☐ ACE American Insurance Company
☐ Illinois Union Insurance Company

# Managed Care Organization Errors & Omissions Policy Application

**NOTICE**

**The Policy for which you are applying is written on a claims-made and reported basis. Only claims first made against the Insured and reported to the Company during the Policy Period are covered subject to the Policy Provisions.**

**The Limits of Liability stated in the Policy are reduced, and may be exhausted, by Claims Expenses. Claims Expenses are also applied against your Retention, if any. If you have any questions about coverage, please discuss them with your insurance agent.**

**INSTRUCTIONS**

The requested information is necessary before a quotation can be obtained. Underwriters will rely on all information provided in this application. Please type or print all answers clearly. Answer all questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply. If there is insufficient space to complete an answer, please continue on a separate sheet using the applicant's letterhead and reference the applicable question number.

If any questions, or any part thereof, do not apply, print N/A in the space. Insert checks in Yes or No answer boxes, if any. This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

## SECTION A. - APPLICANT & RETROACTIVE DATE

1. Legal name of managed care entity to be insured exactly as it shall be shown on the policy. Include location information and retroactive date(s).

| Named Insured | Street Address |
|---|---|
| | |
| City, State, Zip Code | County |
| | |
| Managed Care Organizations' Errors & Omissions Liability Retroactive Date: | |
| Date of Incorporation: | |
| Contact Person and Title: | |
| Contact Person Phone Number and E-mail Address: | |

2. Entities to be included for coverage

| Name | Description of Operations | Ownership Percentage |
|---|---|---|
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |

| Name | Description of Operations | Ownership Percentage |
|---|---|---|
| | | % |

If required, list additional entities on a separate attachment (attach additional information if necessary)

Applicant is:

| | | | |
|---|---|---|---|
| ☐ | Partnership | ☐ | Profit |
| ☐ | Corporation | ☐ | Non-Profit |
| ☐ | Joint Venture | | |
| ☐ | Limited Liability Company | | |
| ☐ | Other: | | |

| | | | |
|---|---|---|---|
| ☐ | HMO | ☐ | MSO/TPA |
| ☐ | PPO | ☐ | Peer Review Organization (PRO) |
| ☐ | PHO | ☐ | Utilization Review Organization (URO) |
| ☐ | IPA | ☐ | Disease Management/Case Management/Health Management |
| ☐ | Other: | | |

3. Does the applicant comply with all federal, state or local licensing requirements? ☐ Yes ☐ No
If No, explain: _____

4. Is the applicant accredited by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state of federal agency? ☐ Yes ☐ No

5. Has the applicant's license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? ☐ Yes ☐ No
If Yes, explain: _____

6. If applying for non-admitted insurance, in accordance with the federal Nonadmitted and Reinsurance Reform ACT of 2010 (NRRA) what is the home state as determined by the applicant's surplus lines broker: _____

## SECTION B. – ENROLLMENT AND REVENUE

Number of enrollees/members insured (wherever used, "enrollees" means covered lives):

| Type | Current or Expiring Year | Projections for Requested Coverage Period |
|---|---|---|
| HMO: | | |
| HMO - Medicaid: | | |
| PPO: | | |
| PPO – Network Access Only/Non-Risk | | |
| Point of Service | | |
| Administrative Service Only (ASO) | | |
| Indemnity | | |
| Consumer Directed Health Plan | | |
| Medicare Supplement: | | |
| Medicare Advantage | | |
| Medicare Part D | | |
| Dental (Not included in enrollment above): | | |
| Vision (Not included in enrollment above): | | |
| Life (Not included in enrollment above): | | |
| Disability (STD/LTD) (Not included in enrollment above) | | |
| Pharmacy/Pharmacy Benefit Management (Not included above) | | |
| Other: _____ | | |
| | | |
| Total Gross Revenue | $ | $ |

## SECTION C. – TYPE OF SERVICES PROVIDED

1. Does the applicant provide any of the following services:

| Services | |
|---|---|
| Credentialing or peer review of health care providers: | ☐ Yes ☐ No |
| Utilization Review: | ☐ Yes ☐ No |
| Handling and adjusting enrollee benefit claims: | ☐ Yes ☐ No |
| Drafting practice guidelines/clinical pathways: | ☐ Yes ☐ No |
| Case Management: | ☐ Yes ☐ No |
| Disease Management: | ☐ Yes ☐ No |
| Application or enrollment processing for enrollees of healthcare plans: | ☐ Yes ☐ No |
| Billing/other processing of enrollee claims under healthcare plans: | ☐ Yes ☐ No |
| Establishing healthcare provider networks: | ☐ Yes ☐ No |
| Nurse Call Line that provides health and wellness information and/or advice: | ☐ Yes ☐ No |
| Ownership of an Indemnity Insurance Company: | ☐ Yes ☐ No |
| Advertising. Marketing or selling healthcare plans or products: | ☐ Yes ☐ No |
| HSA/FSA/HRA Administration: | ☐ Yes ☐ No |
| Applicant Owns Physician Practices or Employs Physicians (other than administrative):<br>If Yes, Number of Full Time Equivalents: | ☐ Yes ☐ No |
| Other – describe: | |

2. Does the applicant provide any of the following services for parties other than the applicant?

| **Services** | | Annual Income for the Current or Expiring Year | Annual Income Projections for the Prospective Coverage Period |
|---|---|---|---|
| Agency and Brokerage Operations: | ☐ Yes ☐ No | $ | $ |
| Insurance Consulting: | ☐ Yes ☐ No | $ | $ |
| Actuarial Services for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Claim Handling for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Utilization Review for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Case Management Services for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Disease Management Services for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Electronic Data Processing or Computer Software Development for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Loss Control or Safety Engineering for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Benefits Stop Loss Placement: | ☐ Yes ☐ No | $ | $ |
| Ownership of an Indemnity Insurance Company: | ☐ Yes ☐ No | $ | $ |
| Premium Financing: | ☐ Yes ☐ No | $ | $ |
| Rehabilitation Services for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Peer Review/Credentialing for Third Parties: | ☐ Yes ☐ No | $ | $ |
| Lease, Franchise or Rent Physician Network to Third Parties: | ☐ Yes ☐ No | $ | $ |
| Other – describe: | ☐ Yes ☐ No | $ | $ |

## SECTION D. – CLAIM HANDLING FOR THIRD PARTIES/TPA SERVICES

1. Does the applicant provide claim handing services for third parties? ☐ Yes ☐ No

If No, disregard all questions in this section.

If Yes, provide:

| | Current 12 Months | Next 12 months |
|---|---|---|
| Total Number of Customers: | | |
| Number of Enrollees Covered for Claim/TPA Services: | | |
| Number of Enrollees participating in benefit plans governed by ERISA: | | |
| Applicant Administers: | | |

| | Current 12 Months | Next 12 months |
|---|---|---|
| Managed Care Plans | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Health and Welfare Plans | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Pension Plans | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Workers' Compensation | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Multiple Employer Trusts | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Municipal, State or Federal Government Plans | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Self-Funded Plans | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Other – describe | _____ | _____ |
| Number of Claims Processed: | | |
| Percentage of claims denied: | % | % |

2. Does the applicant outsource (subcontract) any of these services to third parties? ☐ Yes ☐ No
If Yes, percentage of claims handled by independent adjusters: _____%
If Yes, what minimum limits of Errors and Omissions Liability insurance are required for claim handling services? $_____ Each Occurrence/$_____ Aggregate
If Yes, does the applicant review or audit this process? ☐ Yes ☐ No

3. Is the applicant authorized to set claim reserves and/or have settlement authority on behalf of third parties? ☐ Yes ☐ No
If Yes, explain in detail: _____
Briefly describe any hold harmless agreements in effect with any independent adjusters or others doing work _____

4. Does the applicant indemnify or hold harmless any clients or customers? ☐ Yes ☐ No
If Yes, explain in detail: _____

## SECTION E. – UTILIZATION REVIEW

1. Does applicant perform Utilization review? ☐ Yes ☐ No
If Yes, provide:

| | For Applicants own Enrollees | For others for a Fee |
|---|---|---|
| Number of Enrollees: | | |
| Number of Cases Reviewed in the Current or Expiring Year: | | |
| Number of Cases Reviewed in the Past 12 Months Where Payment or Treatment Was Denied: | | |
| Number of Cases where denials were appealed to the external review process | | |
| Percentage of decisions which go through the external review process ultimately decided in favor of the enrollee | % | % |
| Number of Full Time Equivalent Physician Reviewers: | | |
| Number of Full Time Equivalent Nurse Reviewers: | | |

2. Does the applicant outsource (subcontract) any utilization review services for its enrollees or covered lives to third parties? ☐ Yes ☐ No
If Yes, name of firm and relationship to the applicant: _____
If Yes, what minimum limits of Errors and Omissions Liability insurance are required for utilization review services? $_____each occurrence/$_____annual aggregate
If Yes, does the applicant review or audit this process? ☐ Yes ☐ No

3. Are physician and nurse reviewers credentialed by an entity in the applicant's organization? ☐ Yes ☐ No

4. Are claim denial appeal procedures clearly stated to participants of managed care organizations for which the applicant provides utilization review? ☐ Yes ☐ No

5. Does the applicant have written policies and procedures for utilization review, including denials and appeals? ☐ Yes ☐ No

6. If "yes" do such policies and procedures follow NCQA or URAC standards and comply with applicable laws? ☐ Yes ☐ No

7. Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? ☐ Yes ☐ No

8. Does the applicant have a "fast track" appeals system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life of the enrollee if not performed? ☐ Yes ☐ No

9. Does the applicant have an external review process in all states where it operates? ☐ Yes ☐ No

## SECTION F. – HEALTH CARE PROVIDER NETWORK SELECTION AND CREDENTIALING

1. Participating Network Providers:

| Provider | Current 12 months | Next 12 Months |
|---|---|---|
| Physicians | | |
| Hospitals | | |
| Facilities Other Than Hospitals – describe: _____ | | |
| Other Providers – describe: _____ | | |

2. How often are health care providers credentialed? _____

3. Does the applicant managed care organization credential health care providers? ☐ Yes ☐ No

4. Does the applicant outsource credentialing of healthcare providers to third parties? ☐ Yes ☐ No
   a. If yes, name of firm and relationship to applicant: _____
   b. If yes, what minimum limits of E&O liability are required? _____
   c. If yes, does the applicant audit or review this process? _____

5. Does the applicant require all contracted hospitals and other facilities to be accredited by:

| | |
|---|---|
| Joint Commission on Accreditation of Healthcare Organizations: | ☐ Yes ☐ No |
| Commission on Accreditation of Rehabilitation Facilities: | ☐ Yes ☐ No |
| Other(s) – describe: _____ | ☐ Yes ☐ No |

6. Are all contracted health care providers required to maintain Professional Liability insurance? ☐ Yes ☐ No
   If Yes, what minimum limits of Professional Liability insurance are required?
   $_____ Each Professional Incident/$_____ Aggregate

7. Does the applicant have written policies and procedures in place for Provider Selection, Credentialing, re-credentialing and making decisions which adversely affect a provider's credentials? ☐ Yes ☐ No
   a. Do the written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws? ☐ Yes ☐ No
   b. Are the procedures given to health care providers? ☐ Yes ☐ No
   c. Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final? ☐ Yes ☐ No
   d. Are all providers offered a hearing or appeal prior to termination? ☐ Yes ☐ No

8. Are all health care providers required to provide the applicant with current certificates of insurance as proof of Professional Liability insurance? ☐ Yes ☐ No

9. Does the applicant have any provider agreements that contain "Most favored" clauses?
☐ Yes ☐ No

10. Does the applicant have any provider agreements that contain non-compete clauses?
☐ Yes ☐ No

## SECTION G. – ADVERTISING AND MARKETING

1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state covered and non-covered services, procedures, and treatments, etc.?
☐ Yes ☐ No

2. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state out-of-pocket financial responsibilities? ☐ Yes ☐ No

3. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures contain exclusions or clarifications with regard to investigational or experimental procedures? ☐ Yes ☐ No
If Yes, do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures define what is considered investigational or experimental? ☐ Yes ☐ No

4. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state pre-certification requirements, emergency department access requirements, network provider access, i.e. referrals needed for specialists? ☐ Yes ☐ No

5. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly address and define organ transplants? ☐ Yes ☐ No

6. Does the applicant's legal representative review and approve all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures prior to their use?
☐ Yes ☐ No

7. Do all provider directories clearly state that all contracted health care providers are independent contractors? ☐ Yes ☐ No

8. Are all contracted health care providers always referred to as independent contractors?
☐ Yes ☐ No

9. Are claim denial procedures clearly stated in the applicant's contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures, etc.? ☐ Yes ☐ No

10. Are the applicant's customer service representatives and sales representatives trained to clearly explain benefits, denial procedures, out-of-pocket financial responsibilities, investigational or experimental procedures, emergency department access requirement, network provider access, and organ transplants? ☐ Yes ☐ No

11. Are unsolicited facsimiles, e-mails or other communications disseminated to actual or prospective customers or any other third party? ☐ Yes ☐ No
If Yes, explain: _____

## SECTION H. – CLAIMS INFORMATION

During the past five (5) years, no claims that would fall within the scope of the proposed insurance have been made against the Applicant or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs). If answer is none, so state:

_____
_____
_____
_____

During the past five (5) years, neither the applicant nor any individual or entity proposed for this insurance has submitted claims or given notice of any fact, circumstance, situation, transaction, event, act, error or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self insurance instrument except as follows. If answer is none, so state:

_____
_____
_____
_____

Neither the applicant nor any individual or entity proposed for this insurance is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows. If answer is none, so state:

_____
_____
_____
_____

## SECTION I. – ATTACHMENTS

Please attach copies of the following documents to this Application. These documents shall be part of the Application:

a) Applicant's last 2 audited or accountant-prepared financial statements with notes;
b) If the Applicant is newly-formed, Business Plan, including pro-forma financial statements;
c) Insurance Company-produced loss reports (loss runs) for the past ten (10) years, as applicable
d) Names, occupations and affiliations of the Applicant's directors and officers;
e) Applicant's corporate organizational chart;
f) Written utilization review procedures, including procedures for denials of benefits and appeals;
g) Written credentialing and peer review procedures;
h) Sample contract(s) with health care providers (physicians, hospitals and others);
i) Sample contract(s) with enrollees or member handbook;
j) Sample TPA or ASO contact(s);
k) Sample sales literature, brochures, advertisement or other marketing materials;
l) Privacy policies and procedures; and
m) Sample consent forms

## SECTION J. – FRAUD WARNINGS

**NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND & WEST VIRGINIA 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 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**NOTICE TO 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 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.

**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 MAINE 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 MARYLAND APPLICANTS:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 MINNESOTA APPLICANTS:** 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 INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**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 NEW MEXICO 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.

**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.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he 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.

**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 knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a

fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**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 TENNESSEE, VIRINIA & 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 include imprisonment, fines and denial of insurance benefits.

**NOTICE TO VERMONT APPLICANTS**: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**NOTICE TO ALL OTHER APPLICANTS:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

## SECTION K. – SIGNATURES & WARRANTY

**NOTICE TO ALL APPLICANTS:**

**BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE INSURER THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR BEEN SUPPRESSED OR CONCEALED.**

**THE APPLICANT AGREES THAT IF PRIOR TO THE EFFECTIVE DATE OF ANY POLICY BASED UPON THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.**

**COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY IS ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO.**

**THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND**

**MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MANAGED CARE ERRORS AND OMISSIONS EXPOSURES.**

| | |
|---|---|
| Signature of Applicant | Signature of Agent/Broker |
| Title | Date |
| Date | Signed by Licensed Resident Agent<br>(Where Required By Law) |