TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company
Servicing Address: 29 Mill Street
Unionville, CT 06085

Managed Care Errors & Omissions Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	
	Doing Business As	
	Federal Employee ID# (FEIN)	
2.	Mailing Address	Street:
		City: State: Zip:
		County: Website:
3.	Risk Manager or Contact Person	Name/Title:
		Email Address:
		Telephone Number:
4.	Applicant's Legal Structure	☐Individual ☐Corporation ☐ Partnership ☐ Joint Venture ☐LLC
5.	Tax Status	☐For Profit – Private ☐Not For Profit ☐For Profit – Publicly Traded ☐Government Owned ☐Partnership, Joint Venture, Other (describe):
6.	Date Established	
7.	Number of years Applicant has been under present ownership:	

8. Is the Applicant owned by or controlled by another entity? ☐Yes ☐No

If "Yes," please explain:

9. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

a. Merge, acquire or consolidate with another entity? ☐Yes ☐No

b. Operate in a troubled financial condition, including subject to regulator-approved corrective action? ☐Yes ☐No

c. File or be subject to filing of, a petition under Chapter 7, 11, 9 or 13 of the U.S. Bankruptcy Code? ☐Yes ☐No

d. Enter into any form of receivership proceeding, including conservation, rehabilitation or liquidation? ☐Yes ☐No

If "Yes," describe the essential terms of such transaction:

10. List below all subsidiaries and direct affiliates, with a description of operations, acquisition/formation date and ownership interest.

Name & Address	Description of Operations	Relationship	Date Acquired	Tax Status	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

11. Does the Applicant own, operate or manage any business or facilities other than operations described in this Application? ☐Yes ☐No

If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role.

12. Is the Applicant:

☐HMO (If HMO, please indicate: ☐Staff Model ☐Network / IPA Model ☐Combined)
☐PPO ☐PHO ☐IPA ☐Peer Review Organization
☐Third Party Administrator ☐Utilization Review Organization ☐MSO ☐Medical Group or Clinic
☐Accountable Care Organization ☐Other (describe):

13. List all states where the Applicant has operations:

EXPOSURE DETAILS

14. **Enrollment:**

Note: Wherever used, "enrollees" means covered lives, not just covered employees and member months.

Enrollment Type	Enrollees Last 12 Months As of / /	Enrollees Estimate Next 12 Months As of / /
ACO and/or Exchange		
HMO		
PPO		
Indemnity		
POS		
ASO		
IPA		
Medicaid		
Medicare		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other (please describe):		
Total Enrollment		

15. **Revenue:**

Enrollment Type	Last 12 Months As of / /	Estimate Next 12 Months As of / /
Total Revenue (all operations)		
PPO		
Utilization Review / Case Management		
MSO		
PHO		
IPA		
ACO		
Carve-Out Revenue		
TPA / Claims Administration		
Vision, Dental, PBM, STD, LTD or Other Carve-Out		
Other (please describe):		

16. **Number of Health Care Providers**

Provider type	Last 12 Months As of / /	Estimate Next 12 Months As of / /
Contracted Physicians		
Employed Physicians		

17. **Managed Care Activities**

Please check the managed care activities or services which you perform or subcontract. If you plan on offering any of these services over the next 12 months, please include those as well. Please check all that apply.
(Note: not all checked services may be covered):

Activity or Service	Performed or Subcontracted	Performed for others for a fee
Credentialing or peer review of health care providers		
Utilization review		
Drafting practice guidelines / critical pathways		
Case management		
Disease management		
Handling and adjusting of enrollees' health care benefit claims		
Application or enrollment processing for enrollees of health care plans		
Billing / other processing of enrollees' claims under health care plans		
Advertising, marketing, or selling health care plans / products		
Establishing health care provider networks to provide managed care		
Actuarial services for health care plans		
Assisting customers in securing reinsurance		
Services for automobile liability or disability		
Third party administration (TPA) services		
Employee Assistance Program (EAP)		
Nurse call line		
Other (describe):		

CURRENT COVERAGE

18. Requested Effective Date of Coverage:

19. Provide current insurance information:

	Carrier	Policy Period	Limits	Ded/SIR	Retro Date
Managed Care E&O					
Medical Malpractice					
D&O/EPL					
Stop Loss					
Network Security & Privacy					
Excess Managed Care E&O					

OPERATIONS AND ADMINISTRATION

General Operations

20. Is the Applicant licensed by federal, state or local government? ☐Yes ☐No

If "Yes," identify the licensing government:

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

If "Yes," identify the accrediting/certifying organization:

22. Has your license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? ☐Yes ☐No

If "Yes," please explain:

23. Do you have a formal risk management program? ☐Yes ☐No

24. Are any of your operations subcontracted?

Credentialing	☐Yes ☐No
Utilization Review	☐Yes ☐No
Claim Handling	☐Yes ☐No
Other (describe):	☐Yes ☐No

If "Yes," are any services subcontracted outside of the U.S.? ☐Yes ☐No

Please explain:

25. Are written contracts used for all subcontracted work? ☐Yes ☐No

If "No," please explain:

26. Do you require all subcontractors to carry their own errors and omissions insurance? ☐Yes ☐No

If "Yes," what are required minimum limits?

If "No," please explain:

27. Do you indemnify the subcontractor? ☐Yes ☐No

28. Does the subcontractor indemnify you? ☐Yes ☐No

29. Are any of your operations subcontracted outside of the United States? ☐Yes ☐No

If "Yes," please describe:

Healthcare Reform		
30.	Do you have written policies and procedures surrounding the disbursement of Medical Loss Ratio Rebates?	☐Yes☐No
31.	Do you publish your Medical Loss Ratio calculation process?	☐Yes☐No
32.	Have you ever been sanctioned, fined, investigated or sued for non-compliance related to your Medical Loss Ratio requirements?	☐Yes☐No
33.	Do you have an individual that is responsible for compliance with health care reform?	☐Yes☐No
34.	Have you ever been sanctioned, fined, investigated or sued for Medicare/Medicaid fraud? If "Yes," please explain:	☐Yes☐No
35.	Have you made changes to your policies and procedures to comply with all healthcare reform acts?	☐Yes☐No
36.	Do you offer quality incentives to your providers?	☐Yes☐No
37.	Do you disclose and explain the provider incentives to members? If "Yes," please provide details regarding how much and where the information is disclosed:	☐Yes☐No
38.	Do you have or plan to form a medical home facility? If "Yes," please provide details:	☐Yes☐No
39.	Do you use agents to assist in the completion of applications?	☐Yes☐No
40.	Do you have policy rescission policies? If "Yes," what are your incentives for rescissions?	☐Yes☐No
41.	Do you, or do you have plans to, participate in private or public exchanges? If "Yes," please explain:	☐Yes☐No
Credentialing		
42.	Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws?	☐Yes☐No
43.	Does legal counsel review and make recommendations before any final decision which adversely affects a provider's privileges or credentials?	☐Yes☐No
44.	Are providers allowed a hearing or appeal prior to termination?	☐Yes☐No
45.	Do you clearly express grounds for termination of providers in your contracts?	☐Yes☐No
46.	Do you require and verify that all contracted health care providers maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? If "No," what minimum limits are required?	☐Yes☐No
47.	Do you perform on-site visits of contracted health care providers? If "Yes," how often?	☐Yes☐No

48.	Do you disclose your reimbursement policies for non-par providers on your website? If "No," please explain:	☐Yes ☐No
49.	Do your subscribers have access to non-par provider's rates? If "No," please explain:	☐Yes ☐No
50.	Do you have a provider tiering program? If "Yes," please provide details on tiering criteria and appeal process:	☐Yes ☐No

Utilization Review

51.	Do you have written policies and procedures for utilization review, including for denials and appeals?	☐Yes ☐No
52.	Do your written Utilization Review Procedures:	
	a. Follow NCQA or URAC standards and comply with all applicable laws?	☐Yes ☐No
	b. Require physician review of all proposed denials?	☐Yes ☐No
	c. State that enrollees must be notified of all denials and appeals in writing including the identity of the person who makes decisions regarding appeals?	☐Yes ☐No
	d. Require consultation with legal counsel when considering appeals?	☐Yes ☐No
	e. Allow for a physician to override a practice guideline?	☐Yes ☐No
	f. Use profit sharing, risk sharing or other financial incentives in compensation arrangements with utilization reviewers?	☐Yes ☐No
	g. Utilize same specialty reviewers for benefit/coverage denials?	☐Yes ☐No
	h. Adhere to government mandated external review requirements in the states where you operate?	☐Yes ☐No
	i. Utilize the external review process in states where it is not mandated?	☐Yes ☐No

Claim Handling

53.	Do you utilize profit sharing, risk sharing, or other financial incentives in compensation arrangements with claim handlers or adjusters?	☐Yes ☐No

Advertising – Marketing – Sales

54.	Do all contracts, sales literature, brochures and marketing materials:	
	a. Expressly identify covered and non-covered procedures?	☐Yes ☐No
	b. Expressly refer to all contracted providers as independent contractors?	☐Yes ☐No
	c. Make statements or warranties as to the quality of health care, breadth of the plan?	☐Yes ☐No
	d. Go through legal counsel review and approval prior to use?	☐Yes ☐No

CURRENT & REQUESTED COVERAGE

55.	MISSOURI RESIDENTS – DO NOT ANSWER: Has any insurer cancelled or declined to renew Errors and Omissions or Professional Liability insurance for the Applicant? If "Yes," please provide details:	☐Yes ☐No

CLAIMS HISTORY		
56.	During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed): **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 56 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No
57.	Is the Applicant or any entity or individual proposed for coverage under this insurance 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? If "Yes," please provide details: **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 57 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes ☐No

FRAUD WARNINGS

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 any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any 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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an 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, RHODE ISLAND APPLICANTS AND 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 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.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly 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 oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal 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 if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

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) no 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.

SIGNATURE AND AUTHORIZATION

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 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 accounts, the preceding sentence is replaced with the following: 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 us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We 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.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us 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 us 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, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITITES 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:
Email Address			

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

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.