PLRisk
Professional Liability Risk Advisors

Please Fax or Email
Completed Application To:

(201) 847-9174
apps@plrisk.com

PLRisk
795 Franklin Avenue
Franklin Lakes, NJ 07417
201-847-9174 (fax) 201-847-9175 (phone)

APPLICATION FOR MANAGED CARE AND MEDICAL PROFESSIONAL LIABILITY INSURANCE

This is an Application for a claims made and reported policy. Please read the entire Application carefully before signing. Whenever used in this Application, the term "Applicant" means the Named Insured(s) and the term "Firm" means the Named Insured(s) and any entity identified in Question 4 of this Application. Please answer all questions and attach all requested materials including the following:

□ Promotional brochures, firm resumes, marketing materials or literature (including enrollee packet)
□ Resumes of all principals, partners, managing members, directors, officers, majority owners and any employee who performs credentialing, utilization management or peer review functions
□ Standard contract used with enrollees, health care providers, vendors, MSOs and independent contractors
□ Utilization management (including procedures for denials of benefits and appeals) and credentialing and peer review guidelines
□ Privacy policies and procedures including narrative of HIPAA compliance procedures
□ Latest fiscal year end and current interim financial statements for all entities proposed for coverage

COVERAGE REQUESTED:

Effective Date Requested: _____
Limits Desired: ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $5,000,000 ☐ Other $_____
Self Insured Retention (each claim): ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other $_____

PROPOSED APPLICANT:

1. Name of Applicant: _____

   Date Established (Mo./Yr.): _____

   Business Address: _____

   City, State, Zip: _____ Fax: _____

   Business Website Address: _____ Email: _____

   Individual designated to accept all notices on Applicant's behalf: _____

2. The Applicant is a:
   (a) ☐ Corporation ☐ Taxable Non-Profit ☐ Tax-Exempt Non-Profit ☐ Partnership ☐ LLC ☐ Other: _____
   (b) ☐ Staff Model HMO ☐ Network/IPA Model HMO ☐ Combined HMO ☐ PPO ☐ PHO ☐ IPA ☐ MSO ☐ Medical Group/Clinic ☐ Third Party Administrator ☐ Peer Review Organization ☐ Utilization Review Organization ☐ Other: _____

3. (a) Is the Applicant owned or controlled by, or affiliated with, any other entity? ○ **Yes** ○ **No**
   (b) Has the name of the Applicant ever been changed? ○ **Yes** ○ **No**
   (c) Is the Applicant a franchisee or franchisor? ○ **Yes** ○ **No**
   (d) Are there any branch offices or additional locations? ○ **Yes** ○ **No**
   (e) Is the Applicant a successor-in-interest to any predecessor firm or has the Applicant ever been involved in any merger, acquisition, consolidation, divestiture, bankruptcy or dissolution? ○ **Yes** ○ **No**
   (f) In the next 12 months, does the Applicant have any plans for any merger, acquisition, consolidation, divestiture, bankruptcy, dissolution, or creation of a new business, subsidiary or division? ○ **Yes** ○ **No**

If the response to any part of Question 3 is "YES," please attach complete details.

4. (a) Please provide the following information for all subsidiaries **for which coverage is desired.**

Name of Subsidiary	Location	Nature of Business	Applicant's % of Ownership
			%
			%
			%

(b) Please provide the following information for all additional entities **for which coverage is desired.**

Name of Entity	Location	Nature of Business	Relationship to Applicant

To enter more information for Question 4(a) and/or 4(b), please attach a separate page to the Application.

5. Does the Applicant or any of its principals or partners own, control or manage any other entity not shown in Question 4? ◯ **Yes** ◯ **No If "YES," please attach complete details.**

PROFESSIONAL ACTIVITIES:

6. Please describe, in detail, the professional services or activities performed by the Firm **for which coverage is desired**, indicate if the services or activities involve direct patient contact, and indicate the percentage of total revenue derived from each.

Professional Services	Direct Patient Contact	% of Revenue
	◯ **Yes** ◯ **No**	%
	◯ **Yes** ◯ **No**	%
	◯ **Yes** ◯ **No**	%

To enter more information, please attach a separate page to the Application.

7. (a) During the past 5 years or within the next 12 months, has the Firm been engaged in, or plan to engage in, any services or business activity other than those indicated in Question 6? ◯ **Yes** ◯ **No If "YES," please attach a description of the services, estimated revenues and where the E&O is placed.**
(b) Does the Firm provide any Professional Services over the Internet? ◯ **Yes** ◯ **No If "YES," please attach complete details and estimated revenues.**
(c) Does the Firm provide any Professional Services outside the United States? ◯ **Yes** ◯ **No If "YES," please complete and attach the Foreign Professional Services Supplement.**

8. Please provide the following gross revenue information for the next 12 months and for each of the past three fiscal years derived from those services indicated in Question 6.

Source of Revenue	Next 12 Months	___ / 20___	___ / 20___	___ / 20___
Charitable Contributions	$	$	$	$
Government Funding	$	$	$	$
Fee for Services	$	$	$	$
Other (Describe):	$	$	$	$

TOTAL GROSS REVENUE	$	$	$	$

9. Does the Firm or any individual proposed for coverage:

Perform or assist in any surgical procedures	○ **Yes** ○ **No**
Administer anesthesia (other than topical or by means of local infiltration)	○ **Yes** ○ **No**
Perform radiation therapy	○ **Yes** ○ **No**
Perform psychiatric shock therapy	○ **Yes** ○ **No**
Compound in bulk, manufacture or wholesale medicine	○ **Yes** ○ **No**
Administer artificial insemination	○ **Yes** ○ **No**
Identify contagious diseases in its locality and/or recommend remedial action	○ **Yes** ○ **No**
Own or operate a training school	○ **Yes** ○ **No**
Own, operate or administer any hospital, nursing home or other institution where medical services are customarily performed	○ **Yes** ○ **No**

If the response to any part of Question 9 is "YES," please attach complete details.

10. During the past 5 years or within the next 12 months, has any principal, partner, managing member, director, officer, professional employee, leased employee or independent contractor of the Firm been engaged to provide, or plan to provide, professional services for or in connection with any entity in which he, she, the Applicant, or any other proposed insured had/has an ownership or financial interest?
○ **Yes** ○ **No** **If "YES," please attach complete details.**

ENROLLMENT:

11. (a) Please provide the total number of enrollees/patients who use or will use the contracted health care providers of the Firm as their primary physician (or the total number of referrals to specialist health care providers under contract with the Firm) over the: _____ Next 12 Months _____ Past 12 Months
(b) Please provide the total number of enrollees/patients shown in 12(a) who are Medicare or Medicaid recipients: _____ Next 12 Months _____ Past 12 Months

12. Please indicate the approximate division of your patients or clients among:

Alcoholics	%	Family Planning	%	Psychiatric	%
Bariatrics	%	Hemodialysis	%	Research/Experimental	%
Communicable	%	Holistic Medicine	%	Surgical	%
Dental	%	Obstetrical	%	Other (Specify):	%
Disability Evaluation	%	Pediatric	%		
Drug Addicts	%	Physical Rehab	%	TOTAL	100%

PERSONNEL:

13. (a) Please indicate the number of personnel in each of the following categories:

	Full-Time Employees	Part-Time Employees	Volunteers	Leased Employees	Independent Contractors	Other (Specify):
Number						

(b) Independent Contractor Coverage desired: ○ **Yes** ○ **No** ○ **Not Applicable**
(c) **If "YES" to 13(b),** independent contractors provide the following services: _____

(d) **If "NO" to 13(b),** please indicate the minimum E&O limits independent contractors are required to maintain: $_____

14. Does the Firm supervise any individuals who are not listed in Question 13(a)? ○ **Yes** ○ **No If "YES," please attach complete details.**

15. (a) Please indicate the number of employees/volunteers for each type of profession:

Type of Profession	#	Type of Profession	#	Type of Profession	#
Chiropractors		Nurses (Registered)		Psychologists	
Inhalation Therapists		Opticians		Social Workers	
Laboratory Technicians		Optometrists		Speech Therapists	
Nurse Anesthetists		Perfusionists		Veterinarians	
Nurses (Licensed Practical)		Pharmacists		X-Ray Technicians	
Nurse Practitioners		Physiotherapists		Other (Specify):	

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ○ **Yes** ○ **No If "NO," please attach complete details.**

LICENSING/ACCREDITATION/PROFESSIONAL MEMBERSHIPS:

16. (a) Is the Firm licensed by any federal, state or local governmental agency? ○ **Yes** ○ **No If "YES," please identify the license:** _____
(b) Is the Firm accredited/certified by any organization, state or federal agency? ○ **Yes** ○ **No If "YES," please identify the accreditation/certification:** _____
(c) Has the license, certification or accreditation of the Firm or any individual proposed for coverage ever been investigated, denied, suspended, revoked, or subject to any contingencies or recommendations? ○ **Yes** ○ **No If "YES," please explain:** _____
(d) Is the Firm a member of any professional society or association? ○ **Yes** ○ **No If "YES," please specify:** _____

RISK MANAGEMENT:

17. Does the Firm have:
(a) Written procedures to escalate complaints to senior management or an ombudsman? ○ **Yes** ○ **No**
(b) Written risk management procedures in place including procedures to ensure compliance with all federal, state and local statutes and regulations (including collection procedures for enrollees/patients and billing charges to Medicare, Medicaid and other third party payors)? ○ **Yes** ○ **No**
(c) A formal training program for personnel including HIPPA privacy training? ○ **Yes** ○ **No**
(d) Network security management procedures to prevent breaches of security including identity theft and the spread of computer viruses? ○ **Yes** ○ **No**
(e) Written procedures in place to protect, or provide training for the protection of, the personal and confidential information of clients and prospective clients? ○ **Yes** ○ **No**
(f) Legal/Clearance procedures for media and marketing material and content? ○ **Yes** ○ **No**
(g) Internal control procedures to prevent theft of client funds or other client assets? ○ **Yes** ○ **No**

18. Does the Firm require outside legal counsel with expertise in managed care law to review and approve all:
(a) Management contracts, enrollee/patient contract and health care provider contracts? ○ **Yes** ○ **No**
(b) Utilization management, credentialing, peer review, and quality assurance policies and procedures followed by the Firm? ○ **Yes** ○ **No**
(c) Recommendations/Decisions to terminate, suspend or discipline a health care provider. ○ **Yes** ○ **No**

19. (a) Does the Firm have exclusive agreements with any health care provider? ○ **Yes** ○ **No**
(b) Does the Firm contract with more than 25% of the physicians in any given field of practice within its geographic service area? ○ **Yes** ○ **No**
(c) Do contracted health care providers control more than 20% of the hospital beds within its geographic service area? ○ **Yes** ○ **No**

(d) If "YES" to any of the above, has an anti-trust attorney reviewed the activities of the Firm to ensure that the exposure to allegations of any violation of federal, state, or local antitrust, restraint of trade, unfair competition or price fixing laws, rules or regulations is mitigated? ○ **Yes** ○ **No**

20. Are all contracted health care providers required to maintain medical malpractice insurance? ○ **Yes** ○ **No**
If "YES," minimum limits required: $_____

21. Does the Firm or any individual proposed for coverage have final authority for:
(a) Credentialing, selecting, terminating or suspending any contracted health care provider? ○ **Yes** ○ **No**
(b) Denying benefits or services to enrollees/patients because of medical necessity? ○ **Yes** ○ **No**

If the response to any part of Question 21 is "NO," please attach complete details.

22. Have any health care providers been removed, disqualified, restricted, denied or suspended from participating in any agreements entered into by the Firm to provide or arrange for the provision of health care services? ○ **Yes** ○ **No If YES," please attach complete details.**

PRIOR INSURANCE:

23. List all professional liability insurance carried for each of the past three years. If none, the reason for the present insurance inquiry is: _____

Insurance Company	Limits	Retention	Premium	Policy Period
	$	$	$	
	$	$	$	
	$	$	$	

Retroactive Date on current policy: _____
Prior and Pending Litigation Date on current policy or, if none, Date of first E&O policy: _____

24. Has the Applicant had any Professional Liability Insurance declined, cancelled or non-renewed within the past three years? ○ **Yes** ○ **No If "YES," please attach complete details.**

CLAIMS EXPERIENCE:

25. Have any claims, suits or proceedings (including without limitation: any shareholder action or derivative suit; or any civil, criminal, or regulatory action, or any complaint, investigation or proceeding related thereto) been made during the past five years against: (a) the Applicant; (b) its predecessors in business; (c) any subsidiary or affiliate of the Applicant; (d) any other entity proposed for coverage; or (e) any past or present principal, partner, managing member, director, officer, employee, leased employee or independent contractor of the Applicant, its predecessors in business, any subsidiary or affiliate of the Applicant or any other entity proposed for coverage? ○ **Yes** ○ **No**

26. Is the Applicant (after diligent inquiry of each principal, partner, managing member, director or officer) aware of any fact, circumstance, incident, situation, or accident (including without limitation: any shareholder action or derivative suit; or any civil, criminal, or regulatory action, or any complaint, investigation or proceeding related thereto) that may result in a claim being made against: (a) the Applicant; (b) its predecessors in business; (c) any subsidiary or affiliate of the Applicant; (d) any other entity proposed for coverage; or (e) any past or present principal, partner, managing member, director, officer, employee, leased employee or independent contractor of the Applicant, its predecessors in business, any subsidiary or affiliate of the Applicant or any other entity proposed for coverage?
○ **Yes** ○ **No**

27. Has the Applicant or any individual or entity proposed for coverage ever been the subject of a reprimand, or a disciplinary or criminal action by any federal, state or local authority, professional association or state licensing board? ○ **Yes** ○ **No**

28. Has the Applicant or any individual or entity proposed for coverage been involved during the past five years in any disputes with respect to fees or other compensation which may be due for professional services rendered by the Applicant, any subsidiary or affiliate of the Applicant, or any other entity proposed for coverage? ○ **Yes** ○ **No**

29. Is the Applicant or any individual or entity proposed for coverage aware of any actual or alleged deficiencies, errors or omissions in work performed by the Applicant, any subsidiary or affiliate of the Applicant, any other entity proposed for coverage, or by others for whom the Applicant is legally responsible? ○ **Yes** ○ **No**

If the response to Question 25, 26, 27, 28 and/or 29 is "YES," please attach complete details.

NOTE: It is agreed that any claim or lawsuit against the Applicant, or any principal, partner, managing member, director, officer or employee of the Applicant, or any other proposed insured, arising from any fact, circumstance, act, error or omission disclosed or required to be disclosed in response to Questions 25, 26, 27, 28, and/or 29, is hereby expressly excluded from coverage under the proposed insurance policy.

30. Has the Applicant reported the matters listed in Questions 25-29 to its current or former insurance carrier? ○ **Yes** ○ **No** ○ **Not Applicable**

NOTICE – PLEASE READ CAREFULLY

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after diligent inquiry of each principal, partner, managing member, director, officer and employee of the Firm, the statements in this Application are true and complete and will be relied upon by the Insurer in issuing any policy. The undersigned agrees that if the information provided in this Application changes between the time this Application is executed and the time the proposed insurance policy is bound or coverage is commenced, the Applicant will immediately notify the Insurer in writing of such changes, and that the Insurer may withdraw or modify any outstanding quotations or agreements to bind the insurance. The undersigned hereby authorizes the Insurer to make any inquiry in connection with the information, statements and disclosures provided in this Application and further authorizes the release of claim information from any prior insurer to the Insurer.

The undersigned declares that all individuals and entities proposed for this insurance understand and accept that the policy applied for provides coverage for only those claims that are first made against the Insured and reported in writing to the Insurer during the policy period or any extended reporting period (if applicable) and that the limits of liability contained in the policy will include both Damages and Claim Expenses.

The signing of this Application does not bind the Insurer to offer nor the undersigned to purchase the insurance, but it is agreed this Application shall be the basis of the insurance and shall be considered physically attached to and become part of the Policy should a Policy be bound and issued. All attachments and information submitted to or obtained by the Insurer in connection with this Application are hereby incorporated by reference into this Application and made a part hereof.

The Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

_____ _____

Date (Mo./Day/Yr.) A pplicant Signature

_____

Print or Type Name

_____