APPLICATION for: **Managed Care Organizations and Healthcare Consultants Errors & Omissions Liability**

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)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Web Site: _____

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

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

3. If the firm is a Managed Care organization, please specify what type:
☐ PHO ☐ IPA ☐ Medical Group ☐ MSO ☐ HMO ☐ TPA

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: $ _____

Fiscal year ending: 200 ____

Please attach the latest year's full financial statements, and a current profit/loss statement including a balance sheet, if the audit is not available.

7. Services to be Covered:

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

8. Are the above services provided to others for a fee? ☐ Yes ☐ No

9. 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:

_____ _____%

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

11. 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

12. Is the Applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company? ☐ Yes ☐ No

If "Yes", please list all affiliations:

_____

_____

13. 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:

_____

_____

14. 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: _____

_____

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

16. Do the Applicant's contracts contain indemnification or hold-harmless clauses inuring to the Applicant's benefit?
☐ 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. Applicant's Staff:

	Full Time	Part Time
Total Number:	____	____
Number hired within the past 12 months:	____	____
Number terminated, retired, or resigned within the past 12 months:	____	____

20. Has the Applicant provided services to any governmental entities? ☐ Yes ☐ No
If "Yes", please attach an explanation.

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

22. Is the Applicant licensed by an entity for insurance or managed care professional services? ☐ Yes ☐ No

If the Applicant EMPLOYS OR INDEPENDENTLY CONTRACTS PHYSICIANS, please complete the following section:

23. Does the Applicant employ physicians? ☐ Yes ☐ No
    If "Yes", are they involved in: Direct patient care? ☐ Yes ☐ No
    Non-patient care services? ☐ Yes ☐ No

24. Please specify the number of:

	Last 12 months	Next 12 Months
Independent contractor physicians	_____	_____
Employed physicians	_____	_____
Hospitals/healthcare facilities	_____	_____

25. Does the Applicant require its providers to maintain Medical Malpractice insurance? ☐ Yes ☐ No
    Minimum limits of liability $_____ Deductible $_____

26. In any of the Applicant's marketing regions:
    a) Do Applicant's exclusive participating providers constitute greater than 20% of the market for such providers? ☐ Yes ☐ No
    b) Do Applicant's non-exclusive participating providers constitute greater than 30% of the market for such providers? ☐ Yes ☐ No

27. Are insufficient patient encounters, excessive utilization or any other economic factors grounds to disqualify or remove a provider from the Applicant's panel? ☐ Yes ☐ No
    a) Have any providers been terminated from the Applicant's provider panel in the past 12 months? ☐ Yes ☐ No
    If the answer is "Yes", please indicate how many were terminated and for what reasons, on a separate page.
    b) Were the terminated providers notified of their due process rights, as applicable? ☐ Yes ☐ No

28. Have any providers who applied, been denied membership to the panel in the last twelve (12) months? ☐ Yes ☐ No
    If the answer is "Yes", please indicate how many were denied, and for what reasons, on a separate page.

If the Applicant performs MEDICAL BILLING, please complete the following section:

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

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

If the Applicant performs CLAIMS SERVICES, please complete the following section:

	Last 12 Months	Next 12 Months
31. Total revenue for claims handling and adjusting services performed for others for a fee:	$_____	$_____
32. a) Number of claims processed:	_____	_____
b) Number of FTE claim adjusters:	_____	_____
c) Number or percentage of PTE claim adjusters:	_____	_____
d) Number or percentage of claims denied:	_____	_____

33. What is the average error rate for the Applicant's claim handlers? _____%

34. Please indicate whether the Applicant performs the following services:

Administers health/welfare plans	○ Yes ○ No
Administers pension or profit sharing plans	○ Yes ○ No
Adjusts claims	○ Yes ○ No
Reviews claim denials	○ Yes ○ No
Issuance of denial of claims	○ Yes ○ No
Administers Section 125 Reimbursement or COBRA benefits	○ Yes ○ No
Acts as an insurance agent or broker	○ Yes ○ No
Designs benefit plans (without actuarial analysis)	○ Yes ○ No
Designs benefit plans (with actuarial analysis)	○ Yes ○ No

35. **For TPAs**: What kinds of plans are being administered?

Single employers	_____%
Multi-Employers (METs)	_____%
Multi-Employer Welfare Arrangements (MEWAs)	_____%
Taft-Hartley Plans	_____%
Public/Government Plans	_____%
Partially Self-Funded Minimum Premium Plans	_____%

If the Applicant performs UTILIZATION REVIEW, FILE REVIEW or CASE MANAGEMENT, please complete the following section.

36. Does the Applicant perform:

Prospective utilization review	○ Yes ○ No
Concurrent utilization review	○ Yes ○ No
Retrospective utilization review	○ Yes ○ No
Case management	○ Yes ○ No

37. Does the Applicant utilize guidelines such as Milliman and Robertson and/or InterQual for its utilization decisions? ○ Yes ○ No

38. In any of the Applicant's contracts, does the Applicant have the responsibility to make the final determination as to whether or not a procedure is covered? ○ Yes ○ No

Insurance History

39. 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

Has any carrier canceled or non-renewed any of the above? ○ Yes ○ No

Does the current policy have a prior acts limitation or retroactive date? ○ Yes ○ No

If "Yes", please indicate date: _____ / _____ / _____

Claims History

40. 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 claim summary for each claim consisting of:
    - Name of claimant
    - Type of service provided
    - Date of claim
    - Demand amount
    - Indemnity and expenses paid/reserved
    - Final disposition of claim

41. 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

42. 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

43. Limits of Liability requested: $_____ /_____

    Deductible (each Claim): $_____

    Proposed Effective Date: _____

To complete the submission, please include the following:
- Any brochures or promotional materials.
- 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

PLRisk
Professional Liability Risk Advisors

Please Fax or Email
Completed Application To:

(201) 847-9174
apps@plrisk.com