SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

APPLICATION FOR MANAGED CARE ORGANIZATIONS LIABILITY INSURANCE
(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

PLEASE SUBMIT A SUPPLEMENTAL APPLICATION IF:

* Your organization has assets in excess of $5,000,000
**Your organization has fifty (50) or more employees
***You desire General Liability coverage and have multiple locations.

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

Occupancy: _____, Area: _____sq. ft., Are additional premises owned or operated? ____Yes or ____ No

c. Applicant is: [ ] For Profit Corp. [ ] Not for Profit Corp. [ ] Joint Venture [ ] LLC [ ] Other

d. Date Operations Commenced: _____ State of Incorporation: _____

e. What is the organizations total number of employees? ____Total number of shareholders? ____
Total number of directors & Officers? _____

f. (i) Current Liability Insurance:
(If None, state NONE)

	Limits of Liability Per Claim/Aggregate	Deductible	Claims Made of Occurrence	Retroactive Date
Errors & Omissions	_____/_____	_____	_____	_____
Directors & Officers	_____/_____	_____	_____	_____
Employment Practices	_____/_____	_____	_____	_____
General Liability	_____/_____	_____	_____	_____
Other_____	_____/_____	_____	_____	_____

(ii) Requested Coverage and Limit of Liability: Requested Effective Date of Insurance: _____

Errors & Omissions	_____/_____	_____	_____	_____
Directors & Officers/LLC*	_____/_____	_____	_____	_____
Employment Practices**	_____/_____	_____	_____	_____
General Liability***	_____/_____	_____	_____	_____
Other_____	_____/_____	_____	_____	_____

2. OPERATIONS

a. Applicant operates as an:

(i) [ ] HMO/PPO [ ] Other: ____ Type: [ ] Staff [ ] Group [ ] Network [ ] IPA [ ] Other

(ii) [ ] Third Party Administrator
[ ] Utilization Review/Case Management Contractor
[ ] Management Services Organization (MSO)
[ ] Physician Hospital Organization (PHO)
[ ] Life/Health Insurance Carrier
[ ] Other _____

b. Please describe operations: _____

_____

_____

c. List any subsidiary(ies) or affiliate(s), description of operations, % of ownership and date acquired: _____

_____

d. Managed Care Organization Census Data:

(i) Enrollees:	Last 12 Mos.	Next 12 Mos.
Total insured enrollees:	_____	_____
Percentage of all enrollees in self-insured plans for which applicant acts as administrator:	_____	_____
Percentage of all enrollees in charitable, governmental or religious body sponsored insurance plans:	_____	_____
(ii) Health Care Providers:		
Estimated number of participating health care providers:	_____	_____
Estimated number of enrollees patients treated by participating health care providers:	_____	_____

Are participating health care providers required to maintain individual medical professional liability insurance? [ ] Yes [ ] No If Yes, what limits of liability are required? _____

e. If subsidiary(ies) not 100% owned by parent, provide details of the owners and percentage owned by each:_____

_____

_____

f. Within the next 12 months, do you plan to:

Acquire or merge with another group or entity or make any major operational changes?..... [ ] Yes [ ] No
If Yes, please attach details.

g. Do you, or any subsidiary or affiliate employ physicians, surgeons, dentists, or other health care professionals, in any medical capacity other than to perform administrative duties, peer review, utilization review or case management functions? ..... [ ] Yes [ ] No

h. Do you own, operate, or supervise a hospital, inpatient or outpatient clinic, pharmacy, dispensary or other medical facility? ..... [ ] Yes [ ] No
If Yes, please describe: _____

_____

i. Are you involved in any operations that are not specifically addressed herein?..... [ ] Yes [ ] No
If Yes, please describe: _____

_____

h. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

3. SERVICES

a. Do you provide or contract with others to provide review of health care services including:

Necessity/Cost of health care? ..... [ ] Yes [ ] No

Credentialling of health care providers? ..... [ ] Yes [ ] No

Peer review and quality of health care? ..... [ ] Yes [ ] No

Utilization review and Case Management? ..... [ ] Yes [ ] No

Professional review board or committee activities? ..... [ ] Yes [ ] No

Other services? _____ ..... [ ] Yes [ ] No

For all Yes answers, please provide a description of services rendered:

b. Provide or contract with others to provide:

Benefit/Claims Handling ..... [ ] Yes [ ] No

If Yes, please provide a description of claims handling services: _____

_____

c. Provide or contract with other to provide:

Marketing/Advertising ..... [ ] Yes [ ] No

Management ..... [ ] Yes [ ] No

Data Processing ..... [ ] Yes [ ] No

Insurance/Risk Management/Actuarial ..... [ ] Yes [ ] No

For all Yes answers, please provide a description of services rendered: _____

_____

d. Revenues/Fees/Receipt from Services:

	Last 12 Mos.	Next 12 Mos.
Question a above	_____	_____
Question b above	_____	_____
Question c above	_____	_____

e. For those services itemized in (a), (b), and (c) above that are provided by others under contract are contractors required to show evidence of professional liability insurance? ..... [ ] Yes [ ] No

If Yes, what limits of liability are required? _____

4. CLAIMS/HISTORY

a. If you answer "Yes" to any of the following, please attach details:

Are you aware of any claims that have been made against you or incidents that may give rise to a claim? ..... [ ] Yes [ ] No

Please attach a schedule of claims and suits made against you in the past five years, including date of incident, date claim made, description of the incident, and the current paid and reserved indemnity and expense amounts.

b. Are you, as of this date, aware of any conduct, circumstance(s) or claim(s) against you that have not been reported to your current or prior insurer(s)? ..... [ ] Yes [ ] No

c. Has any Director/trustee or Officer been charged or convicted of any criminal act in the past five years, or is any Director/trustee or Officer the subject of a pending criminal proceeding? ..... [ ] Yes [ ] No

d. Has any insurer canceled, refused to issue or renew any insurance policy? ..... [ ] Yes [ ] No

e. Has any federal or state regulatory authority or any certifying or accrediting body criticized or noted deficiencies in any of your operations or finances? ..... [ ] Yes [ ] No

f. During the past seven years, have you, your directors, officers, trustees, employees, volunteers or staff, review or committee members had any claim or suit brought against you for wrongful termination, employment-related discrimination, sexual harassment or retaliatory treatment against employees, including complaints filed with the Equal Employment Opportunity Commission to any similar state or local agency or authority? .....[ ] Yes [ ] No

g. Are you, or any of your directors, officers, trustees, employees, volunteers or staff, review or committee members aware of any fact, conduct, or circumstance which might give rise to a claim or suit alleging wrongful termination, employment-related discriminations, sexual harassment or retaliatory treatment against employees? .....[ ] Yes [ ] No

With prejudice to any other rights and remedies of the Company, any claim or suit arising from any fact, conduct, circumstances or situation required to be disclosed in response to any of the above questions, is excluded from the proposed insurance.

5. SUPPLEMENTARY INFORMATION

Please include the following with the application: (Check items included):

- ☐ Specimen of each type of contract and service agreement used for providers, subscribers, other.
- ☐ Peer review procedures, utilization review procedures, and credentialing process.
- ☐ Latest audited financial information or forecasted budget.
- ☐ Advertising brochures and marketing materials.
- ☐ Claim processing procedures, including denial of benefits procedures and complaint or grievance process.
- ☐ Organizational chart (if more than one entity).
- ☐ Employment application forms.
- ☐ Employee benefits hand book.
- ☐ Employee evaluation forms.
- ☐ If an LLC: Operating or Organizing Agreement Indemnification provisions of the by-laws, charter or articles of incorporation.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

Name of Applicant*	Title (Officer, partner, etc.)
Signature of Applicant*	Date

Signing this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

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BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: