years, including any periods without coverage.

Name of Insurer	Policy Period From: MM/DD/YY To: MM/DD/YY	Limits of Liability	Retention	Premium

b) Has any carrier canceled or non-renewed any of the above? ☐ Yes ☐ No

c) Does the Applicant maintain medical malpractice insurance? ☐ Yes ☐ No

d) Has any person proposed for coverage retired from the practice of medicine? ☐ Yes ☐ No

If "Yes", please provide details: _____

_____

e) Does the current policy have a prior acts limitation or retroactive date? ☐ Yes ☐ No
If "Yes", please indicate date: _____ / _____ / _____

Claims History

26. Have any claims, suits, or demands been made against the Applicant, a predecessor firm, any past or present principals, partners, officers, or employees within the past **five (5) years?** ☐ Yes ☐ No
If "Yes", please provide a completed NAS supplemental claim form.

27. After inquiry with all principals, partners and officers, is the Applicant aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become a claim under the policy for which this application is submitted to the Underwriters? ☐ Yes ☐ No

28. Has the Applicant even been audited, investigated, sanctioned or accused of errors by any local, state or federal government agency or private payor? ☐ Yes ☐ No

29. Limits of Liability requested: $_____ / _____

Deductible (each Claim): $_____

Proposed Effective Date: _____

To complete the submission, please include the following:

- Résumés of the Applicant's principals or key employees.
- Claim Supplement(s), if applicable.

NOTICE TO APPLICANT: PLEASE READ CAREFULLY

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this application does not bind the undersigned to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and this application will be attached and become a part of such policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this application as they deem necessary.

It is warranted that the particulars and statements contained in the application for the proposed policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed policy and are to be considered as incorporated into and constituting a part of the proposed policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the policy, the applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by this application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

_____ _____
Print Name of Insured, Owner, Partner or Principal Title

_____ _____
Signature Date