

**OneBeacon Insurance Company  
 Homeland Insurance Company of New York  
 York Insurance Company of Maine**

**HEALTH CARE CONSULTANT  
 PROFESSIONAL LIABILITY INSURANCE APPLICATION**

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS MADE AND REPORTED BASIS.

**NOTICE: THE POLICY PROVIDES THAT THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY DEFENSE EXPENSES, AND THAT DEFENSE EXPENSES SHALL BE APPLIED AGAINST THE RETENTION.**

1. Name of **Applicant**: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
 Website: \_\_\_\_\_

2. The **Applicant** is (check all that apply):  
 Individual  Corporation  
 Non-profit or Not-for-profit  Privately Held  
 Partnership  LLC

3. Year established: \_\_\_\_\_ Number of consultants to be covered: \_\_\_\_\_  
 Total number of employees: \_\_\_\_\_

If operation is a start-up, business plan and resumes (including professional qualifications/designations) of all partners, principals, and key employees must be attached.

4. Is the **Applicant** controlled or owned by or associated or affiliated with, or does it own, any other firm or business enterprise?  Yes  No  
 If "Yes," please attach an explanation.

5. Estimated annual revenue: Last 12 months: \$ \_\_\_\_\_ Next twelve (12) months: \$ \_\_\_\_\_

6. Please identify the professional services for which coverage is desired (please check all that apply):

Activity	Yes	No	% Annual Revenue
a. Advertising, marketing, or selling health care plans or services	<input type="checkbox"/>	<input type="checkbox"/>	_____%
b. Billing, coding, reimbursement, repricing consulting	<input type="checkbox"/>	<input type="checkbox"/>	_____%
c. Billing/submitting health care claims	<input type="checkbox"/>	<input type="checkbox"/>	_____%
d. Case management	<input type="checkbox"/>	<input type="checkbox"/>	_____%
e. Compliance consulting	<input type="checkbox"/>	<input type="checkbox"/>	_____%
f. Credentialing or peer review of health care providers	<input type="checkbox"/>	<input type="checkbox"/>	_____%
g. Disease management	<input type="checkbox"/>	<input type="checkbox"/>	_____%
h. Educational programming or seminars	<input type="checkbox"/>	<input type="checkbox"/>	_____%
i. Expert witness testimony services	<input type="checkbox"/>	<input type="checkbox"/>	_____%
j. Human Resource policy and procedure consulting	<input type="checkbox"/>	<input type="checkbox"/>	_____%
k. Independent medical file review	<input type="checkbox"/>	<input type="checkbox"/>	_____%
l. Marketing research	<input type="checkbox"/>	<input type="checkbox"/>	_____%
m. Network development, physician contracting or managed care contracting	<input type="checkbox"/>	<input type="checkbox"/>	_____%
n. Quality assurance or clinical improvement consulting	<input type="checkbox"/>	<input type="checkbox"/>	_____%
o. Utilization review	<input type="checkbox"/>	<input type="checkbox"/>	_____%
p. Other (describe in detail): _____	<input type="checkbox"/>	<input type="checkbox"/>	_____%

7. Are these services provided to others for a fee?  Yes  No  
If "No," please explain: \_\_\_\_\_
8. Please list the **Applicant's** five (5) largest contracts and associated annual revenue:  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_
9. a. Has the **Applicant** ever acted, or will the **Applicant** act, in any capacity in which it has the ability to exercise decision-making authority for a client or an assignment?  Yes  No  
If "Yes," please attach an explanation.
- b. Does the **Applicant** assist in negotiating or have any authority to alter or enter into contractual relationships on any client's behalf?  Yes  No  
If "Yes," please attach an explanation.
10. During the past three (3) years, has the **Applicant's** name been changed or has the **Applicant** purchased, or merged or consolidated with, any other business or has the **Applicant** been purchased?  Yes  No  
If "Yes," please attach an explanation.
11. Are any material changes in the nature or size of the **Applicant's** business anticipated over the next twenty-four (24) months?  Yes  No  
If "Yes," please attach a detailed explanation.
12. Please list professional associations to which the **Applicant** belongs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
13. Does the **Applicant** provide services to any governmental entities or programs (Medicaid, Medicare, CHAMPUS, etc.), or does it plan to do so?  Yes  No  
If "Yes," please attach an explanation.
14. Does the **Applicant** provide services to any employee benefit plans, including any pension plans, or does it plan to do so?  Yes  No  
If "Yes," please attach an explanation.
15. a. Does the **Applicant** use a written contract with clients?  In all cases  Sometimes  Never
- b. Does the **Applicant** agree to hold its clients "harmless" or agree to indemnify its clients?  Yes  No
- c. Do clients agree to hold **Applicant** "harmless" or agree to indemnify **Applicant**?  Yes  No
16. Does the **Applicant** subcontract work to others?  Yes  No  
If "Yes," please attach an explanation.
17. Does the **Applicant** have promotional literature?  Yes  No  
If "Yes," please attach sample copies.

18. Is any errors and omissions or professional liability insurance currently in force?  Yes  No  
 If "Yes," please indicate:  
 Name of Insurer: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_ Limit: \_\_\_\_\_  
 Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_  
 Length of time coverage has been continuously in force: \_\_\_\_\_

19. Limits of Liability desired: \$ \_\_\_\_\_ each Claim or Related Claims.  
 \$ \_\_\_\_\_ aggregate for all Claims.

20. Retention desired:  \$5,000  \$10,000  \$25,000  Other: \$ \_\_\_\_\_

**21. MISSOURI RESIDENTS - DO NOT ANSWER THIS QUESTION.**

Has any errors and omissions or professional liability insurance ever been declined or canceled?  Yes  No  
 If "Yes," please attach an explanation.

22. Does any director, officer, employee, or partner of the **Applicant** have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim?  Yes  No  
 If "Yes," please attach an explanation.

**Please Note: Without prejudice to any other rights and remedies of the Underwriter, it is agreed that any claim required to be disclosed in response to Question 22 is excluded from the proposed insurance.**

23. Please attach a list and the current status of all errors and omissions claims made during the past three (3) years against the **Applicant** or any director, officer, employee, or partner of the **Applicant**.  
 If none, please check here:  None

24. Has the **Applicant** or any director, officer, employee, or partner of the **Applicant** ever been the subject of disciplinary action as a result of professional activities?  Yes  No  
 If "Yes," please attach an explanation.

**Please Note: Information provided in response to questions 21–24 does not constitute notice of claim or potential claim under any insurance policy. All such notices must be submitted in accordance with the policy.**

25. The basic policy for which the **Applicant** has applied will not cover acts committed before the inception date of the policy. If the **Applicant** desires a quote for these prior acts, please enter the date from which the **Applicant** wants prior acts covered: \_\_\_\_\_. (Please note: Coverage does not apply to known or expected claims or those which any insured could have reasonably foreseen.)

**ATTACHMENTS**

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

1. Sample copies of all types of client contracts, including sub-contractor contracts.
2. Copies of all promotional or marketing materials.
3. The **Applicant's** most recent interim and/or accountant-prepared financial statement.
4. Resumes (including professional qualifications or designations) of all partners, principals, and key employees.
5. Description of the **Applicant's** services, if not fully described in promotional or marketing materials or in Question 6 above.

FOR THE PURPOSES OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF ALL PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT, TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS APPLICATION, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE. THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. ACCEPTING THIS APPLICATION DOES NOT BIND THE UNDERWRITER TO ISSUE A POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE UNDERWRITER AND IS CONSIDERED PHYSICALLY ATTACHED TO THIS APPLICATION. THIS APPLICATION AND SUCH INFORMATION WILL BECOME PART OF, AND BE CONSIDERED PHYSICALLY ATTACHED TO, ANY POLICY ISSUED AS A RESULT OF THIS APPLICATION. IF, AS A RESULT OF THIS APPLICATION, A POLICY IS ISSUED, THE UNDERWRITER WILL HAVE RELIED UPON THIS APPLICATION AND ON SUCH ATTACHMENTS.

IF THE STATEMENTS IN THIS APPLICATION OR IN ANY ATTACHMENT CHANGE BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT MUST NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION.

THE UNDERSIGNED DECLARES THAT THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND THAT:

- (A) THE POLICY FOR WHICH APPLICATION IS MADE WILL APPLY ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AND REPORTED TO THE UNDERWRITER DURING THE PERIOD IN WHICH THE POLICY IS IN EFFECT;
- (B) THE LIMITS OF LIABILITY CONTAINED IN THE POLICY WILL BE REDUCED, AND MAY BE COMPLETELY EXHAUSTED, BY THE PAYMENT OF DEFENSE EXPENSES AND, IN SUCH EVENT, THE UNDERWRITER WILL NOT BE RESPONSIBLE FOR THE CONTINUED DEFENSE OF ANY CLAIM OR BE LIABLE FOR THE DEFENSE EXPENSES OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT ANY OF THE FOREGOING EXCEED ANY APPLICABLE LIMIT OF LIABILITY; AND
- (C) DEFENSE EXPENSES WILL BE APPLIED AGAINST ANY APPLICABLE RETENTION.

NOTICE TO 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.

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 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.

NOTICE TO DISTRICT OF COLUMBIA, MAINE AND VIRGINIA 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 FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERET O, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND 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 MARYLAND 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 MAY BE GUILTY OF INSURANCE FRAUD.

**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 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 OKLAHOMA APPLICANTS: 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 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.**

**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.**

APPLICANT		
By ( <i>President and/or CEO</i> )	TITLE	DATE

Please note: This Application must be signed by the President and/or CEO of the **Applicant** acting as authorized agent of the person(s) or entity(ies) proposed for this insurance.

**REQUIRED INFORMATION**

PRODUCED BY ( <i>Insurance Agent</i> ) Please print and sign name  _____  _____		
INSURANCE AGENCY		
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.	
ADDRESS ( <i>No., Street, City, State, and ZIP</i> )		
EMAIL ADDRESS		
SUBMITTED BY ( <i>Insurance Agency</i> )	INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	AGENT LICENSE NO.