

HEALTHCARE ORGANIZATION

MANAGEMENT LIABILITY RENEWAL APPLICATION



< OBI National Insurance Company >

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NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY POLICY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE UNDERWRITER BE LIABLE FOR "DEFENSE EXPENSES" OR OTHER "LOSS" IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

If additional space is needed to answer the below questions, attach a separate document to this Application to provide complete answers. If the answer to a question is none, state "None" or "0" in the space provided.

Application Instructions:

Whenever used in this Application, the term "Applicant" shall mean the organization identified in response to Question 1 of Section I. of this Application.



I. APPLICANT

1. Name of Applicant:

2. Street Address:
Mailing Address (if different):

3. City: State: Zip Code:
Website Address: Telephone:
Primary SIC Code:

4. State of incorporation: Date of incorporation:

5. Authorized individual (Executive Officer) to receive notices and information regarding the proposed insurance:
Name: Title:
E-mail address: Phone: Fax:

6. Individual responsible for Human Resources or employment law matters:
Name: Title:
E-mail address: Phone: Fax:



II. SPECIFIC INFORMATION

7. Please indicate below which coverages for which Applicant seeks renewal.

Note: The requested coverage is not automatically provided. The terms and conditions of the policy, if issued, will determine actual coverage.

Coverage Requested	Limit of Liability Requested	Retention/Deductible Requested
<input type="checkbox"/> Directors and Officers Liability	\$ _____	\$ _____
<input type="checkbox"/> Employment Practices Liability	\$ _____	\$ _____
<input type="checkbox"/> Fiduciary Liability	\$ _____	\$ _____
<input type="checkbox"/> Crime	\$ _____	\$ _____
<input type="checkbox"/> Employed Lawyers Professional Liability	\$ _____	\$ _____
<input type="checkbox"/> Information Risk & Recovery*	\$ _____	\$ _____

*If the Applicant is applying for Information Risk and Recovery, please complete the Information Risk and Recovery

Supplemental Application.

8. Applicant is:
- Not-For-Profit Tax Exempt Organization (Applicable Federal or State Revenue Code)
- Not-For-Profit Taxable Organization For-Profit Corporation Partnership Limited Liability Company
- Other (please describe):

9. Please complete the following information:

Based on Financial Statements Dated:	Most Recent FYE (Month/Year) (____/____)	Prior FYE (Month/Year) (____/____)
Current Assets	\$	\$
Total Assets	\$	\$
Current Liabilities	\$	\$
Total Liabilities	\$	\$
Retained Earnings	\$	\$
Total Revenues/Contributions	\$	\$
<input type="checkbox"/> Net Income or <input type="checkbox"/> Net Loss	\$	\$
Cash flow from Operations	\$	\$

10. Has the Applicant or any of its subsidiaries in the past eighteen (18) months completed or agreed to, or does any such entity contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:
- a. Reorganization or arrangement with creditors under federal or state law? Yes No
 - b. Branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes No
 - c. Mergers, acquisitions or divestitures? Yes No
 - d. Registration for a public or private offering of securities? Yes No
 - e. Issuance of any debt or non-taxable bonds? Yes No
 - f. Entering into any new government contracts? Yes No
 - g. Conversion from non-profit to for-profit status? Yes No

If "Yes" to any part of Question 10, please describe the essential terms of each such transaction as an attachment.

 **III. DIRECTORS AND OFFICERS LIABILITY INFORMATION – Complete if coverage is requested.**

11. Has the Applicant or any of its subsidiaries experienced changes to its Board or to its Key Executives over the past year? Yes No
- If "Yes," please attach complete details.

12. Complete if the Applicant has stock or other equivalent ownership instrument:
- a. Total number of common shareholders: _____
 - b. Total number of common shares outstanding: _____
 - c. Total number of common shares owned by officers: _____
 - d. Total number of shares owned by directors who are not officers: _____
 - e. If any shareholder owns 5% or more of shares, complete the following information:

Shareholder	Class of Security	% Owned	Director, Officer or Trustee?
		%	<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

13. Over the past twelve (12) months has the Applicant or any of its subsidiaries entered into exclusive contracts with any providers? Yes No

If "Yes," please provide details by separate attachment.

14. Over the past twelve (12) months has the Applicant or any of its subsidiaries controlled more than twenty percent (20%) of the market share in any given geographical area of: (a) providers in any given field of practice; (b) hospital beds; (c) healthcare services; or (d) if the Applicant or any of its subsidiaries provides managed care products or services, the market share of health plan members? Yes No

If "Yes" to Question 14(a), (b), (c) or (d), please provide market share percentages by separate attachment.

15. a. Over the past two (2) years has the Applicant or any of its subsidiaries closed or restricted staff admissions and/or privileges of a provider for reasons other than professional competence, including but not limited to, a conflict of interest? Yes No

If "Yes," how many? _____

b. Are there any formal plans for future staff admission/privilege closings or restrictions? Yes No

If "Yes," please provide details by separate attachment.



IV. EMPLOYMENT PRACTICES LIABILITY AND THIRD PARTY LIABILITY INFORMATION – Complete if coverage is requested.

16. Enter the TOTAL number of Employees (by type) in the boxes below for the Applicant and its subsidiaries.
Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).
Number of Employees in ALL STATES/JURISDICTIONS:

	Domestic		Foreign
	Union	Non-Union	
Full Time			
Part Time			
Total Number of Independent Contractors			
Total Number of Volunteers:			
Total Number of Employed Physicians (not included above)			

17. Enter the TOTAL number of Employees (by type) located in California in the boxes below for the Applicant and its subsidiaries.
Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).
Number of Employees located in CALIFORNIA ONLY:

	Domestic	
	Union	Non-Union
Full Time		
Part Time		
Total Number of Independent Contractors		
Total Number of Volunteers:		
Total Number of Employed Physicians (not included above)		

18. Enter the TOTAL number of Employees (by type) located in DC, Florida, Michigan and Texas in the boxes below for the Applicant and its subsidiaries.
Note: Seasonal, Temporary and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).

Number of Employees located in DC, FLORIDA, MICHIGAN & TEXAS ONLY:

	Domestic	
	Union	Non-Union
Full Time		
Part Time		
Total Number of Independent Contractors		
Total Number of Volunteers:		
Total Number of Employed Physicians (not included above)		

19. In the past twelve (12) months, what has been the annual percentage of turnover rate of all employees for the Applicant and its subsidiaries (all locations)?
 Voluntary _____% Involuntary _____%

20. In the past twelve (12) months have there been any changes to the Human Resources or Personnel Department? Yes No
 If "Yes," please attach complete details.

21. In the past twelve (12) months have there been any changes to the employee handbook? Yes No
 If "Yes," please attach a copy of the updated materials and a description of changes.

 **V. FIDUCIARY LIABILITY COVERAGE INFORMATION – Complete if coverage is requested.**

22. Please list the Applicant's and any of its subsidiaries' employee benefits plan(s) for which coverage is requested:

Plan names (Do not include health & welfare plans)	Total assets (market value)	Type of plan*	Under funded by more than 25%? (DB only)	Number of plan participants

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

23. In the past twelve (12) months has any plan(s) (or portion of a plan) been sold, transferred or terminated? Yes 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.

 **VI. CRIME COVERAGE INFORMATION – Complete if coverage is requested.**

24. Total number of employees of the Applicant and its subsidiaries: _____
25. Of the total employees listed above, how many employees handle, have access to or maintain records of money, securities or other property including, but not limited to, directors, officers, trustees and any person handling or having access to employee welfare or benefit plan assets? _____

26. Total number of locations of the Applicant and its subsidiaries:
 Domestic locations: _____ Foreign locations: _____
 List Countries: _____
27. Were any material weaknesses or significant deficiencies in internal controls identified by the Applicant's or any of its subsidiaries' CPA firm or internal audit staff during the past twelve (12) months? Yes No
 N/A
 If "Yes," please attach a description of the weaknesses/deficiencies and corrective measures and implementation timeframe.
28. Does a second person review the reconciliation with supporting documentation on a monthly basis and initial their approval of the information? Yes No
29. Are all checks countersigned? Yes No
 a. If there is no countersignature, who signs the Applicant's checks? _____
 b. Over what amount is a dual signature required? \$ _____
30. How often and by whom are physical inventory counts conducted? _____
31. Are background checks performed on vendors in order to determine ownership and financial capability prior to doing business with them? Yes No

 VII. EMPLOYED LAWYERS PROFESSIONAL LIABILITY COVERAGE INFORMATION –
 Complete if coverage is requested

32. Current number of the following in the legal department of the Applicant and its subsidiaries:
 Employed Lawyers _____ Paralegals, legal assistants and staff _____
 Contract/leased attorneys _____ Law students/others: _____
33. Describe the type of work done by Employed Lawyers:
34. Describe the types of pro bono and moonlighting legal services performed by Employed Lawyers:
35. Does any Employed Lawyer issue written legal opinions to or for the use of:
 The Board of Directors: Yes No
 Subsidiaries or joint ventures: Yes No
 Others: _____ Yes No
 If "Yes," please provide details:
36. Does any Employed Lawyer prepare, review, comment on, or approve financial statements, proxy statements, prospectuses, registration statements, annual or quarterly reports, or other reports filed with federal or state agencies or released to shareholders or the public regarding the Applicant or any of its subsidiaries? Yes No
 If "Yes," please describe the role of Employed Lawyers in such preparation, review, comment or approval:
37. Does any Employed Lawyer provide personal legal services to any director, officer, or employee of the Applicant or any of its subsidiaries in such director's, officer's or employee's individual capacity? Yes No
 If "Yes," please indicate the type of personal legal services provided and the percentage of the Employed Lawyer's time devoted to the provision of personal legal services:

38. Does any Employed Lawyer serve as a director, officer or partner of any organization, other than the Applicant or any of its subsidiaries, which is exempt from taxation under Section 501(c)(3) of the Internal Revenue Code? Yes No

If "Yes," please list the organizations served:

39. Do the Applicant's Employed Lawyers appear in court on behalf of the Applicant, any of its subsidiaries or any other party? Yes No

40. Has any Employed Lawyer ever been the subject of a reprimand, sanction, fine or discipline by, or been refused admission to, a bar association, court, administrative or regulatory agency? Yes No

If "Yes," please provide the name of the Employed Lawyer and a brief explanation:



VIII. ATTACHMENTS

41. Please attach copies of the following documents for the Applicant and all subsidiaries seeking coverage:

- a. Last audited or accountant-prepared financial statement with notes; and
 - b. Current list of Board of Directors and organizational chart listing each subsidiary.
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Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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.

ARKANSAS, MINNESOTA, 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 or deceptive statement is guilty of insurance fraud, which is a crime.

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.

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.

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.

KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO 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 civil fines and criminal penalties.

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.

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.

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.

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.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.



X. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER OR CHIEF FINANCIAL OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: State: Zip: