Beazley Insurance Company, Inc.

Beazley Remedy Renewal Management Liability Application

THE APPLICABLE LIMITS OF LIABILITY AND ARE SUBJECT TO THE RETENTIONS.
PLEASE READ THIS POLICY CAREFULLY.

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker. This Application, including all materials submitted herewith, shall be held in confidence.

1. ORGANIZATIONAL INFORMATION:

Applicant Name:		Years in Business	
Principal Address:			
Primary Business Activity:		SIC Code/NAICS Code	
Total Assets			
Annual Revenue			
Number of beds			
Business Organization: For Profit Corporation___ Partnership ___ Limited Liability Corporation ___ Not-For-Profit Tax Exempt Corp___ Not-For-Profit Taxable Corp___ Publicly Traded___ Other ___			

If Applicant is a subsidiary of another company, please provide the name of the Parent Company:

_____

Has the Applicant received a going concern opinion from an auditor? ☐ Yes ☐ No

2. COVERAGE INFORMATION:

	D&O	EPL	Fiduciary	Regulatory Liability
Current:				
Limit				
Retention				
Premium				
Insurer				
Policy Period				
Requested:				
Limit				
Retention				
Effective Date				

APPLICANTS IN MISSOURI: DO NOT ANSWER THE FOLLOWING QUESTION.

Have any of the Applicant's current liability insurers indicated intent not to offer renewal terms? ☐ Yes ☐ No

If yes, please attach details.

3. DIRECTORS AND OFFICERS COVERAGE
Please complete only if applying for this coverage:

A. Please list all subsidiaries including ownership by percentage:

Subsidiary Name	Applicant's Ownership Percentage	Nature of Business
	%	
	%	
	%	

Attach additional page if necessary.

B. Is the Applicant a party to any joint venture arrangements or partnership agreements? ☐ Yes ☐ No

If yes, please attach details.

C. Shareholder Information:

Total Number of Shareholders:		
Shareholders:	% Voting Shares Owned:	Board Representation Yes/No

D. How many employed lawyers (in-house counsel) does the Applicant employ? _____

E. If the Applicant is a tax exempt organization, are there any challenges to the tax exempt status pending or anticipated by any party, private or governmental? ☐ Yes ☐ No

If yes, please explain:_____

F. Does the Applicant perform any peer review and/or credentialing? ☐ Yes ☐ No

If yes, have any providers been removed or disqualified from the Applicant's panel in the last 12 months? ☐ Yes ☐ No

If yes, how many and for what reason? _____

G. Has there been any change in the board of directors or senior management over the last 12 months? ☐ Yes ☐ No

If yes, please explain:_____

H. Has Applicant within the past 12 months completed or agreed to, or does it contemplate in the next 12 months, any of the following? If yes, please attach details.

	Next 12 months	Past 12 months
1. A merger, acquisition, creation, divestiture, or tender offer of or for any entity, plant, office, subsidiary, branch or division?	☐ Yes ☐ No	☐ Yes ☐ No
2. Sale, distribution or divestiture of any assets or stock other than in the ordinary course of business?	☐ Yes ☐ No	☐ Yes ☐ No
3. Reorganization or arrangement with creditors under federal or state law?	☐ Yes ☐ No	☐ Yes ☐ No
4. Any registration for a public offering or private placement of securities? If yes, please attach a copy of the Prospectus or other document.	☐ Yes ☐ No	☐ Yes ☐ No
5. Any breach or violation of any debt covenant or loan agreement or any other material contractual obligation?	☐ Yes ☐ No	☐ Yes ☐ No

I. Antitrust: *If additional room is needed please attach*

1. Does the Applicant control more than 20% of inpatient, physician or specialty services for the Applicant's geographical area? ☐ Yes ☐ No

   If yes, Please specify?_____

2. Has the Applicant's market share by bed, specialty or physician count increased by more than 15% in the past 12 months? ☐ Yes ☐ No

3. Have any acquisitions been abandoned in the past 12 months? ☐ Yes ☐ No

   If yes, please explain:_____

4. Are all contemplated acquisitions reviewed by outside counsel for antitrust compliance? ☐ Yes ☐ No

   If no, please explain:_____

5. Has the Applicant been the subject of any inquiries by the Federal Trade Commission? ☐ Yes ☐ No

   If yes, please explain:_____

4. REGULATORY COVERAGE *Please complete only if applying for this coverage:*
****For higher than 1M limit please complete our new business regulatory application:*

A. Has there been any change to the Medical Billings or Chief Compliance Officer? ☐ Yes ☐ No

Who does this individual report to?_____

How often does the medical billings or compliance officer report to the board?_____

How many full time employees of the Applicant are dedicated to compliance?_____

B Has there been any changes to the formal compliance program? ☐ Yes ☐ No

When was it last updated?_____

1. Does the Applicant maintain internal audits and compliance analysis on medical billing? ☐ Yes ☐ No

2. Has the Applicant had an external compliance and billing analysis performed in the past 12 months? ☐ Yes ☐ No

   If yes, please provide the name of the outside firm._____

3. Does the Applicant maintain a hotline to receive complaints concerning incorrect billing procedures or any other compliance concerns? ☐ Yes ☐ No

   If yes, how many hotline calls are reported per month?_____

4. Has regular compliance education and training taken place in the past 12 months? ☐ Yes ☐ No

   If yes, how often was it performed? _____

C Percent of Revenues Derived From: Medicare___ Medicaid___ Commercial Payor___ Self Pay__

5. EMPLOYMENT PRACTICES LIABILITY COVERAGE
Please complete only if applying for this coverage:

A. Does the Applicant have a full time Human Resources Department Manager? ☐ Yes ☐ No

Human Resources Manager contact information:

Name:	Phone:	Email:

B. Total number of Employees of Applicant including all Subsidiaries and all, doctors, medical staff, leased/seasonal employees and independent contractors:

Please provide the number of total Employees in the following categories:

	Current Year	Previous Year
Full Time:		
Part Time:		
Volunteers:		
Employed Physicians: (Not included above)		

Independent Contractors:		
Percentage of terminated: (involuntary)		
Percentage of resigned: (voluntary)		
Layoffs:		

C. What percentage of employees are union members?_____

D. Locations of Applicant by state or country (if foreign) and number of employees for each State or Country: (attach schedule if necessary)

State or Country	# of Employees	# of locations

E. Has there been any changes to the Applicants written policies and procedures for personnel? ☐ Yes ☐ No

If yes, please specify_____

F. Is the Applicant in compliance with Title III of the American with Disabilities Act (building and premises requirements)? ☐ Yes ☐ No

G. Does the applicant provide an employee complaint hotline for all employees? ☐ Yes ☐ No

H. Have there been any employee layoffs in the past twelve (12) months, or does the Applicant contemplate in the next twelve (12) months any employee layoffs, including anything resulting from a branch, location, facility, office or subsidiary closing or consolidation? ☐ Yes ☐ No

If yes, please answer the following:

a) What percentage of employees will be laid off? _____

b) Will the Applicant consult with outside counsel prior to layoffs? ☐ Yes ☐ No

c) Will severance packages offered in exchange for releases not so sue? ☐ Yes ☐ No

d) Does the Applicant provide laid off employees assistance in finding work? ☐ Yes ☐ No

I. Do you restrict employee access to employees' personal information such as social security numbers, account information and health care information? ☐ Yes ☐ No

J. Sexual Harassment & Misconduct/Pay Equity: *If additional room is needed please attach*

1. Has the applicant entered into any confidential settlement agreements relating to complaints or allegations of sexual harassment and/or misconduct within the last three years? ☐ Yes ☐ No

If yes, please attach details.

2. Has the applicant had an external resource review pay and compensation related procedures and policies for compliance with equal pay laws in the past two years? ☐ Yes ☐ No

3. Does the applicant utilize arbitration agreements for all employees? ☐ Yes ☐ No

4. Does the applicant make inquiries into a candidate's prior salary when considering that candidate for employment? ☐ Yes ☐ No

5. a) Has the applicant performed any type of internal or external pay equity study, analysis or audit within the past two years? ☐ Yes ☐ No

   b) If so, have all recommendations and/or findings been implemented or has a plan been put in place to implement? ☐ Yes ☐ No

6. Has the applicant specifically reviewed all pay and compensation-related procedures and policies (including, but not limited to, job descriptions, review and evaluation policies and protocols, and employee handbooks) for compliance with pay equity laws in the past two years? ☐ Yes ☐ No

7. Has the applicant mandated and ensured completion of sexual harassment training for all employees within the past twelve months? ☐ Yes ☐ No

If no has been selected for 5, 6 or 7 above, please comment on how the applicant ensures compliance with all relevant federal, state, or local laws governing equity in pay including, but not limited to, the Equal Pay Act and Title VII of the Civil Rights Act.

6. FIDUCIARY LIABILITY INSURANCE COVERAGE

Please complete only if applying for this coverage:

Benefits Manager or Plan Administrator:	Phone:	e-mail:

A. List all Plans for which coverage is requested:

Plan Name	Total Assets	Number of Participants	Type of Plan*

*W = Welfare Benefit, DC = Defined Contribution, DB = Defined Benefit, ESOP= Employee Stock ownership Plan, O = Other

Indicate if additional Plans are listed on an attachment.

B. Sponsored Plans

1. Has any Plan experienced an event reportable to the PBGC or been the subject of an investigation by the DOL, the IRS or any similar foreign agency in the last 12 months? ☐ Yes ☐ No

If yes, please attach details.

2. Do all Plans conform to the provisions of ERISA including those regarding eligibility, investments and vesting? ☐ Yes ☐ No

3. In the past 12 months, has there been any amendment(s) to any Plan that has resulted in or may result in any change or reduction of Benefits or are any such amendments contemplated? ☐ Yes ☐ No

   If yes, attach details of the amendment(s).

4. In the last 12 months has any Plan or portion of any Plan been sold, transferred or terminated? ☐ Yes ☐ No

   If yes, attach the date of sale or termination, whether assets have been fully distributed or reverted to a party other than the Plan participants and name of annuity provider if Benefits have been secured by annuities and whether the Department of Labor has approved such termination.

5. In the last 12 months, has there been, or is there now under consideration, any merger, acquisition, restructuring or consolidation which may result in Plan participants transferring to another Plan? ☐ Yes ☐ No

   If yes, attach complete details.

C. Defined Benefit Plan Funding: *if applicable*

1. Has an actuary certified that all Plans are adequately funded in accordance with ERISA or any applicable similar common or statutory law of the United States, Canada or any state or other jurisdiction anywhere in the world? ☐ Yes ☐ No

   If no, attach complete details including plans for bringing funding to adequate levels.

2. Has any Plan received an adverse opinion as to its financial condition by an independent public accountant? ☐ Yes ☐ No

   If yes, please attach audit.

3. Are there any overdue employer contributions for any Plan or has a waiver of contributions been requested? ☐ Yes ☐ No

   If Yes, attach complete details including the Plan name and the amount of any overdue employer contributions for each such Plan.

4. Does the Applicant have plans to convert any defined benefit plan to a cash balance plan within the next twelve months? ☐ Yes ☐ No

   If yes, attach complete details including the date of conversion.

5. If there are defined benefit plans please provide the current funding percentage of any defined benefit plans. _____

ATTACHMENTS: Attach the following materials regarding the Applicant:
- Audited financials
- Interim financials (if audit is over 6 months old)
- 5500s or sponsored plan financials
- 5 years of valued loss runs

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO 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.

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED EMPLOYEE OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED EMPLOYEE AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITER OF SUCH CHANGES, AND THE UNDERWRITER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE. NO COVERAGE SHALL BE AFFORDED FOR ANY CLAIMS NOT PROPERLY REPORTED UNDER THE TERMS AND CONDITIONS OF THE APPLICABLE POLICIES.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

AUTHORIZED SIGNATURE OF APPLICANT TITLE

_____ _____

(Must be a principal of the Applicant and a person at risk)

Printed Name _____

Date _____ Effective Date Requested for this Insurance _____ _____

PLEASE MAKE CERTAIN ALL QUESTIONS ARE ANSWERED AND THAT ALL APPLICABLE SUPPLEMENTS IF APPLICABLE ARE COMPLETED. THIS APPLICATION WILL NOT BE PROCESSED UNLESS ALL QUESTIONS ON THIS APPLICATION AND APPLICABLE SUPPLEMENTS ARE ANSWERED.

Please provide the Insurance Agent's name and license number as designated.

Name of Insurance Agent _____

License Identification No. _____

Authorized Representative

_____

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance - Producer