TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Plan Purchaser Errors and Omissions Liability Application

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	
	Doing Business As	
	Federal Employee ID# (FEIN)	
2.	Mailing Address	Street:
		City: State: Zip:
		County: Website:
3.	Risk Manager or Contact Person	Name/Title:
		Email Address:
		Telephone Number:
4.	Applicant's Type of Business	
5.	Please list the state(s) where the Applicant operates:	
6.	Is the Applicant self-insured?	☐ Fully ☐ Partially ☐ No If fully or partially self-insured, attach most recent audited financial statement.
7.	If partially self-insured, what dollar amount of loss is retained? $ _____ per claim $ _____ per annual aggregate	
8.	Is/are the Applicant's health insurance plan(s) self-administered?	☐ Yes ☐ No

9. Does the Applicant purchase health care services exclusively for its own employees and dependents? ☐Yes ☐No

If "No," please explain.

10. If coverage is desired for any other entities (subsidiaries, joint ventures, or partnerships) please list each such entity below. If required, list additional entities on a separate attachment

Name & Address	Description of Operations	Relationship	Types of Health Plans	Tax Status	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

11. Is the Applicant currently, or has the Applicant ever been insured for Plan Purchaser Errors and Omissions Liability? ☐Yes ☐No

If "Yes," for each such policy provide information on policy period, carrier, limits, retroactive date, deductible, retention and annual premium.

EXPOSURE DETAILS

Enrollment

12. List all health plans available through the Applicant:

Name of Insurer, Plan, Network or Vendor	Type of Benefit (Health Care, Dental, Vision)	Type of Plan (HMO, POS, PPO, Indemnity, TPA, etc.)	Average Number of Enrollees, Covered Lives, Dependents Per Year

13. Does the Applicant use a consultant for choosing health care plans or benefits? ☐Yes ☐No

If "Yes," provide the consultant's name and address:

a.) Describe the process for selecting insurer(s), plan(s), network(s) or vendor(s):

b.) Who on the Applicant's staff makes the final selection of insurer(s), plan(s), network(s) or vendor(s)?

c.) Are all contracted insurers, plans, networks or vendors required to maintain professional liability or errors and omissions insurance? ☐Yes ☐No
If "No," please explain:

d.) Provide details of the Applicant's indemnification arrangements with contracted insurers, plans, networks or vendors or attach copies of sample contracts,

OPERATIONS AND ADMINISTRATION

Utilization Review/Cost Containment

14. Who performs utilization review?
Applicant : ☐Yes ☐No

Subcontractor: ☐Yes ☐No Name: _____

Other: ☐Yes ☐No Name: _____

a.) Number of benefits denied/avoided (e.g., denial rate): _____

b.) Number of cases reviewed in last year: _____

c.) Number of full-time equivalent (FTE) reviewers: _____

Number of part -time equivalent (PTE) reviewers: _____

d.) If utilization review is subcontracted:
i. Does the Applicant review or audit the utilization review process? ☐Yes ☐No
ii. Is the subcontractor required to maintain errors and omissions insurance? ☐Yes ☐No

If "Yes," what minimum limits are required? _____
Is the Applicant named as an additional insured? ☐Yes ☐No

e.) Does the Applicant have written policies and procedures for utilization review, including denials and appeals? ☐Yes ☐No

If "Yes," do such policies and procedures follow NCQA or URAC standards and comply with any applicable law? ☐Yes ☐No

f.) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? ☐Yes ☐No

g.) Does a physician review all proposed denials of benefits prior to issuance of the denial? ☐Yes ☐No

h.) Does the Applicant have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? ☐Yes ☐No

i.) Does the Applicant use practice guidelines as part of its utilization review procedures? ☐Yes ☐No
If "Yes," do guidelines state in writing that the physician's judgement may override a guideline?

j.) Does the Applicant utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? ☐Yes ☐No

k.) Does the Applicant utilize specialty reviewers for benefit/coverage denials? ☐Yes ☐No

Credentialing or Selection of Health Care Providers (answer only if Applicant contracts directly with health care providers)

15. If the Applicant contracts directly with providers (e.g. doctors, hospitals, etc.), please provide the number of:
    a. Providers under direct contract to Applicant: _____
    b. Hospitals/Clinics under direct contract to Applicant: _____
    c. Providers available to Applicant through Network Vendor: _____

16. Are all medical services provided under a written contract or agreement between the health care provider and the Applicant or Applicant's vendor? ☐Yes ☐No

17. Who does the credentialing of contracted health care providers?
    Applicant: ☐Yes ☐No
    Subcontractor: ☐Yes ☐No Name: _____
    Other: ☐Yes ☐No Name: _____

18 If credentialing is subcontracted:
    a. Does the Applicant review or audit the process? ☐Yes ☐No
    b. Is the subcontractor required to maintain errors and omissions insurance? ☐Yes ☐No
    If "Yes," what minimum limits are required? _____
    Is the Applicant an additional insured on the policy? ☐Yes ☐No

19. Does the Applicant have written policies and procedures in place for provider selection, credentialing, re-credentialing and making decisions which adversely affect a provider's credentials? ☐Yes ☐No

20. Do your written credentialing procedures comply with JCAHO or NCQA standards and all applicable laws? ☐Yes ☐No
    a. Are the procedures given to health care providers? ☐Yes ☐No
    b. Is legal counsel consulted before any recommendations or decisions which adversely affect a provider's privileges or credentials becomes final? ☐Yes ☐No

21. Does the Applicant or its vendors query any data source as part of the credentialing process? ☐Yes ☐No
    If "Yes," which one(s)?

22. How often does the Applicant re-credential contracted health care providers?_____

23. Do you perform on-site visits of contracted health care providers? ☐Yes ☐No
    If "Yes," how often?

24. Does the Applicant restrict the practice of any health care provider who has a mental or physical disorder which may impair his/her ability to practice? ☐Yes ☐No
    If "Yes," please explain:

25. Have any providers been removed or disqualified from the Applicant's panel in the last (12) months? ☐Yes ☐No
    If "Yes," how many for credentialing or professional conduct reasons? _____
    How many for reasons other than professional competence? _____

Advertising – Marketing – Sales – Employee Communications

26. Who prepares plan booklet / communications to enrollees?
    Applicant ☐Yes ☐No
    Other ☐Yes ☐No Name: _____

27. Do all contracts, sales literature, brochures and marketing materials:

    a. Expressly identify covered and non-covered procedures? ☐Yes ☐No

    b. Use the term(s) "investigative" or "experimental" procedures? ☐Yes ☐No

    If "Yes," do all such materials define what is considered "investigative" or "experimental"? ☐Yes ☐No

    Do all such materials clearly state that the Applicant has discretionary authority in the interpretation and administration of the plan provisions? ☐Yes ☐No

    c. Expressly refer to all contracted providers as independent contractors? ☐Yes ☐No

    d. Make statements or warranties as to the quality of health care, breadth of the plan? ☐Yes ☐No

    e. Go through legal counsel review and approval prior to use? ☐Yes ☐No

Medical Services Provided by Applicant

28. Does the Applicant own, operate, or supervise an on-site clinic or sickroom, a hospital, inpatient or outpatient clinic, pharmacy, dispensary, or other medical facility? ☐Yes ☐No

    If "Yes," please explain:

29. Does the Applicant employ physicians, surgeons, dentists, or other health care professionals, in any medical capacity except to perform administrative duties, peer review or utilization review functions? ☐Yes ☐No

    If "Yes," please explain:

CLAIMS HISTORY

30. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐Yes ☐No

    If "Yes," please provide dates 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 OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 30 IS EXCLUDED FROM THE PROPOSED INSURANCE.

31. Is the Applicant or any entity or individual proposed for coverage under this insurance 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? ☐Yes ☐No

    If "Yes," please provide details:

    NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, 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 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.

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, 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.

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 any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any 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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an 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, RHODE ISLAND APPLICANTS AND WEST VIRGINIA 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.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly 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 oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal 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 if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

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) no 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.

SIGNATURE AND AUTHORIZATION

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

We 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.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us 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 us 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, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	
NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT 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:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.			