

**HEALTHCARE ORGANIZATION  
MANAGEMENT LIABILITY  
INSURANCE APPLICATION**

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



[Intactspecialty.com/management-liability](http://Intactspecialty.com/management-liability)

**NOTICE: THE LIABILITY COVERAGE SECTIONS 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.**

**Application Instructions:**

Whenever used in this Application, the term "Applicant" shall mean the Named Organization and all Subsidiaries, as defined by the Policy, unless otherwise stated.

The Applicant must complete the relevant sections of this Application and any applicable Supplemental Application in accordance with the specific coverages requested, along with any additional underwriting information or attachments as indicated.

**I. APPLICANT**

1. Name of Applicant: \_\_\_\_\_
2. Street Address: \_\_\_\_\_
3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. Description of the Applicant's business: \_\_\_\_\_
5. Website: \_\_\_\_\_

**II. GENERAL INFORMATION**

6. Applicant's total number of employees and location information:

	<b>Physicians</b> (including Partners, Shareholders, Employed and Contracted)	<b>Full Time</b> (Non-Physician)	<b>Part Time</b> (Non-Physician, including Seasonal & Temporary)	<b>Contractors</b> (Non-Physician, including Independent or Leased)
Worldwide, Except California:				
California				

7. Applicant is:  Nonprofit Tax Exempt     Nonprofit Taxable     For-Profit Corporation  
 Partnership     Limited Liability Company     Other (please describe): \_\_\_\_\_

8. Years in operation: \_\_\_\_\_

*Skip Question 9. if the Applicant meets any of the criteria described below in Section IX. and is required to provide financial statements as an attachment to this Application*

9. Please provide the following for the Applicant's most recent fiscal year end:

Total Assets:	Long Term Debt:	Total Liabilities:
Equity:	Revenues:	Net Income:

10. Has the Applicant in the past 18 months completed, or is the Applicant anticipating 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 divestitures?  Yes  No
- d. Breach or violation of any debt covenant?  Yes  No
- e. Registration for a public or private offering of securities?  Yes  No
- f. Changes in ownership structure?  Yes  No
- g. Changes to senior executive officers other than due to illness?  Yes  No

If "Yes" to any question in a. – g., please provide details:

11. Does the Applicant 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 provides managed care products or services, the market share of health plan members?  Yes  No

If "Yes" to any question in a. – d., please provide details, including market share percentages:

12. Is the Applicant seeking coverage for entities that are not direct or indirect Subsidiaries of the Named Organization (i.e., commonly owned entities, affiliates, entities without controlling interest but managed by the Applicant via contract or agreement)?  Yes  No

If "Yes," please provide the name(s), nature of operations and the % ownership for all such entities as an attachment to this Application.

**Please note that coverage for any such entity is not automatically included. The policy, if issued, will determine coverage for any such entity.**

13. Has the Applicant:

- a. Voluntarily disclosed to any governmental entity, or is the Applicant aware of, any violations or potential violations of the False Claims Act, the Stark Act, or any similar law or regulation?  Yes  No
- b. Been subject to any regulatory inquiry, investigation or indictment involving patient billing, business referral(s) or any anti-kickback law?  Yes  No
- c. Been subject to any notice, contact letter or mandate from any government entity or agency, including the Department of Justice (DOJ), Office of Inspector General (OIG), or an audit contractor?  Yes  No
- d. Been subject to any type of regulatory monetary settlement, fine or penalty?  Yes  No

If "Yes" to any question in a. – d., please provide details:

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

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

Shareholder Name	% Owned	Is this shareholder a Director or Officer or represented by a designated Director on the board?
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No

15. Is any of the Applicant's stock held by an Employee Stock Ownership Plan (ESOP)?  Yes  No  
 If "Yes", please complete the ESOP Supplemental Application.

16. Does the Applicant perform any professional ethics, peer review, accreditation, standard setting, credentialing, or licensing activities?  Yes  No  
 If "Yes," please provide details (including any written policies and procedures that address decisions that could adversely affect healthcare staff membership, privileges, or licensing):

17. Approximately what percentage of the Applicant's revenues are derived from government sources? \_\_\_\_\_%

18. During the past 3 years, has the Applicant or any person proposed for coverage in their capacity as a director, officer, trustee, member of any duly constituted committee, or employee of any entity been named as a party in any civil action or administrative, alternative dispute resolution or investigative proceeding?  Yes  No  
 If "Yes," please provide details:

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

19. Please provide the average salary (including bonuses and commissions) of all employees, including officers, owners, and partners, for the Applicant's most recent year-end:  
 Less than \$50,000     \$50,000 - \$100,000     \$100,000 - \$150,000     Greater than \$150,000

20. Annual Employee Turnover Rate: Most Recent 12 months \_\_\_\_\_% Prior 12 months \_\_\_\_\_%

21. Has the Applicant in the past 18 months completed, or is the Applicant anticipating in 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. Was severance available, or will it be available, to all laid off employees in exchange for a signed release?  Yes  No

22. During the past 3 years, has the Applicant, in any capacity, been involved in any EEOC or other similar employment-related administrative proceeding?  Yes  No  
 If "Yes," please provide details:

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

23. Please complete the following for all benefit plans maintained by the Applicant:

*Plan Type	Current Plan Asset Value	Funding % (DBs only)
	\$	
	\$	
	\$	

\* (DC) Defined Contribution Plan(s) (typically 401ks, 403bs, IRAs, and/or SEPs), (DB) Defined Benefit Plan(s) (typically traditional pension plans), (ESOP) Employee Stock Ownership Plan, or (O) Other – Please Describe

24. During the past 24 months has (or during the next 12 months will) any plan maintained by the Applicant:  
 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

If "Yes" to any question in a. – c., please provide details:

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25. During the past 3 years, has the Applicant had any claims (other than for benefits) against any benefit program or any current or past fiduciary(ies) or had 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," please provide details:

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

26. Applicant's Number of Employed Lawyers:

Employed Attorneys: \_\_\_\_\_ Contract/Leased Attorneys: \_\_\_\_\_

27. Describe the legal services provided by the Applicant's Employed Lawyers:

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28. Do any of the Applicant's Employed Lawyers provide legal services for any entity, other than the Applicant, or for individuals who are not employed by the Applicant?

Yes  No

If "Yes," please provide details:

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29. Does the Applicant currently maintain Directors & Officers and/or Errors & Omissions coverage?

Yes  No

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30. 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 details:

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**VII. CRIME INFORMATION – Complete if coverage is requested.**

31. How many employees handle, have access to or maintain records of money or securities? \_\_\_\_\_

32. Applicant's total number of locations: Domestic: \_\_\_\_\_ Foreign: \_\_\_\_\_

*For the purposes of this Section VII., "Domestic" means the United States and Canada*

If the Applicant has foreign locations, please answer the following:

a. Do all foreign locations use the same controls as operations in the Domestic locations?

Yes  No

b. List all countries and the number of employees in each country where the Applicant has foreign locations:

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33. Does the Applicant:

a. Allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits?

Yes  No

b. Have custody or control over any funds, accounts, or materials of any of its clients?

Yes  No

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

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34. Does the Applicant:

a. Perform pre-employment background checks for all its potential employees?

Yes  No

b. Have internal controls designed so that the individual who verifies the existence of vendors does not also have the authority to edit the authorized master vendor list?

Yes  No

c. Provide anti-fraud training, including social engineering, phishing, masquerading, and other fraud schemes, to all employees responsible for authorizing and executing payments or funds-transfers requests?

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
- f. Require confirmation of all change requests regarding account information (including bank accounts, invoices, telephone numbers, location, and contact information) by a direct call confirming those changes and using only the contact number previously provided by the accountholder before the request was received?  Yes  No

If "No" to any question in a. – f., please provide details:

35. How many times does the Applicant perform a physical inventory of stock and equipment per year?
- None  1 time or more  N/A (Applicant does not have material physical inventory)

36. During the past 3 years, has there been any employee theft, burglary, robbery, forgery, or any other crime losses, whether or not insured, that would fall within the scope of the proposed insurance?  Yes  No

If "Yes," please provide details:

## VIII. CLAIMS AND LOSS HISTORY

37. 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, to any insurer or under any 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, OR ANY CLAIM OR LOSS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION, REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 37 IS EXCLUDED FROM THE PROPOSED INSURANCE.**

*Complete Question 38. below if the Applicant is requesting any liability coverage that the Applicant does not currently purchase or is requesting limits of liability that are higher than the Applicant currently purchases.*

38. 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 or any such individual or 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 38 IS EXCLUDED FROM THE PROPOSED INSURANCE.**

## IX. ATTACHMENTS

39. If the Applicant meets any of the following criteria, please provide year-end audited financial statements and the most recent interim financial statements as an attachment to this Application:
- More than 100 employees
  - 2 years or less in operation
  - Operating at a net loss
  - Directors and Officers Liability coverage is requested

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## X. 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 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 fines and confinement in prison.

**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.

**VERMONT APPLICANTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

## XI. 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.

THE UNDERWRITER AND THE APPLICANT AGREE THAT THIS APPLICATION MAY BE ELECTRONICALLY SIGNED AND THAT AN ELECTRONIC SIGNATURE APPEARING ON THIS APPLICATION IS THE SAME AS A HANDWRITTEN SIGNATURE FOR PURPOSES OF VALIDITY, ENFORCEABILITY AND ADMISSIBILITY.

TO ELECTRONICALLY SIGN THIS APPLICATION, THE APPLICANT'S AUTHORIZED AGENT SHOULD DO SO BY CHECKING THE BELOW BOX AND TYPING THEIR NAME, TITLE AND THE DATE BELOW.

An electronic signature is a simple as:

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

The box must be checked by the chairperson, president, CEO or CFO of the Named Organization (or equivalent positions thereof).

**AUTHORIZED AGENT ELECTRONIC SIGNATURE AND ACCEPTANCE**

<b>Name/Title</b>	
<b>Date</b>	

IF THE APPLICANT DOES NOT WANT TO SIGN THIS APPLICATION ELECTRONICALLY, THE APPLICANT'S AUTHORIZED AGENT SHOULD TYPE THEIR NAME, TITLE AND THE DATE ABOVE, SIGN BELOW AND PROVIDE A SCANNED OR PAPER COPY TO THE APPLICANT'S AGENT OR BROKER.

**By (Authorized Signature)** \_\_\_\_\_

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHAIRPERSON, PRESIDENT, CHIEF EXECUTIVE OFFICER OR CHIEF FINANCIAL OFFICER OF THE NAMED ORGANIZATION (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: