TDC National Assurance Company
TDC GROUP

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

Health Care Organizations Management Liability Insurance Renewal Application

APPLICATION INSTRUCTIONS

NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE HEALTHCARE ORGANIZATIONS 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 COSTS," AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE UNDERWRITER BE LIABLE FOR "DEFENSE COSTS" OR OTHER "DAMAGES" IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

WHENEVER USED IN THIS APPLICATION, THE TERM, "APPLICANT" SHALL MEAN THE ORGANIZATION IDENTIFIED IN RESPONSE TO QUESTION 1 BELOW, AND ALL SUBSIDIARIES, UNLESS OTHERWISE STATED.

ACCOUNT INFORMATION

1.	Applicant Name	
	Doing Business As (DBA)	
	Federal Employee ID# (FEIN)	
	State of Domicile	
2.	Mailing Address	Street:
		City: State: Zip:
		County:
		Website:
3.	Risk Manager or Contact Person	Name/Title:
		Email Address:
		Telephone Number:
4.	Applicant's Legal Structure	☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC
5.	Tax Status	☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not For Profit

REQUESTED COVERAGE

6. Please indicate below which coverages are being requested.
NOTE: The requested coverage is not automatically provided. The terms and conditions of the coverage section, if issued, will determine actual coverage.

Coverage Section	Limit of Liability Requested	Retention Requested
☐ Directors and Officers Liability	$ _____	$ _____
☐ Employment Practices Liability	$ _____	$ _____
☐ Fiduciary Liability	$ _____	$ _____

FINANCIAL AND EXPOSURE DETAILS

7. Complete if Applicant has stock or other equivalent ownership instrument:

   a. Total number of common shareholders: _____

   b. Total number of common shares outstanding: _____

   c. Total number of common shares owned by officers: _____

   d. Total number of shares owned by directors who are not officers: _____

   e. If any shareholder owns 5% or more of shares, designate name and percentage:

8. Does the Applicant have any publicly traded securities or debt? ☐Yes ☐No

   If "Yes," please attach details.

9. Please complete the following information:

   a. Total assets: _____

   b. Revenues: Previous twelve (12) months: _____

      Projected next twelve (12) months: _____

   c. Employees: Previous twelve (12) months: _____

      Projected next twelve (12) months: _____

10. What percentage of revenue does the Applicant or any of its Subsidiaries receive from government sources?

    ☐ None ☐ Less than 50% ☐ Greater than 50% to 60%

    ☐ Greater than 60% to 70% ☐ Greater than 80%

11. Does the Applicant have any subsidiaries, joint ventures or affiliates or control any other 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.

12. Does the Applicant or any Subsidiary contract with a third party to manage, operate or administer its facility or operations? ☐Yes ☐No

13. Has the Applicant within the past 36 months completed or agreed to, or does it contemplate during the next 12 months, any of the following, whether or not such transactions were or will be completed:

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

    b. Branch, location, facility, office or subsidiary closings, consolidations or layoffs? ☐Yes ☐No

    c. Merge, acquire or consolidate with another entity? ☐Yes ☐No

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

    e. Issuance of any debt or non-taxable bonds? ☐Yes ☐No

    f. Enter into any new business activities or services? ☐Yes ☐No

    g. Conversion from non-profit to for-profit status? ☐Yes ☐No

Directors and Officers Liability Information (Complete if coverage is requested)

14. Are board members elected? ☐Yes ☐No

15. Has the Applicant or any subsidiary experienced changes to its Board of Directors or to its key executives over the past year? ☐Yes ☐No

    If "Yes," please attach complete details.

16. Does the Board hold meetings at least three (3) times per year? ☐Yes ☐No

17. Does the Applicant participate in a risk management program? ☐Yes ☐No

Employment Practices Liability and Third Party Information (Complete if coverage is requested)

18. Enter the TOTAL number of Employees (by type) in the boxes below for the Applicant and any of its subsidiaries (**Note:** Seasonal, Temporary, and Leased Employees are to be included as Part-Time Employees (Non-Union if Domestic).

Number of Employees in ALL STATES/JURISDICTIONS:

	Union	Non-Union	Foreign
Full Time Employees (include employed physicians)			
Part Time (include employed physicians)			
Employed Physicians (full and part time)			
Total Number of Independent Contractors			

19. Enter the TOTAL number of Employees (by type) in the boxes below for the Applicant and any of its subsidiaries (**Note:** Seasonal, Temporary, and Leased Employees are to be included as Part-Time Employees.

Number of Employees in CALIFORNIA ONLY:

	Union	Non-Union
Full Time (include employed physicians)		
Part Time (include employed physicians)		
Employed Physicians (full and part time)		
Total Number of Independent Contractors		

20. Enter the TOTAL number of Employees (by type) in the boxes below for the Applicant and any of its subsidiaries (**Note:** Seasonal, Temporary, and Leased Employees are to be included as Part-Time Employees.

Number of Employees in FLORIDA, MICHIGAN, TEXAS, NEW JERSEY, DC and COOK COUNTY, ILLINOIS ONLY:

	Union	Non-Union
Full Time (include employed physicians)		
Part Time (include employed physicians)		
Employed Physicians (full and part time)		
Total Number of Independent Contractors		

21. For the past 3 years, what has been the annual involuntary turnover rate of all employees at all locations?

Year_____, _____% Year_____, _____% Year_____, _____%

22. Is the Applicant or any of its subsidiaries currently undergoing, or anticipating within the next twelve (12) months, any employee layoffs or early retirement programs (including ones resulting from any type of company restructuring or office or facility closing.) ☐Yes ☐No

If "Yes," please provide details:

23. Does the Applicant have a Human Resources or Personnel Department? ☐Yes ☐No

If "No," who manages the HR function? Please provide complete details:

24. Are employment issues relating to terminations, discrimination, sexual harassment, layoffs, transfers, or promotions handled by the Human Resources Department, outside counsel and/or the Legal Department? ☐Yes ☐No

If "No," please attach complete details.

25. Does the Applicant have an employee handbook which is distributed to all employees or maintained in an internet location? ☐Yes ☐No

If "Yes," is the employee required to sign and acknowledge receipt of the handbook? ☐Yes ☐No

26. Does the Applicant have written procedures in place that are distributed to each employee regarding:

a. Employment-at-will? ☐Yes ☐No

b. EEO statement and ADA accommodation statement? ☐Yes ☐No

c. Progressive discipline and termination? ☐Yes ☐No

d. Anti-discrimination and anti-harassment policies? ☐Yes ☐No

e. Complaint resolution and internal grievance procedures? ☐Yes ☐No

f. Bonus compensation programs? ☐Yes ☐No

g. Employee conduct when dealing with third parties including non-discrimination and non-harassment statements? ☐Yes ☐No

h. Response to complaints of harassment, discrimination or civil rights violations from third parties? ☐Yes ☐No

Fiduciary Liability Coverage Information (Complete if coverage is requested)

27. Please list the Applicant's employee benefit plan(s) for which coverage is requested:

Plan Names (Do not include health & welfare plans)	**Total Assets** (Market Value)	**Type of Plan***	**Under Funded 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)

28. If any plan for which coverage is requested holds or invests in securities of the Organization or of any subsidiary or affiliate, please provide details, including name of plan, number of shares held, and most recent share value.

If no such securities, check here: ☐

29. Are assets managed by an investment manager as defined by ERISA? ☐Yes ☐No

If "No," or if only some assets are invested by an investment manager as defined in ERISA, please attach details.

30. How often is the performance of the plans' investment managers reviewed?

☐ At least semi-annually ☐ Less than semi-annually (please describe) _____

31. How often do fiduciaries establish or amend the investment manager's guidelines and goals for the plans?

☐ At least semi-annually ☐ Less than semi-annually (please describe) _____

32. Does the Applicant follow a written procedure to determine the reasonableness of all plan fees, including revenue sharing arrangements? ☐Yes ☐No

33. Is any plan a multiemployer or multiple employer plan? ☐Yes ☐No

If "Yes," list and identify the types of plans on an attachment.

34. Please list all third party investment, actuarial, legal, administrative and benefits consulting service providers.

If no such service providers, check here: ☐

35. Are any plans NOT in compliance with the plan agreements or ERISA? ☐Yes ☐No

If "Yes," please explain:

36. In the past two (2) years, has any plan(s) (or portion of a plan) been sold, transferred or terminated? ☐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.

OPERATIONS AND ADMINISTRATION

37. 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 provides managed care products or services, the market share of health plan members? ☐Yes ☐No

If "Yes," to Question 39 (a)-(d), please provide market share percentages by separate attachment.

38. Does the Applicant or any subsidiary have any exclusive contracts with any providers? ☐Yes ☐No

If "Yes," please provide details by separate attachment.

39. Does the Applicant or any subsidiary perform provider selection? If "**No**," skip to Question 40. ☐Yes ☐No

a. Are written policies and procedures in place for provider selection? ☐Yes ☐No

b. Is legal counsel consulted before any adverse recommendation or decision becomes final? ☐Yes ☐No

c. Within the last two (2) years has the Applicant or any subsidiary closed or restricted staff admission and/or privileges of a provider for reasons other than professional competence, including but not limited to, a conflict of interest? ☐Yes ☐No

If "Yes," how many? _____

d. Are there any formal plans for future staff admission/privilege closings or restrictions? ☐Yes ☐No

If "Yes," please provide details by separate attachment.

40. Is any of the Applicant's or any of its subsidiary's medical malpractice exposure self-insured or insured by means of a funded trust, captive, subsidiary, or reciprocal risk sharing operation? ☐Yes ☐No

If "Yes," please provide details of the insurance program by separate attachment and attach a copy of the most recent actuarial study.

41. Applicant and/or subsidiary Accreditation:

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

a. Has the Applicant's license, certification or accreditation ever been investigated, denied, suspended, revoked, or granted subject to any contingencies or recommendations? ☐Yes ☐No

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

c. Has any federal or state regulatory authority criticized or noted deficiencies in any of the Applicant's operations, procedures or finances? ☐Yes ☐No

42. Does the Applicant or any subsidiary have a plan for ongoing training on HIPAA and other privacy laws? ☐Yes ☐No

43. Does the Applicant or any subsidiary have a regulatory compliance program in place? ☐Yes ☐No

If "Yes," date of implementation: _____

44. Does the Applicant or any subsidiary maintain a process, such as a hotline, to receive complaints and allegations of wrongdoing? ☐Yes ☐No

If "Yes," what is the average number of hotline complaints or allegations per month? _____

a. Are all hotline complaints or allegations investigated? ☐Yes ☐No

REQUIRED INFORMATION

Required Attachments

Please attach copies of the following documents for the Applicant and all subsidiaries seeking coverage:

☐ Last audited or accountant-prepared financial statements with notes

☐ Organization chart

☐ Complete list of all Directors and Officers by name, affiliation and date of nomination

☐ Loss runs for the past five (5) years for any carrier for which the coverage requested is a direct or indirect replacement

☐ Bylaws and Certificate of Incorporation

FRAUD WARNINGS

Any person who knowingly and with intent to defraud an 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.

For applicants in the following states:

Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

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

Colorado: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Delaware: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: 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: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: 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: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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.

Maine: 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 denial of insurance benefits.

Maryland: 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.

Michigan: 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.

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

Nevada: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a category D felony.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico: 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.
Ohio: Any person who, with intent to defraud or knowing that he 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.
Oklahoma: 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: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.
Pennsylvania: 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: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
Rhode Island: 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.
Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
West Virginia: 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.

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.