HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY INSURANCE APPLICATION

Atlantic Specialty Insurance Company
(Stock company owned by Intact Insurance Group USA LLC)

intact INSURANCE management liability

intactspecialty.com/management-liability

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

If additional space is needed to answer the below questions, attach a separate document to this Application to provide complete answers. If the answer to a question is none, state "None" or "0" in the space provided.

Application Instructions:

Whenever used in this Application, the term "Applicant" shall mean the organization identified in response to Question 1 of Section I. of this Application.

I. APPLICANT

1. Name of Applicant:

2. Street Address:

3. City: State: Zip Code:

4. Description of the Applicant's business:

II. GENERAL INFORMATION

5. Number of Employees at the Applicant and its subsidiaries: Full Time: Part Time: Independent Contractor:

   Of the employees and independent contractors listed above, how many are physicians? _____

6. Applicant is:

   ☐ Not-For-Profit Tax Exempt Organization (Applicable Federal or State Revenue Code)

   ☐ Not-For-Profit Taxable Organization ☐ For-Profit Corporation ☐ Partnership ☐ Limited Liability Company

   ☐ Other (please describe):

7. Years of operation:

8. Please provide the following for the most recent fiscal year end for the Applicant:

   If financial statements are provided as an attachment to this Application, this Question 8. does not need to be completed.

   Total Assets: Revenues: Net Income:

   Long Term Debt: Equity:

9. Has the Applicant or any of its subsidiaries in the past 18 months completed, or is any such entity contemplating completing in the next 12 months, any of the following:

a. Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No

b. Facility or subsidiary closings or layoffs? ☐ Yes ☐ No

c. Mergers, acquisitions or divestures? ☐ Yes ☐ No

d. Registration for a public or private offering of securities? ☐ Yes ☐ No

If "Yes" to a., b., c. or d., please provide details:

10. What percentage of revenues does the Applicant and its subsidiaries receive from government sources?

☐ None ☐ Less than 5% ☐ 5% to 50% ☐ Greater than 50%

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

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

12. Has the Applicant or any of its subsidiaries voluntarily disclosed to any governmental entity, or is it aware of, any violations or potential violations of the following:

a. The False Claims Act? ☐ Yes ☐ No

b. The Stark Act? ☐ Yes ☐ No

c. Any similar law or regulation? ☐ Yes ☐ No

13. Has the Applicant or any of its subsidiaries:

a. Been subject to any regulatory investigation or indictment involving patient billing, business referral(s) or any anti-kickback law? ☐ Yes ☐ No

b. Been subject to any type of federal or state mandate or regulatory compliance oversight (for example, a corporate integrity agreement)? ☐ Yes ☐ No

c. Been subject to any type of regulatory monetary settlement, fine or penalty? ☐ Yes ☐ No

If "Yes" to a., b. or c., please provide details.

14. As an attachment to this Application, please list all direct and indirect subsidiaries for which the Applicant requests coverage. Please include the subsidiary name(s), nature of operations and the % owned by the Applicant.

Please note that coverage for any entity of which the Applicant owns 50% or less of its voting shares is not automatically included. The policy, if issued, will determine coverage for any such entity.

III. DIRECTORS AND OFFICERS LIABILITY INFORMATION – Complete if coverage is requested.

15. Total number of common shareholders, partnership interests or LLC units: _____
Common shares outstanding: _____

For any shareholder owning 5% or more of the Applicant's voting shares, complete the following:

Shareholder Name	% Owned	Is this shareholder a private equity or venture capital firm?	Does this shareholder have board representation?
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No

16. Is any of the Applicant's stock held by an Employee Stock Ownership Plan (ESOP)? ☐ Yes ☐ No

17. Has the Applicant or any of its subsidiaries experienced any changes to key executives (Chairman, President, CEO, CFO) in the past 12 months due to reasons other than death or retirement at the normal retirement age? ☐ Yes ☐ No

If "Yes," please provide details:

18. Is the Applicant or any of its subsidiaries in violation of any debt covenant? ☐ Yes ☐ No

If "Yes," please provide details:

IV. EMPLOYMENT PRACTICES LIABILITY INFORMATION – Complete if coverage is requested.

19. Please provide the following information for the Applicant and its subsidiaries:

Estimated annual remuneration* of all employees, including officers, owners or partners: _____

*Note: Remuneration includes salary, commissions, bonuses and other incentives and does not include dividends or security based distributions.

Employee Turnover: Most Recent 12 months _____% Prior 12 months _____%

Number of employees located in CALIFORNIA:

Full Time: Part Time: Independent Contractor:

Of the employees and independent contractors located in CALIFORNIA, how many are physicians? _____

20. Has the Applicant or any of its subsidiaries in the past 18 months completed, or does any such entity contemplate completing during the next 12 months, any layoffs? ☐ Yes ☐ No

If "Yes," please answer the following:

a. How many employees were or will be laid off? _____

b. Did the Applicant or subsidiary consult with outside counsel or will they consult with outside counsel prior to the layoffs? ☐ Yes ☐ No

21. During the past 3 years, has the Applicant or any subsidiary, in any capacity, been involved in any EEOC or other similar employment-related administrative proceeding? ☐ Yes ☐ No

If "Yes," please provide details of each such proceeding in response to Question 40. of this Application.

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

22. Provide the total assets for the benefit plans maintained by the Applicant and its subsidiaries: $ _____

23. Which types of benefit plans does the Applicant and its subsidiaries maintain? Check all that apply.

☐ Defined Contribution Plan(s) (typically 401ks, 403bs, IRAs, and/or SEPs)

☐ Defined Benefit Plan(s) (typically traditional pension plans)

☐ Employee Stock Ownership Plan (ESOP)

24. If Defined Benefit Plan(s) was checked above, what is the funded percentage (as shown on Schedule SB of the 5500)? _____%

25. During the past 24 months has (or during the next 12 months will) any plan for which coverage is requested:

a. Been (Be) merged with another plan, terminated or sold? ☐ Yes ☐ No

b. Been (Be) the subject of an investigation by the DOL, IRS, or similar domestic or foreign agency? ☐ Yes ☐ No

c. Had (Have) any outstanding or delinquent contributions? ☐ Yes ☐ No

d. Held (Hold) investments in more than 10% of any corporation or partnership, including but not limited to the Applicant? ☐ Yes ☐ No

If "Yes" to a., b., c. or d., please provide details:

VI. EMPLOYED LAWYERS INFORMATION – Complete if coverage is requested.

26. Number of Lawyers at the Applicant and its subsidiaries:

Employed Lawyers _____ Contract/Leased Attorneys _____

27. Does the Applicant currently maintain Directors and Officers and/or Errors & Omissions Coverage? ☐ Yes ☐ No

28. Has any Employed Lawyer ever been the subject of a reprimand, sanction, fine or discipline by, or been refused admission to, a bar association, court, administrative or regulatory agency? ☐ Yes ☐ No

If "Yes," please provide the name of the Employed Lawyer and a brief explanation:

29. Do any Lawyers, in their position with the Applicant, provide legal services for any entity other than the Applicant and its subsidiaries or for individuals who are not employed by the Applicant or its subsidiaries? ☐ Yes ☐ No

If "Yes," please provide details:

VII. INFORMATION RISK AND RECOVERY (CYBER) – Complete the IRR Supplemental Application if coverage is requested.

VIII. CRIME INFORMATION – Complete if coverage is requested.

30. Total number of locations of the Applicant and its subsidiaries in the United States and Canada: _____

Total number of locations of the Applicant and its subsidiaries outside the United States and Canada: _____

List any countries, outside of the U.S. and Canada, where the Applicant and its subsidiaries have locations and provide the number of employees in each country:

31. Does the Applicant:

a. Allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? ☐ Yes ☐ No

b. Allow the same individual who verifies the existence of vendors to also have the authority to edit the authorized master vendor list? ☐ Yes ☐ No

c. Have custody or control over any funds, accounts, or materials of any of its clients? ☐ Yes ☐ No

If "Yes" to a., b. or c., please explain:

32. Are at least two signatures required on checks? ☐ Yes ☐ No

If "Yes," above what amount? $_____

33. Does the Applicant:

a. Perform pre-employment background checks for all its potential employees? ☐ Yes ☐ No

b. Maintain a list of authorized vendors? ☐ Yes ☐ No

c. Have a procedure in place to verify the existence and ownership of new vendors prior to adding them to the authorized master vendor list? ☐ Yes ☐ No

d. Strictly comply with dual recorded authorizations for all outgoing wire transfers? ☐ Yes ☐ No

e. Have internal controls designed so that no employee can control a process from beginning to end (for example, request a check, approve a voucher and sign the check)? ☐ Yes ☐ No

If "No" to a., b., c., d. or e., please explain:

34. How many times does the Applicant perform a physical inventory of stock and equipment per year?

☐ None ☐ 1 time or more ☐ Not applicable (Applicant does not have material physical inventory)

35. How many employees handle, have access to or maintain records of money or securities? _____

36. Do operations outside the United States use the same controls as operations in the United States? ☐ Yes ☐ No ☐ Not Applicable

If "No," please explain:

37. With respect to the Crime coverage requested, have there been during the past 3 years any employee theft, burglary, robbery, forgery or any other crime losses, whether or not insured, that would fall within the scope of the Crime Coverage Section of the proposed insurance? ☐ Yes ☐ No

If "Yes," provide details including the date of loss, description of loss, total amount of loss, and corrective action taken to prevent such loss from occurring in the future.

IX. ADDITIONAL INFORMATION

38. Please provide the current insurance information for the Applicant:

	Limit	Retention	Premium	Prior & Pending Date
Directors & Officers Liability				
Employment Practices Liability				
Fiduciary Liability				
Crime				
Information Risk and Recovery (Cyber)				
Employed Lawyers Professional Liability				

39. MISSOURI RESIDENTS – DO NOT ANSWER: Has the insurer of any of the above coverages notified the Applicant that it is cancelling or non-renewing such coverage(s)? ☐ Yes ☐ No

If "Yes," please provide details:

X. CLAIMS AND LOSS HISTORY

40. During the past 3 years, has the Applicant or any individual or entity proposed for coverage under this insurance submitted any claim or loss, or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission, which the Applicant, any such individual or any such entity has reason to believe may, or could reasonably be foreseen to, give rise to a claim or loss that may 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? ☐ Yes ☐ No

If "Yes," please provide details, including (if applicable) date 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, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM OR LOSS REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 40 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM OR LOSS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 40 IS EXCLUDED FROM THE PROPOSED INSURANCE.

Complete Question 41. below if the Applicant is requesting coverage that the Applicant does not currently purchase or is requesting limits of liability that are higher than the Applicant currently purchases.

41. With respect to any liability coverage that the Applicant does not currently purchase or any requested limits of liability that are higher than the Applicant currently purchases, is the Applicant or any individual or entity proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such individual or any such entity has reason to believe may, or could reasonably be foreseen to, give rise to a claim or loss that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please provide details:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM OR LOSS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 41 IS EXCLUDED FROM THE PROPOSED INSURANCE.

XI. ATTACHMENTS

42. If the Applicant meets any of the below criteria, please submit year-end audited financial statements and the most recent interim financial statements with this Application.

- More than 100 employees
- 2 years or less in operation
- Operating at a net loss
- Directors and Officers Liability coverage is requested

XII. 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 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.

CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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.

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.

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, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or 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.

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

LOUISIANA, NEW MEXICO AND RHODE ISLAND 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.

MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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) nor 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.

XIII. SIGNATURE AND AUTHORIZATION

The undersigned, as the 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 Applicants, the preceding sentence is replaced with the following sentence: 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 the Underwriter. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Underwriter 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.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter 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 the Underwriter 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, the Applicant must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance. Note this sentence does not apply to Maine Applicants.

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.

REPRODUCED SIGNATURES, INCLUDING PHOTOCOPIES, WILL BE TREATED AS ORIGINAL.

IF THE APPLICANT PREFERS TO ELECTRONICALLY SUBMIT THIS APPLICATION TO THE UNDERWRITER, ITS AUTHORIZED AGENT SHOULD DO SO BY CHECKING THE BELOW BOX AND TYPING HIS/HER NAME AND THE DATE. BY DOING SO, THE APPLICANT AND ITS AUTHORIZED AGENT HEREBY CONSENT AND AGREE THAT SUCH AUTHORIZED AGENT'S USE OF A KEY PAD, MOUSE OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES HIS/HER/ITS SIGNATURE, ACCEPTANCE AND AGREEMENT AS IF ACTUALLY SIGNED BY SUCH AUTHORIZED AGENT IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.

A digital signature is a simple as:

1. Check the box.
2. Type authorized agent's name and the date.

The box must be checked by the chairperson, president, chief executive officer or chief financial officer of the Applicant (or equivalent positions thereof).

☐ **AUTHORIZED AGENT SIGNATURE AND ACCEPTANCE**

Applicant Name	
By (Authorized Signature) *Or Sign/Type/Print the Name of the chairperson, president, CEO or CFO (or equivalent positions thereof) who signed this form electronically by checking the box above.*	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHAIRPERSON, PRESIDENT, CHIEF EXECUTIVE OFFICER OR CHIEF FINANCIAL OFFICER OF THE APPLICANT (OR EQUIVALENT POSITIONS THEREOF) ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES 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:

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