TRAVELERS

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***Health Care Organization Directors, Officers and Trustees and Employment Practices Liability Renewal Coverage Application***

**Travelers Casualty and Surety Company of America**

**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 AND MAY BE EXHAUSTED 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 IS SPECIFICALLY PROVIDED.**

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

***GENERAL INFORMATION***

1. Name of **Applicant**: _____

2. Street Address: _____

   City, State, ZIP Code: _____

3. Does the **Applicant** now have tax exempt status under the United States Internal Revenue Code? Yes ☐ No ☐

4. Is there now, or has there been within the last 12 months, any dispute as to the **Applicant's** Tax exempt status? Yes ☐ No ☐
   *If yes, attach an explanation.*

5. Does the **Applicant** currently file, or does it anticipate filing in the next 12 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

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

7. Is the **Applicant** managed or administered by any third party under contract or agreement? Yes ☐ No ☐

8. In the next 12 months (or during the past 12 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:
   a. Any actual or proposed merger, acquisition, affiliation, or divestiture? Yes ☐ No ☐
   b. Any creation of a new business, subsidiary, or division? Yes ☐ No ☐
      *If yes, attach a description of operations, ownership, and tax status for each such entity:*
   c. Any registration for a public offering or a private placement of securities (stocks or bonds)? Yes ☐ No ☐
   d. Any debt issuance or tax exempt bond offerings? Yes ☐ No ☐
   e. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

f. Any branch, location, facility, office, or subsidiary closings, consolidations, downsizing or layoffs? Yes ☐ No ☐

*If any of the questions above were answered yes, attach an explanation, including the timing, the essential terms of the event, arrangement, whether outside legal counsel was consulted, impact on employee base and the surrounding circumstances.*

## *REQUESTED INSURANCE TERMS*

1. Does the **Applicant** desire any changes to the expiring limit or retention of any Liability Coverage? Yes ☐ No ☐
   *If yes, indicate the desired changes in the table below:*

| Liability Coverage | Expiring Limit (A) | Requested Limit (B) | Expiring Retention (C) | Requested Retention (D) |
|---|---|---|---|---|
| **Health Care Organization Directors, Officers & Trustees D&O** | $ | $ | $ | $ |
| **Health Care Organization Employment Practices Liability** | $ | $ | $ | $ |

*Do not answer the next question unless the Requested Limit in Column (B) exceeds the Expiring Limit in Column (A).*

2. Solely with respect to any higher limit requested or that may ultimately be issued for the proposed renewal, is the **Applicant**, or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage? Yes ☐ No ☐

   *If yes, attach an explanation.*

   *Solely with respect to any portion of the Limit for Liability Coverage(s) in the proposed policy that exceeds the amount of the Expiring Limit for such Liability Coverage(s) in the expiring policy, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.*

## *DIRECTORS AND OFFICERS LIABILITY – complete only if coverage is desired*

1. In the past 12 months has there been, or in the next 12 months do you anticipate, any change in any of the following:
   a. The number of shareholders? Yes ☐ No ☐
   b. Shareholders that own(ed) greater than 5% of any class of security or class of shares outstanding? Yes ☐ No ☐
   c. The number of shares outstanding? Yes ☐ No ☐

   *If any of the questions above were answered yes, please attach an explanation.*

2. Have there been any changes in the Board of Directors or Senior Management of the **Applicant** within the past 12 months for reasons other than death or retirement? Yes ☐ No ☐

3. In the past 12 months 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 the **Applicant**? Yes ☐ No ☐

4. Does the **Applicant**:
   a. contract with more than 25% of the providers in any specific field of practice within its geographic service area? Yes ☐ No ☐
   b. control more than 25% of the hospital beds or specialty services within its geographic service area? Yes ☐ No ☐
   c. have exclusive contracts with any providers or hospitals? Yes ☐ No ☐
   d. have provider agreements that contain “Most Favorable” pricing provisions? Yes ☐ No ☐

e. have any provider agreements that contain non-compete provisions? Yes ☐ No ☐

*If yes, to any of 4a. – e. above, please attach full details.*

f. seek an opinion from antitrust legal counsel to confirm that any mergers, acquisitions and network development activities are not in violation of antitrust law? Yes ☐ No ☐

g. seek an opinion from the Federal Trade Commission (FTC) to confirm that any mergers, acquisitions and network development activities are not in violation of antitrust law? Yes ☐ No ☐

*If no, to either f. or g. above, please attach full details.*

5. What percentage of the **Applicant's** total revenue is generated from federal, state or local government sources? _____%

6. Does the **Applicant** have 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:_____

As part of this Application, please provide copies of the document listed below for each **Applicant** requesting insurance*:

- Most recent CPA audited financial statement or if CPA audit is not performed or not currently completed provide the most current year-end (12 months) internal financial report.
- Interim financial statements if CPA audited financial or year-end internal statements are six months or older.
- List of Directors and Officers.

*the documents, as well as the representations and facts contained within such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

## *EMPLOYMENT PRACTICES LIABILITY – complete only if coverage is desired*

1. Total number of employees:* _____
2. Total number of employees* outside the U.S.: _____
3. Total number of locations: _____
4. Complete the table providing the number of Full Time and Part Time Employees*, Volunteers and natural person Independent Contractors:

| As of Date of Application | | Previous 12 Months | | As of Date of Application | |
|---|---|---|---|---|---|
| **Full Time Employees** | **Part Time Employees** | **Full Time Employees** | **Part Time Employees** | **Volunteers** | **Independent Contractors** |
| | | | | | |

**Full and part time including leased, seasonal, and temporary employees*

5. Complete the table providing employee information for the ***5 states or foreign countries*** with the greatest number of **Applicant** employees:

| State or Foreign Country | Number of Employees |
|---|---|
| | |
| | |
| | |
| | |
| | |

6. Complete the table providing the *maximum* number of employees at any one point during the previous 12 months for the following classifications (regardless of whether they are full or part time):

| Leased | Temporary | Employed Physicians | Union |
|---|---|---|---|
| | | | |

7. Complete the table by providing employee turnover figures for each of the last 3 years:

| Type of Turnover | Year - 20____ | Year - 20____ | Year - 20____ |
|---|---|---|---|
| **Voluntary** | # | # | # |
| **Involuntary** (excluding layoffs/downsizing) | # | # | # |
| **Layoffs/Downsizing** | # | # | # |

8. Within the past 24 months how many officers have been involuntarily terminated or laid off? _____

9. Prior to employee terminations does the **Applicant** consult with:
   a. Human Resources personnel? Yes ☐ No ☐
   b. An attorney with experience in employment law? Yes ☐ No ☐

10. During the past 12 months, has the **Applicant** made amendments to any Human Resources policies or procedures or Employee handbook? Yes ☐ No ☐
    *If yes*, *provide copies of such policies or procedures or handbook*:

As part of this Application, please provide copies of the documents listed below for each **Applicant** requesting insurance*:

- If **Applicant** has 250 or more employees, attach employee handbook.
- If **Applicant** has 1,000 or more employees, most recent EEO-1 report and complete the Wage and Hour Supplemental Application.
- If limit requested is $2,000,000 or greater, most recent annual financial statement.
- If **Applicant** layoffs are either 10% of the workforce or more than 100 employees, complete the Downsizing Supplemental Application.

*the documents, as well as the representations and facts contained within such documents are made a part of this Application; the Insurer may elect to obtain requested information from public sources, including the Internet.

## *COMPENSATION NOTICE*

**Important Notice Regarding Compensation Disclosure**

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://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.

## *FRAUD WARNINGS*

***Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island***
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***Attention: Insureds in 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.

***Attention: Insureds in 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.

***Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and 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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

***Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and 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.

***Attention: Insureds in Oregon***
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

***Attention: Insureds in 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 with the penalty of 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.

***SIGNATURE SECTION***

**THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (CHAIRMAN, PRESIDENT, OR CEO) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION FOR INSURANCE, INCLUDING ANY SUPPLEMENTS OR MATERIALS MADE PART OF THIS APPLICATION, ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF ANY INFORMATION IN THIS APPLICATION, OR ANY SUPPLEMENTS OR MATERIALS SUBMITTED THEREWITH, CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY THAT TRAVELERS MAY ISSUE TO THE APPLICANT, THE APPLICANT WILL NOTIFY TRAVELERS OF SUCH CHANGES AND TRAVELERS MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. TRAVELERS IS AUTHORIZED TO MAKE ANY INVESTIGATION OR INQUIRY IN CONNECTION WITH THIS APPLICATION.**

**THE SIGNING OF THIS APPLICATION DOES NOT BIND TRAVELERS TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IF THE POLICY IS ISSUED, IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY SUPPLEMENTS OR MATERIALS MADE PART OF THIS APPLICATION, WILL HAVE BEEN RELIED UPON BY TRAVELERS IN ISSUING THE POLICY, WILL BE THE BASIS OF THE INSURANCE, AND WILL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO, AND PART OF, THE POLICY.**

**ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.**

Signature* of **Applicant's** Authorized Representative (Chairman, President, or CEO)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND 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.**

**AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE** ☐

**PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, AND IOWA):**

| Producer Signature | Producer Name (Printed) | |
|---|---|---|
| Agency Name | Agency Code | License Number |