TRAVELERS

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Health Care Organization Directors, Officers and Trustees and Employment Practices Liability

Coverage Application

NOTICE: ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST "INSUREDS" DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS "DEFENSE EXPENSES", AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY "CLAIM" UNLESS DUTY-TO-DEFEND COVERAGE HAS BEEN SPECIFICALLY PROVIDED HEREIN.

AGENCY	CODE	AGENT NAME / LICENSE NUMBER

The term "**Applicant**" means the first named insured organization and all other corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

Please submit the following documents and indicate below which are included in conjunction with this application. Note that the Company may elect to obtain some of this information from public sources, including the internet.

REQUIRED GENERAL ATTACHMENTS

- ☐ Most recent CPA audited financial statements including notes and schedules.
- ☐ Most recent CPA letter to management and management's response.
- ☐ Interim financial statements, if audited financial statements are six (6) months or older.
- ☐ Loss runs for the past five (5) years and a status report of any litigation filed within the last five (5) years by or against any person(s) or **Applican**t proposed for this insurance including amount of any settlements or judgments, costs of defense and any corrective procedures implemented by the Applicant.

REQUIRED D&O ATTACHMENTS

- ☐ A listing of the Board of Directors, Board of Managers or the Board of Trustees, as applicable, with employers and occupations of each, as well as other boards on which such directors, managers or trustees serve.
- ☐ If applicable for any **Applicant**, any private placement memorandum(s) or any other documents filed with the Securities Exchange Commission during the last three (3) years.
- ☐ Copy of the **Applicant's** bylaws, health care/medical staff by-laws, and other operating agreements.
- ☐ Current organizational chart of the first named insured organization, listing each subsidiary, controlled non-profit organization and joint venture, including the ownership percentage and tax status of each.
- ☐ A copy of the most recent actuarial study, if any **Applicant's** health care/medical professional liability exposure is self-insured or insured by means of a trust, captive, risk sharing arrangement or pool.

REQUIRED EPL ATTACHMENTS

- ☐ Directors, Officers & Trustees required attachments.
- ☐ Employee Handbook, including current amendments.
- ☐ Most recent EEO-1 report, if **Applicant** has 1,000 or more employees.

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A. COMMON SECTION

GENERAL INFORMATION

Applicant Information:

Name of first named insured organization: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Website address: _____ Date established or incorporated: _____

Tax Status of the first named insured organization: ..... ☐ Non-Profit ☐ For-Profit

Entity Type:

☐ 501(c)(3)	☐ S Corporation	☐ General Partnership (GP)	☐ Other: _____
☐ 501( )( )	☐ C Corporation	☐ Limited Partnership (LP)	_____
	☐ Limited Liability Company (LLC)	☐ Limited Liability Partnership (LLP)	

CONTACT INFORMATION FOR AUTHORIZED REPRESENTATIVE(S)

Risk Manager or authorized representative(s) designated to receive any and all notices concerning this insurance.

Designated Contact: _____ Contact Email: _____

Title: _____ Contact Phone: _____

Complete address if different than provided on this Application under General Information.

Street Address: _____ City, State, Zip: _____

NATURE OF BUSINESS (CHECK ALL THAT MAY APPLY)

☐ Adult day Care	☐ HMO, PPO, Health Plan	☐ Non-Profit Health Care Foundation
☐ Affiliate Hospital System	☐ Home Health Care	☐ Physician Group
☐ Ambulatory Surgery Center	☐ Hospice Care	☐ Physician Hospital Organization (PHO)
☐ Assisted Living Facility / CCRC	☐ Hospital	☐ Psychiatric Hospital
☐ Behavioral & Mental Health	☐ Integrated Delivery System	☐ Rehabilitation Facility
☐ Blood / Organ Collection Center	☐ IPA, PPO, MSO	☐ Respite Care
☐ Clinical Research Facility	☐ Laboratory	☐ Skilled Nursing Facility / Retirement Home
☐ Dependency Rehab	☐ Management Company System	☐ Social Service
☐ Eye Care Center	☐ Network Provider	☐ Surgical Center
☐ Faculty Practice Group	☐ Non-Profit Clinic	☐ Trade Association
☐ Health System	☐ Non-Profit Health Care Association	☐ Other: _____

If necessary, please attach full details.

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SUBSIDIARY AND CONTROLLED NON-PROFIT ORGANIZATION INFORMATION

Subsidiary and controlled non-profit organization information (Include 50% owned joint ventures under management control):

Name	% Owned	Year Started	Description of Operations	Tax Status*	Entity Type**

*Tax Status: FP = For Profit or NP = Non-Profit
**Entity Types, for example: 501(c)(3); S Corporation, General Partnership (GP); Limited Partnership (LP); Limited Liability Partnership (LLP); Limited Liability Company (LLC)

If there are additional subsidiaries or controlled organizations, please attach a detailed listing or organizational chart.

CURRENT INSURANCE INFORMATION

Coverage	Carrier	Limit	Retention	Premium	Policy Period
Directors, Officers & Trustees (D&O)		$	$	$	
Employment Practices Liability (EPL)		$	$	$	
Excess D&O and/or EPL		$	$	$	
Health care / Medical Professional Liability		$	$	$	
General Liability		$	$	$	
Fiduciary Liability		$	$	$	
Crime		$	$	$	
Kidnap & Ransom		$	$	$	
Identity Fraud Expense Reimbursement		$	$	$	

1. Have any of the coverages above been cancelled or non-renewed during the last three years? (not applicable in Missouri) *If "Yes", please attach full details.* ..... ☐ Yes ☐ No
2. Are any of the **Applicant's** health care/medical professional liability or general liability coverages self-insured or insured by means of a self-insured trust, captive, risk sharing arrangement or pool?..... ☐ Yes ☐ No

   If "Yes", regarding the **Applicant's** self-insurance program:

   (a) Is an annual independent actuarial exam performed?..... ☐ Yes ☐ No
   If "Yes", please provide a copy.

   (b) Is the program funded in accordance with annually determined actuarial requirements? ..... ☐ Yes ☐ No
   If "No", please attach full details.

   (c) Does the program provide insurance to third parties? ..... ☐ Yes ☐ No
   If "Yes", please attach full details.
3. Does the **Applicant** have coverage for peer review and credentialing activities under any other insurance policy, self-insured trust, captive, risk sharing arrangement or pool?..... ☐ Yes ☐ No

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B. DIRECTORS, OFFICERS & TRUSTEES LIABILITY COVERAGE

NOTICE: The section below only pertains to Directors, Officers & Trustees Liability Coverage. If Employment Practices Liability Coverage is desired, please complete Section C. of this application.

SECURITYHOLDER INFORMATION

1. **Total Shares**	**Common**	**Preferred**	**Other**
Authorized			
Outstanding (stock held by shareholders)			
Voting Shares Outstanding			
Voting Shares Owned by Directors and Officers (direct & beneficial)			
Number of Voting Shareholders			

If there are multiple classes of stock, please attach full details.

2. Please list all secuityholders that own more than 5% of any class of security.

Securityholder	**Class of Security**	**% Owned**	**Director, Trustee or Officer?**
		%	☐ Yes ☐ No
		%	☐ Yes ☐ No
		%	☐ Yes ☐ No
		%	☐ Yes ☐ No
		%	☐ Yes ☐ No

If there are more securityholders, please attach full details.

3. Does any **Applicant** have an Employee Stock Ownership Plan (ESOP) or any stock option program? ..... ☐ Yes ☐ No

If "Yes", please provide the most recent stock evaluation report and program documentation.

BUSINESS OPERATIONS

1. Is any **Applicant** presently JCAHO accredited? ..... ☐ N/A ☐ Yes ☐ No

If "Yes", please provide the **Names of the Organizations**	**Date**	**Last Overall Score**

2. During the last 3 years, has any regulatory or accrediting body denied, suspended, revoked or granted, or subjected to contingency or recommendation, any license, certification or accreditation of any operation, department or facility of any **Applicant**? *If "Yes", please attach full details.* ..... ☐ N/A ☐ Yes ☐ No

3. Does the **Applicant** perform peer review or credentialing activities for its health care staff?..... ☐ Yes ☐ No

   (a) Does the **Applicant** have formal written policies and procedures in effect that address peer review, credentialing, re-credentialing and decisions that could adversely affect health care staff membership, privileges or licensing? ..... ☐ Yes ☐ No

   If "Yes", (i) Do written policies and procedures meet NCQA or JCAHO standards or applicable law?..... ☐ Yes ☐ No

   (ii) Are written policies and procedures provided to all members of the health care staff? ..... ☐ Yes ☐ No

   (b) Is legal counsel consulted before any recommendation or decision is finalized that could adversely affect health care staff membership, privileges or licensing? ..... ☐ Yes ☐ No

   (c) During the last five (5) years has any **Applicant** been subject to any legal recourse associated with restriction or suspension of the license or privileges of any member of the health care staff? ..... ☐ Yes ☐ No

   If "Yes", please attach full details.

4. Does any **Applicant** render any standard setting, accrediting, peer review, credentialing, licensing or similar services to any third party? *If "Yes", please attach full details.* ☐ Yes ☐ No

5. Does any **Applicant** provide any non-clinical management or administrative services to any third party under any contract or agreement? *If "Yes", please attach full details.* ☐ Yes ☐ No

6. Is any **Applicant** managed or administered by any third party under contract or agreement?

   If "Yes", please attach full details. ☐ Yes ☐ No

7. Have any **Applicants** had any changes in the Board of Directors, Board of Managers, Board of Trustees or executive officers within the past two (2) years for reasons other than completion of their term or retirement? *If "Yes", please attach full details.* ☐ Yes ☐ No

8. Does the **Applicant** have a formal committee of independent Directors, Managers or Trustees that reviews executive compensation? ☐ Yes ☐ No

9. The **Applicant's** Directors, managing members or Trustees assume the position by?

   ☐ Membership Vote ☐ Appointed by: _____ ☐ Other: _____

10. Has any **Applicant** undergone during the last twelve (12) months or does any **Applicant** plan to undergo during the next twelve (12) months any of the following

    (a) actual creation or proposed merger, acquisition, or divestiture? ☐ Yes ☐ No

    (b) creation of a new subsidiary, a division or area of business? ☐ Yes ☐ No

    (c) issuance of debt, a tax exempt bond offering, a public offering or a private placement of securities? ☐ Yes ☐ No

    (d) reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No

    (e) closure or consolidations of any branch, location, facility, office, or subsidiary? ☐ Yes ☐ No

    If "Yes" to any of 11(a) – (e) above, please attach full details.

11. Does the **Applicant's** market share (whether hospital beds, providers, health care services provided or membership in a network) exceed 25% within any of its geographical service areas? *If "Yes", please attach full details.* ☐ Yes ☐ No

12. Does the **Applicant** seek outside legal advice on matters of non-compete clauses, exclusive contracts or preferred pricing contracts? ☐ Yes ☐ No

COMPLIANCE POLICIES AND PROCEDURES

1. Does the **Applicant:**

   (a) have a formal written regulatory compliance policies and procedures *(for example, the federal False Claims Act and Health Insurance Portability and Accountability Act (HIPAA))* addressing the responsibilities of the **Applicant**, its business partners, vendors and employees? ☐ Yes ☐ No

   If "Yes": Date Implemented: _____ Date Last Revised: _____

   (b) implement regular compliance education and training? ☐ Yes ☐ No

   (c) utilize audits or other evaluation techniques to monitor compliance? ☐ Yes ☐ No

   (d) utilize outside counsel to provide an opinion as to whether there could be a violation of law? ☐ Yes ☐ No

2. Has any **Applicant:**

   (a) been subject to any regulatory investigation or indictment involving patient billing, business referral(s) or any anti-kick back 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 any of 2(a)- (c) above, please attach full details.

3. Does the **Applicant** have a formal written conflict of interest policy? ☐ Yes ☐ No

4. Does the **Applicant** have a formal charity care policy that meets or exceeds applicable minimum state and federal requirements? ☐ Yes ☐ No

DIRECTORS, OFFICERS AND TRUSTEES LOSS INFORMATION

1. Has there been during the past five years, or are there now pending, any securities claims, criminal actions, administrative or regulatory proceedings, charges, hearings, demands or lawsuits including shareholder, creditor, antitrust, fair trade law, copyright or patent litigation, against any **Applicant**, or any person proposed for this insurance, whether or not such claim or action would be covered under the Health Care Organization Directors, Officers and Trustees Liability Coverage? ..... ☐ Yes ☐ No
   If "Yes", please provide the date, a brief description, and the damages sought or settlement paid, of such a claim, and the current status if pending.
2. During the past five years, has any claim, or notice of circumstances that could reasonably give rise to a claim, been reported to any previous or existing insurer providing coverage for directors, officers and trustees liability, or management liability, including any coverage for the entity? ..... ☐ Yes ☐ No
   If "Yes", please attach full details.

To the extent that any matter required to be disclosed in response to questions 1 or 2 above constitutes a "Claim" as defined by the Policy, such matter was made prior to the policy period requested hereunder and therefore would be excluded from coverage.

3. Does the **Applicant**, or any person proposed for this insurance have any knowledge or information of any fact, circumstance or situation related to the Health Care Organization Directors, Officers and Trustees Liability Coverage that could reasonably give rise to a claim against them?..... ☐ Yes ☐ No
   If "Yes", please attach full details.

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed in question 3 above is excluded from the proposed insurance.

C. EMPLOYMENT PRACTICES LIABILITY COVERAGE

NOTICE: Please complete the section below if Employment Practices Liability coverage is desired.

1. Please provide the total number of employees for all **Applicants** for each category below:

Full Time Employees	Part Time Employees	Leased Employees	% Union Employees	Total Employees	Employed Physicians	Independent Contractors

Provide EEO-1 report only if an Applicant has 1,000 or more employees.

2. Turnover of total full time employees for all **Applicants** for each of the last three years (in number of employees).:	**20__**	**20__**	**20__**
Voluntary Terminations of Full Time Employees			
Involuntary Terminations of Full Time Employees			
Layoffs of Full Time Employees			

HUMAN RESOURCES

Does the **Applicant:**

1. Have a centralized Human Resources (HR) department? ..... ☐ Yes ☐ No
   Number of dedicated HR employees: _____
   Does the HR department:
   (a) provide formal employment practices liability training, including sexual harassment training, to the **Applicant's** managers and supervisors? ..... ☐ Yes ☐ No
   (b) follow a formal manual when implementing HR policies and procedures? ..... ☐ Yes ☐ No
   If "Yes", date last updated: _____
   (c) consult with legal counsel prior to every termination, lay off or staff reduction?..... ☐ Yes ☐ No
2. Utilize an employment application?..... ☐ Yes ☐ No
   Does the employment application contain:
   (a) "Employment at Will" language? ..... ☐ Yes ☐ No
   (b) an "Equal Employment Opportunity" statement? ..... ☐ Yes ☐ No

3. Have an Employee Handbook? ☐ Yes ☐ No

   If "Yes", date last updated: _____

   (a) Is it distributed to all employees? ☐ Yes ☐ No

   (b) Is it intranet based? ☐ Yes ☐ No

4. Use any test to screen applicants or employees? ☐ Yes ☐ No
   If "Yes", please attach full details.

5. Please indicate whether the **Applicant** has formal written policies and procedures related to the following and indicate whether employees sign and acknowledge receipt:

	Written Policy or Procedure	Sign & Acknowledge Receipt
Employment at Will	☐ Yes ☐ No	☐ Yes ☐ No
Equal Employment Opportunity	☐ Yes ☐ No	☐ Yes ☐ No
New Employee Orientation	☐ Yes ☐ No	☐ Yes ☐ No
Annual Written Performance Evaluation	☐ Yes ☐ No	☐ Yes ☐ No
Zero Tolerance for Sexual Harassment	☐ Yes ☐ No	☐ Yes ☐ No
Discrimination and Harassment	☐ Yes ☐ No	☐ Yes ☐ No
Family Medical Leave Act	☐ Yes ☐ No	☐ Yes ☐ No
Disabled Employees and Accommodations	☐ Yes ☐ No	☐ Yes ☐ No
Grievance Procedures	☐ Yes ☐ No	☐ Yes ☐ No
Employee Discipline	☐ Yes ☐ No	☐ Yes ☐ No
Anti-Retaliation (including employee whistleblower protection)	☐ Yes ☐ No	☐ Yes ☐ No
Employee conduct when dealing with the general public	☐ Yes ☐ No	☐ Yes ☐ No
Consumer or other third party complaints	☐ Yes ☐ No	☐ Yes ☐ No

6. Does the **Applicant** perform criminal background checks on all employment applicants considered for hire? ☐ Yes ☐ No

7. Have the policies and procedures in questions 1-6 above been reviewed by legal counsel within the last 24 months? ☐ Yes ☐ No

8. Are the policies and procedures in questions 1-6 above (consistent or centralized) throughout all of the **Applicants**? ☐ Yes ☐ No

9. Has any **Applicant** undergone within the last 12 months or does any **Applicant** plan to undergo, during the next 12 months any lay-offs, downsizing or any other reduction in work force? ☐ Yes ☐ No
   If "Yes", please attach full details.

EMPLOYMENT PRACTICES LOSS INFORMATION

1. Has there been during the past five years, or is there now pending, any employment-related claims, administrative proceedings, charges, hearings, demands or lawsuits against the **Applicant** or any person proposed for this insurance whether or not insured, including claims involving employees, temporary, leased employees or independent contractors? ☐ Yes ☐ No
   If "Yes", please provide the date, a brief description, and the damages sought or settlement paid, of such claim, and the current status if pending.

2. During the past five years, has any claim, or notice of circumstances that could reasonably give rise to a claim, been reported to any previous or existing insurer providing coverage for employment practices liability? ☐ Yes ☐ No
   If "Yes", please attach full details.

To the extent that any matter required to be disclosed in response to questions 1 or 2 above constitutes a "Claim" as defined by the Policy, such matter was made prior to the policy period requested hereunder and therefore would be excluded from coverage.

3. Does any **Applicant**, or any person proposed for this insurance have any knowledge or information of any fact, circumstance or situation involving any law related to employment that could reasonably give rise to a claim against them? ☐ Yes ☐ No
   If "Yes", please attach full details.

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts or circumstances required to be disclosed in question 3 above is excluded from the proposed insurance.

Attention: Insureds in AR, CO, DC, KY, LA, NJ, NM, NY, and OH
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 may also be subject to a civil penalty.

(In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation.)

(In Colorado, 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.)

Attention: Insureds in FL
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 felony of the 3rd degree, and may also be subject to a civil penalty.

Attention: Insureds in ME, TN, VA, and WA
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.

Attention: Insureds in PA
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.

Attention: Insureds in PR
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 with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, 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.

D. SIGNATURE

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

E. REQUIRED COMPLETION – PLEASE READ AND SIGN

First Named Insured	
Signature of Chairman, President, CEO or Administrator (required)	**Date**
Title	

G.J. Sullivan Co. Excess and Surplus Lines Brokers, *on behalf of the Company, is hereby authorized to make any investigation and inquiry in connection with this application as they may deem necessary.*

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IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.