Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

Health Care Portfolio℠
New Business Application
(For organizations with more than 250 employees)

BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

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

APPLICATION INSTRUCTIONS:

Whenever used in this Application, the term "**Applicant**" means the Parent Organization and all of its subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____

2. Address of **Applicant**: _____
   City: _____ State: _____ Zip Code: _____ Telephone: _____
   Website: _____

3. State and Date of Incorporation: _____ _____

4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:
   Name: _____ Title: _____
   E-Mail Address: _____ Phone: _____ Fax: _____

5. Individual responsible for Human Resources or employment law matters:
   Name: _____ Title: _____
   E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which coverages are being requested and complete supplemental questionnaires if required.

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

Coverage Requested	Limit of Liability Requested	Retention Requested
☐ Directors & Officers Liability	$	$
☐ Optional Entity Liability	$	$
☐ Optional Employment Practices Liability	$	$
☐ Optional Third Party Liability	$	$
☐ Fiduciary Liability		
☐ Optional Separate Defense Costs Coverage	$	$
☐ Crime	$	$
☐ Kidnap/Ransom & Extortion	$	$
☐ Outside Directorship Liability*	$	$
☐ Supplemental Regulatory Coverage Sublimit*	$_____Sublimit (cannot exceed $1,000,000)	$

*Separate applications must be completed.

2. Describe nature of **Applicant's** business:

_____

_____

3. (a) **Applicant** is a:

☐ Not-For-Profit Tax Exempt Corp. ☐ For-Profit Corp.
☐ Not-For-Profit Taxable Corp. ☐ Limited Liability Company
☐ Partnership ☐ Other (describe): _____

(b) Is the **Applicant** owned or operated by a state, city, town or county or by an agency, authority or other governmental or quasi-governmental entity established by state or local law? ☐ Yes ☐ No
If "Yes," by whom? _____

(c) Complete if **Applicant** has stock or other equivalent ownership instrument:
(i) Total number of common shareholders: _____
(ii) Total number of common shares outstanding: _____
(iii) Total number of common shares owned by officers: _____
(iv) Total number of shares owned by directors who are not officers: _____
(v) If any shareholder owns 5% or more of shares, designate name and percentage:
_____

(d) Please complete the following information:
(i) Revenues: Previous twelve (12) months: _____
Projected next twelve (12) months: _____
(ii) Employees: Previous twelve (12) months: _____
Projected next twelve (12) months: _____
(iii) Total Assets: _____

4. Does the **Applicant** have any subsidiaries**,** joint ventures or affiliates or control any other entity or organization? ☐ Yes ☐ No
If "Yes," please attach a description of the operations, ownership, and the tax status of each such entity, and indicate whether coverage is requested for each such entity.

5. **Applicant's** Affiliation and Accreditation (note all that apply):

☐ American Hospital Association ☐ JCAHO
☐ NCQA . ☐ Other: _____

(a) Has any **Applicant's** license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? ☐ Yes ☐ No
If "Yes," please explain: _____

(b) Has the JCAHO, NCQA or any other certifying or accrediting body found any **Applicant** to be out of substantial compliance with its certifying or accrediting standards? ☐ Yes ☐ No
If "No," please provide details by separate attachment.

(c) Has any federal or state regulatory authority criticized or noted deficiencies in any of the **Applicant's** operations, procedures or finances? ☐ Yes ☐ No
If "Yes," please provide details by separate attachment.

6. Is any of the **Applicant's** medical malpractice/health care professional liability exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk-sharing arrangement or pool? ☐ Yes ☐ No

If "Yes," please describe that insurance program by separate attachment, state how the program is administered and attach a copy of the most recent actuarial study. If a funded trust, captive or subsidiary is used:

(a) Does the funded trust, captive or subsidiary provide insurance other than to the **Applicant**? ☐ Yes ☐ No
(b) Is the program funded in accordance with annually determined actuarial requirements? ☐ Yes ☐ No

MISSOURI APPLICANTS: DO NOT ANSWER QUESTIONS 7 AND 8.

7. Has the **Applicant** been declined, canceled or non-renewed for any of the liability insurance mentioned above? ☐ Yes ☐ No
If "Yes," please attach an explanation.

8. Has any insurer under any other coverages listed above indicated an intent not to offer renewal terms to the **Applicant**? ☐ Yes ☐ No

III. DIRECTORS AND OFFICERS AND OPTIONAL ENTITY LIABILITY INFORMATION:

1. Who names the **Applicant's** directors and trustees?
☐ Membership Vote ☐ Appointed by: _____
☐ Other: _____

2. (a) How many board members does **Applicant** have? _____
(b) How often does the **Applicant's** board meet? _____
(c) Have any **Applicant** board members resigned or terminated in the last two (2) years for reasons other than expiration of their term? ☐ Yes ☐ No
If "Yes," please describe: _____

3. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? ☐ Yes ☐ No

If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? ☐ Yes ☐ No
If "Yes," please explain: _____

4. Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

	Organization	Persons
(a) Anti-trust, copyright or patent litigation?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws?	☐ Yes ☐ No	☐ Yes ☐ No
(c) Any other criminal actions?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes" to any of the above in Question 4, please attach a full description of the details.

5. Other than those identified in your response to Question 4, has any civil proceeding been brought at any time during the last five (5) years against (a) any **Applicant** or (b) any proposed insured individual in his or her capacity as a director, officer, trustee or member of any duly constituted committee of any entity? ☐ Yes ☐ No
If "Yes," please attach a full description of the details.

6. Does the **Applicant** render any professional services, including but not limited to providing any standard setting, accrediting, credentialing or licensing activities, management or administration for others for a fee? ☐ Yes ☐ No
If "Yes," please describe: _____

BUSINESS PRACTICES:

To answer questions in this section, you may want to consult with the Applicant's legal counsel, or with the individual(s) responsible for administering or overseeing the Applicant's provider selection practices, which include peer review and credentialing practices.

7. Does the **Applicant** perform provider selection? ☐ Yes ☐ No
If "Yes," please complete the following questions. If "No," skip to Question 8.

(a) Does the **Applicant** have written policies and procedures in place for provider selection, including credentialing, re-credentialing, and making decisions that adversely affect a provider's credentials? ☐ Yes ☐ No

For Self? _____ For Others for a fee? _____

8. (a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department 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 closings or restrictions? ☐ Yes ☐ No

If "Yes," provide details by separate attachment.
If the answer to any part of this Question 8 is "Yes," has the **Applicant** consulted with legal counsel regarding proper procedures and safeguards in such instance? ☐ Yes ☐ No

9. Does the **Applicant** control more than twenty percent (20%) in any given geographical area of: (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? ☐ Yes ☐ No

If "Yes," to Question 9 (a), (b), (c) or (d), please provide market share percentages by separate attachment.

10. Does the **Applicant** have any exclusive contracts with any providers? ☐ Yes ☐ No
If "Yes," provide details by separate attachment.

11. Does the **Applicant** have a plan for ongoing training on HIPAA and other privacy laws? ☐ Yes ☐ No

12. Does the **Applicant** have a conflict of interest policy in place applicable to all directors, officers, trustees, staff and employees? ☐ Yes ☐ No

13. Are all directors, officers, trustees, staff and employees required to disclose any potential financial or other conflicts of interest annually? ☐ Yes ☐ No

14. (a) Are all compensation arrangements and business transactions evaluated annually for compliance with Excess Benefit Transaction rules as defined Section 4958 of the Internal Revenue Code of 1986? ☐ Yes ☐ No
If "No," please provide details by separate attachment.

(b) Has the **Applicant** been subject to an investigation or paid a fine for an Excess Benefit Transaction violation? ☐ Yes ☐ No

TRANSACTIONAL INFORMATION:

15. In the past seven (7) years has the **Applicant** merged into, been acquired by, consolidated with or affiliated with another entity? ☐ Yes ☐ No
If "Yes," answer the following questions, otherwise proceed to Question 16.

(a) Did the **Applicant** seek an outside attorney's opinion on antitrust matters? ☐ Yes ☐ No
Please provide details as a separate attachment.

(b) After such merger or acquisition did the **Applicant's** market share (whether of hospital beds, providers, health care services provided or membership in a network) exceed 20%? ☐ Yes ☐ No

16. Has the **Applicant** in the past two (2) years completed or agreed to, or does it contemplate within the next twelve (12) months, any of the following, whether or not such transactions were or will be completed?
If "Yes," please describe the essential terms of each such transaction as an attachment to this Application.
Also, if the **Applicant** answers "Yes" to Question 16 (b) or (c) below, attach a copy of any applicable prospectus.

(a) Sale, distribution or divestiture of any assets or stock other than in the ordinary course of business? ☐ Yes ☐ No
(b) Registration for a public offering or any private placement of securities? ☐ Yes ☐ No
(c) Issuance of debt? ☐ Yes ☐ No
(d) Reorganization or arrangement with creditors under federal or state law, whether or not such reorganization or arrangement was or will be completed? ☐ Yes ☐ No
(e) Entering into new governmental contracts? ☐ Yes ☐ No
(f) Conversion from non-profit to for-profit status? ☐ Yes ☐ No
(g) Undertaking new areas of business? ☐ Yes ☐ No
(h) Branch, location, facility, office or subsidiary closings, consolidations or layoffs? ☐ Yes ☐ No
(i) Acquisitions of any type? ☐ Yes ☐ No

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

1. Number of Employees and Independent Contractors:

		Current year	**Previous year**
(a)	Full-time employees (include employed physicians):	_____	_____
(b)	Part-time employees (include leased and seasonal, and employed physicians):	_____	_____
(c)	Employed Physicians (full and part-time):	_____	_____
(d)	Volunteers:	_____	_____
(e)	Independent Contractors:	_____	_____
(f)	Employees located in California:	_____	_____

2. Does the **Applicant**:

(a) Distribute and document the receipt of its employee handbook to all employees? ☐ Yes ☐ No
If "Yes," is the employee required to sign and acknowledge receipt of the handbook?

(b) Have written procedures in place that are distributed to each employee regarding:
(i) Employment-at-will? ☐ Yes ☐ No
(ii) EEO statement and ADA accommodation statement? ☐ Yes ☐ No
(iii) Progressive discipline and termination? ☐ Yes ☐ No
(iv) Anti-discrimination and anti-harassment policies? ☐ Yes ☐ No
(v) Complaint resolution and internal grievance procedures? ☐ Yes ☐ No
(vi) Bonus compensation programs? ☐ Yes ☐ No
(vii) Employee conduct when dealing with third parties including non-discrimination and non-harassment statements? ☐ Yes ☐ No
(viii) Response to complaints of harassment, discrimination or civil rights violations from third parties? ☐ Yes ☐ No
(c) Have a full-time human resources manager or department? ☐ Yes ☐ No
If "No," who is responsible for this function? _____
(d) Confer with human resources department or in-house legal counsel prior to any terminations? ☐ Yes ☐ No
(e) Have a manual of its human resources procedures? ☐ Yes ☐ No
If "Yes," please indicate the date it was last revised: _____
(f) Provide formal training for its supervisors in administering these procedures? ☐ Yes ☐ No
Who provides this training? _____
(g) Provide formal anti-discrimination and anti-harassment training for all of its employees? ☐ Yes ☐ No

3. Please list any specific locations in California where the **Applicant** has employees:

   _____

   Number of employees at each location _____

4. During the past 3 years, has any **Applicant** or any person proposed for coverage been involved in any capacity in any of the following matters?
   (a) EEOC, NLRB or other similar administrative proceeding? ☐ Yes ☐ No
   (b) Employment-related civil suit? ☐ Yes ☐ No
   If "Yes" to either of the above in Question 4, please provide a full description of the details by separate attachment.

ADDITIONAL QUESTIONS FOR APPLICANTS WITH 1,000 OR MORE EMPLOYEES:

If the **Applicant** employs **more than 1,000 employees** on either a full-time or a part-time basis, **or** has **5% or more of its employees in California**, and is requesting Employment Practices Liability (with or without Third Party Liability) coverage, complete this Section and submit the following documents as part of this Application:

- Employee handbook;
- Employment application form;
- Most recent EEO-1 (s); and
- Third-party policies and statements (if applying for Third Party Liability coverage).

5. Percentage of employees that are: Union _____% Non-union _____%
   List name(s) of union(s): _____

6. What was the annual employee turnover rate for the last three (3) years?
   Past year _____% One (1) year previous _____% Two (2) years previous _____%

7. State the **Applicant's** percentage of each:
   Involuntary terminations: Past year: _____ One (1) year previous: _____
   Voluntary terminations: Past year: _____ One (1) year previous: _____

8. Percentage (%) of employees with salaries (including bonuses):
   Less than $50,000: _____%
   $50,000 - $100,000: _____%
   $100,000 - $250,000: _____%
   Greater than $250,000: _____%

9. Is a written application required from all applicants? ☐ Yes ☐ No

10. Is outside counsel used to review:
    - Layoffs, staff reductions or downsizings? ☐ Yes ☐ No
    - Terminations? ☐ Yes ☐ No
    - Written policies and procedures? ☐ Yes ☐ No

11. Is Alternative Dispute Resolution used? ☐ Yes ☐ No

12. Has the **Applicant** been audited by the EEOC or DOL? ☐ Yes ☐ No

13. During the last three (3) years, has any **Applicant** in any capacity been involved in a conciliation, settlement or consent agreement with either the EEOC or the OFCCP? ☐ Yes ☐ No

    If "Yes," provide details by separate attachment. Please include: (a) date, (b) type, (c) allegation(s), (d) current status, (e) judgment or settlement amount, and (f) defense costs incurred.

14. Does the **Applicant** have established policies or procedures:
    (a) Outlining employee conduct when dealing with third parties, including non-discrimination and non-harassment statements? ☐ Yes ☐ No
    (b) For responding to complaints of harassment, discrimination or civil rights violations from third parties? ☐ Yes ☐ No

15. Does the **Applicant** have a grievance or complaint hotline or other type of communication process? ☐ Yes ☐ No

    If "Yes," how are complaints or grievances investigated?

    _____

16. What percentage of the **Applicant's** employees perform a majority of their functions off-site? _____%

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

1. Please list the names and types of **Applicant's** employee benefits plan(s). Attach additional pages if needed.

Plan names (Do not include health & welfare plans)	**Plan assets** (current year)	**Plan assets** (previous year)	**Type of plan***	**Underfunded 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)

2. Does the **Applicant** handle any investment decisions in-house? ☐ Yes ☐ No
   If "Yes," please describe: _____

3. In the past two (2) years, has the **Applicant** merged or terminated any plan(s)? ☐ 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.

4. Are any plans NOT in compliance with plan agreements or ERISA? ☐ Yes ☐ No
   If "Yes," please describe: _____

5. Past activities:
   (a) Has any fiduciary been:
      (i) accused, found guilty or held liable for a breach of trust? ☐ Yes ☐ No
      (ii) convicted of criminal conduct? ☐ Yes ☐ No
   (b) Have any claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries? ☐ Yes ☐ No
   (c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? ☐ Yes ☐ No
   If "Yes" to any of the above in Question 5, please attach a full description of the details.

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

1. Does the **Applicant**:
   (a) Allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? ☐ Yes ☐ No

(b) Does an independent CPA provide a Management Letter to the **Applicant**? ☐ Yes ☐ No
If "Yes," please attach the most recent copy and management's response to the letter.

2. What is the limit above which the **Applicant** requires countersignature for their checks? $_____

3. Please describe the services the **Applicant** provides for clients (including, but not limited to, accounting, payroll or purchasing functions): _____

4. Does an annual external audit include all subsidiaries and joint ventures? ☐ Yes ☐ No

5. Do the **Applicant's** external audits include all of its locations? ☐ Yes ☐ No
If "No," please explain _____

6. (a) How often does the **Applicant** perform a physical inventory check of stock and equipment? _____
(b) Who performs these reconciliations? _____

7. Does the **Applicant** have procedures in place to verify the existence and ownership of all new vendors prior adding them to the authorized master vendor list? ☐ Yes ☐ No

8. Does the **Applicant** verify invoices against a corresponding purchase order, receiving report and the authorized master vendor list prior to issuing payment? ☐ Yes ☐ No

9. Number of: domestic locations: _____; foreign locations: _____and countries _____

10. Are international and domestic purchasing, inventory and payable procedures and controls consistent? ☐ Yes ☐ No
If "No," please attach an explanation.

11. Does the **Applicant** perform pre-employment reference checks for all its potential employees? ☐ Yes ☐ No
If "No," please attach an explanation.

Client Services

12. Do any of the **Applicant's** clients require the **Applicant** to carry crime insurance or to be bonded? ☐ Yes ☐ No
If "Yes," please explain and specify amount _____

13. List all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last 5 years, itemizing each loss separately. Include date of loss, description and total amount of loss. (Attach additional pages if necessary.) _____

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION: – Complete if coverage is requested.

1. Please complete the following regarding **Applicant's** risk profile:

List countries in which you have operations	Type of operation	Number of locations	Number of employees	Revenues
U.S. and Canada				$
				$
				$
TOTAL:				$

2. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling

3. Please identify:
   (a) any precautions taken to protect those individuals or facilities noted in Questions 1 and 2, above:
   _____
   _____
   _____

   (b) the individual responsible for the **Applicant's** corporate security:
   Name: _____ Title: _____
   Email Address: _____

4. Please provide details on all network security precautions taken to secure sensitive client data that exists on your corporate networks or databases. If you do not keep client data on your networks or databases, check none: ☐
   _____
   _____

5. Does the **Applicant** have a nursery, pediatric floor and/or an on-site child care/day care center? ☐ Yes ☐ No
   If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.

6. Has the **Applicant** had any incidents or threats with respect to infant abductions during the past five (5) years? ☐ Yes ☐ No
   If "Yes," please provide details by separate attachment.

7. List all kidnapping, extortion threat, cyber extortion, hijacking, wrongful detention or political threat events discovered by the **Applicant** in the last five (5) years, which would have been covered under the policy for which this **Application** is made, itemizing each loss separately. Include date of loss, treat or event; description of the loss, threat or event; and total amount of each loss. Attach additional pages if necessary.
   _____
   _____
   _____
   _____

VIII. CURRENT INSURANCE INFORMATION:

Coverage Sections	The Applicant currently purchases this coverage		Current Limit of Liability	Current Retention	Premium	Current Carrier
	Yes	No				
Directors & Officers And Entity Liability	☐	☐	$	$	$	
Employment Practices Liability and Third Party Liability	☐	☐	$	$	$	
Fiduciary Liability	☐	☐	$	$	$	
Crime	☐	☐	$	$	$	
Kidnap Ransom & Extortion	☐	☐	$	$	$	
Medical Professional Liability	☐	☐	$	$	$	
Managed Care Errors & Omissions	☐	☐	$	$	$	

IX. CLAIMS AND REPRESENTATIONS/PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES:

1. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage has submitted any 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 of which the requested coverages would be a direct or indirect replacement, except as follows:

   If the answer is none, so state:

   _____

   _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. Neither the **Applicant** nor any individual or entity proposed for coverage 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 the answer is none, so state:

   _____

   _____

   NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, 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 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

XI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES:

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, any coverage section. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the contract should any coverage section providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such coverage section; and that the Company will have relied on all such materials in issuing any such overage section.

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

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime,

and may be subject to civil fines and criminal penalties.

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, Tennessee 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 and Oklahoma 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 containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

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 material fact thereto, commits a fraudulent insurance act which is a crime.

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 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 New York and 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 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 (in New York) or criminal and civil penalties (in Pennsylvania).

This Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
_____	_____	Chief Executive Officer
_____	_____	Chief Financial Officer

XII. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- ☐ Most recent CPA-audited financial statements (last two (2) fiscal years with notes, schedules);
- ☐ Most recent CPA Letter to Management and management's response (if this Letter is not issued, so indicate);
- ☐ Interim financial statements including balance sheet(s), income statement(s) and cash flow statement(s), if audited financial statements are six (6) months or older;
- ☐ Current organizational chart of the organization, listing each subsidiary, joint venture or affiliate, including the ownership percentage and tax status of each;
- ☐ Loss runs for the past five (5) years from any carrier for which the coverage requested is a direct or indirect replacement;

☐ A summary and status report of any litigation filed within the last two (2) years by or against any person(s) or entity(ies) proposed for this insurance (including any litigation that has been resolved) which is not included in the loss runs but may be covered under the coverage section(s) requested;
☐ Copies of the **Applicant's** current charter, by-laws, medical staff by-laws and other operating agreements;
☐ If **Applicant** has defined benefit plan(s), most audited pension financial statements for each plan;
☐ Fiduciary Liability: if **Applicant** has an ESOP, include most recent stock valuation report.

Complete the Regulatory Supplemental Application to the Executive Liability, Entity Liability and Employment Practices Liability Coverage Section, if Regulatory coverage is requested.

Complete the Outside Directorship Liability Application, if a separate limit for such liability is desired.

Produced By: Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.:_____ Agent License No.:_____

Address _____

City:_____ State:_____ Zip Code:_____

Submitted By: Agency:_____

Taxpayer ID or SS No.:_____Agent License No.:_____

Address _____

City:_____ State:_____ Zip Code:_____