McGowan Risk Specialists
145 Wyckoff Road, Suite 103
Eatontown, NJ 07724
P: 732.450.9730 • F: 440.333.3214
mcgowanrisk.com

FORCEFIELD[SM]

HEALTHCARE ORGANIZATIONS
INSURANCE APPLICATION FOR MANAGEMENT LIABILITY PACKAGE POLICY

(Inclusive of Directors and Officers Liability, Employment Practices Liability, Fiduciary Liability, Employed Lawyers Liability, Crime and Kidnap and Ransom/ Extortion Insurance)

THE FOLLOWING NOTICES ARE APPLICABLE TO ALL PROPOSED COVERAGE, EXCEPT THE CRIME AND THE KIDNAP AND RANSOM/EXTORTION COVERAGE.

THE INSURANCE FOR WHICH THIS APPLICATION IS SUBMITTED, IS GENERALLY LIMITED TO COVERAGE FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD AND REPORTED IN WRITING TO THE INSURER PURSUANT TO THE TERMS HEREIN.

THE LIMIT OF LIABILITY TO PAY JUDGMENTS OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY PAYMENT OF DEFENSE COSTS. DEFENSE COSTS WILL BE APPLIED AGAINST THE RETENTION AMOUNT.

THE INSURER DOES NOT ASSUME THE DUTY TO DEFEND ANY CLAIM UNDER THE POLICY; HOWEVER, IF THE INSURED TENDERS THE DEFENSE OF ANY CLAIM TO THE INSURER IN ACCORDANCE WITH THE TERMS THEREIN, THE INSURER SHALL ASSUME THE DEFENSE OF SUCH CLAIM.

THIS APPLICATION MUST BE COMPLETED IN FULL. PLEASE READ THE ENTIRE APPLICATION CAREFULLY, BEFORE SIGNING.

Note: If additional space is required for any response, please provide in a separate attachment, labeled with the question number.

I. GENERAL INFORMATION

1. Name of Applicant:____

   Web Site Address:____

2. Address of Applicant: ____

   City: ___________________ State: _____________ Zip Code: __________

3. Telephone Number: (_____)________________________
4. Date of Incorporation or Organization:___________________________
5. Years in Operation:_____________________________
6. States in which the Applicant operates: ____

7. Business Type:
- ☐ Not-For-Profit Tax Exempt
- ☐ Not-For-Profit Taxable
- ☐ Joint Venture
- ☐ For-Profit Corporation
- ☐ Limited Liability Company
- ☐ General Partnership
- ☐ Limited Liability Partnership
- ☐ Other (please specify):____

8. Name of Risk Manager:______________________ Telephone Number:__________________

   Mailing Address:____

   Email Address:______________________

9. Applicant is a (check all that apply):

- ☐ Hospital
- ☐ Third Party Administrator
- ☐ HMO (If you selected "HMO," please indicate: ☐ Staff Model ☐ Network/Panel Model ☐ Combined Model
- ☐ Health System
- ☐ Peer Review Organization
- ☐ Medical Group
- ☐ Managed Behavioral Health
- ☐ Surgery Center
- ☐ MSO
- ☐ IPA
- ☐ Nursing Home
- ☐ PHO
- ☐ PPO
- ☐ URO
- ☐ CVO
- ☐ PBM
- ☐ Other (describe):____

II. COVERAGE REQUESTED BY APPLICANT

Please indicate below which Coverage Sections the Applicant is seeking coverage under for its organization:

- ☐ **Directors and Officers (Complete Sections V-IX)**
- ☐ **Employment Practices Liability (Complete Section X)**
- ☐ **Fiduciary Liability (Complete Section XII)**
- ☐ **Employed Lawyers (Complete Section XIII)**
- ☐ **Crime (Complete Section XIV)**
- ☐ **Kidnap and Ransom/Extortion (Complete Section XV)**

ALL APPLICANTS MUST COMPLETE SECTIONS I-IV AND XVI–XIL OF THIS APPLICATION.

PLEASE COMPLETE ONLY THE ADDITIONAL SECTIONS OF THIS APPLICATION WHICH CORRESPOND TO THE COVERAGES YOU HAVE SELECTED ABOVE.

III. FINANCIAL INFORMATION

1. Has the Applicant or any of its Subsidiaries changed auditors in the past year? ☐ Yes ☐ No
   (If "Yes," please provide details in an attachment.)

2. Has the auditor of the Applicant or any of its Subsidiaries identified any material weaknesses in the entity's internal controls? ☐ Yes ☐ No
   (If "Yes," please provide details in an attachment.)

3. Please provide the following information for the Applicant and all Subsidiaries.

Based on Financial Statements Dated:	____________________ (indicate Month & Year)
Total Assets	$
Total Liabilities	$
Total Annual Revenues/Contributions	$
☐ Net Income or ☐ Net Loss	$
Cashflow from Operations	$

IV. ORGANIZATIONAL STRUCTURE

1. Please list all Subsidiaries for which coverage is desired:

   (Attach a separate sheet if necessary.)

Name of Subsidiary	Nature of Business	Date Acquired or Created	Percentage of Ownership	Incorporated State or Country

If the Applicant is seeking coverage for other entities in addition to the Subsidiaries listed, please provide complete details in an attachment to the Application, indicating their relationship to the proposed Named Insured.

2. Has the Applicant or any of its Subsidiaries completed any of the following in the past twenty four (24) months, or proposed or contemplated any of the following in next twelve (12) months:

   (a) Merger, Acquisition or Consolidation with another entity? ☐ Yes ☐ No
   (b) Sale, Distribution or Divestiture of assets or stock? ☐ Yes ☐ No
   (c) Registration for a Public Offering or a Private Placement of Securities? ☐ Yes ☐ No
   (d) Bankruptcy, Receivership, Liquidation or Reorganization? ☐ Yes ☐ No
   (e) Entering in any new Governmental Contracts? ☐ Yes ☐ No
   (f) Undertaking any new areas of business? ☐ Yes ☐ No

(If "Yes" to any of the above, please provide details in an attachment.)

3. Is the Applicant owned or operated by a state, city, town, municipal authority or other governmental entity? ☐ Yes ☐ No

4. Does the Applicant contract with any third party to manage, operate or administer any of its facilities or operations? ☐ Yes ☐ No

V. DIRECTORS AND OFFICERS INFORMATION

1. Stock/Equity Ownership of Applicant:
   (*If Applicant is a not-for-profit organization, please proceed to 3.*)

   Total number of common shares outstanding:____________________

   Total number of common shareholders:____________________

   Total number of shares held by Directors and Officers:____________________

2. Does any shareholder of the Applicant own five percent (5%) or more of the voting shares directly or beneficially? ☐ Yes ☐ No
   (If "Yes," please provide name and percentage of holdings in an attachment.)

3. Has the Applicant experienced changes to its Board of Directors or to its Key Executives over the past year? ☐ Yes ☐ No
   (If "Yes," please provide complete details in an attachment.)

4. Does the Applicant have any of the following Board Committees?
   (Please check all that apply.) ☐ Audit ☐ Compensation ☐ Nominating ☐ Finance

5. Do the Applicant's By-Laws limit or eliminate by indemnification, the personal liability of the directors, officers, trustees, employees, volunteers, staff, faculty and committee members, to the broadest extend permitted by law? ☐ Yes ☐ No

VI. ANTITRUST MARKET POSITION

1. Does the Applicant contract with more than 25% of the physicians in any given field of practice within its geographical service area? ☐ Yes ☐ No
   If "Yes," please explain:____

2. Does the Applicant control more than 25% of the hospital beds or specialty services within your geographic service area? ☐ Yes ☐ No
   If "Yes," please explain:____

3. Does the Applicant have exclusive contracts with any hospitals or providers? ☐ Yes ☐ No

4. Has the Applicant obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? ☐ Yes ☐ No

5. Has the Applicant received an opinion from the Federal Trade Commission (FTC) confirming that these activities will not violate antitrust laws? ☐ Yes ☐ No

6. Does the Applicant have any provider agreements that contain "Most Favored" pricing clauses? ☐ Yes ☐ No

7. Does the Applicant have any provider agreements that contain non-compete clauses? ☐ Yes ☐ No

VII. PEER REVIEW AND CREDENTIALING

1. Does the Applicant perform any peer review or credentialing activities? ☐ Yes ☐ No

   If "Yes," please complete the following questions. If "No," skip to part VIII.

   (a) Who does the credentialing of contracted health providers? ____________________________

   (b) Does the credentialing process include querying the National Practitioner Data Bank? ☐ Yes ☐ No

   (c) Are there written policies and procedures in place for such activities? ☐ Yes ☐ No

   (d) Do the procedures follow NCQA or JCAHO standards? ☐ Yes ☐ No

   (e) Does the Applicant audit and track utilization statistics to identify potential issues relating to medical necessity? ☐ Yes ☐ No

   (f) Is legal counsel consulted before any recommendation or decision, which adversely affects a provider's privileges or credentials, becomes final? ☐ Yes ☐ No

   (g) Have any providers been removed or disqualified from the Applicant's Panel in the last twelve (12) months? ☐ Yes ☐ No

   If "Yes," please indicate:
   How many (total number)? _______
   How many for reasons of professional incompetence? _________
   How many for reasons other than professional incompetence? _________

VIII. REGULATORY COMPLIANCE

1. Name of Applicant's Chief Compliance Officer:____

2. Does the Insured Entity have a Regulatory Compliance Plan in effect? ☐ Yes ☐ No
   If "Yes", what date was it originally put into effect? _____________________

3. Does training of new employees include training on compliance issues? ☐ Yes ☐ No

4. Does the Applicant maintain a procedure, such as a hotline, to receive complaints and allegations of regulatory non-compliance or wrongdoing? ☐ Yes ☐ No

   If "Yes", what is the average number of complaints or allegations per month? ____________
   Are all complaints recorded and investigated? ☐ Yes ☐ No

5. Does the Applicant have medical billing and coding software in place to discover errors? ☐ Yes ☐ No

6. Does the Applicant utilize an external audit firm to monitor billing and coding compliance? ☐ Yes ☐ No

7. Has the Applicant been subjected to any type of audit investigating overpayments received for services provided? ☐ Yes ☐ No
   If "Yes," please provide details in an attachment.

8. Has the Applicant or any proposed Insured voluntarily disclosed to any governmental entity a violation or potential violation of the Civil False Claims Act or the Physician Ownership & Referral Law (Stark Self-Referral Law)? ☐ Yes ☐ No

9. Has the Applicant or any proposed Insured retained legal counsel to provide an opinion as to whether or not a certain course of conduct would be in violation of the Civil False Claims Act or the Physician Ownership & Referral Law (Stark Self-Referral Law)? ☐ Yes ☐ No
   If "Yes," please provide details in an attachment.

IX. SECURITY PROCEDURES (Complete only if Applicant is a Hospital.)

1. Does the hospital have written policies and procedures for the prevention of abductions that includes all areas of pediatrics (i.e. nursery, birth unit, maternity unit, pediatric care unit, emergency care unit, daycare/childcare center, etc.)? ☐ Yes ☐ No

2. Are parents provided with instruction materials on safeguarding children during their hospital stay? ☐ Yes ☐ No

3. Does the policy address procedures for transporting children to and from patient care units? ☐ Yes ☐ No

4. Are identically numbered ID bands placed on the infant and mother immediately after delivery? ☐ Yes ☐ No

5. Are there policies and procedures to ensure the proper ID of the father or significant other? ☐ Yes ☐ No

6. Does the staff assigned to work in the maternity/child unit wear a badge with a current color photo and a second form of ID known only to that unit and the parents? ☐ Yes ☐ No
   If "Yes," are ID badges and hospital clothing strictly controlled? ☐ Yes ☐ No

7. Do the policies address visitation and outside deliveries such as flowers for patients? ☐ Yes ☐ No

8. Is the number of visitors per patient restricted? ☐ Yes ☐ No

9. What type of infant security system is in place? ______________________________

10. Does the security system include cameras, a locked unit, key pad entry, specially coded staff badges? ☐ Yes ☐ No

11. What vendor is used for the security system? ______________________________

12. Does staff training for the prevention of child abduction include all staff in the facility? ☐ Yes ☐ No

13. If "Yes" to the above, is it conducted at new hire orientation and at regular intervals thereafter? ☐ Yes ☐ No

14. What procedures are in place for monitoring the effectiveness of security measures?
____

15. What procedures are in place for monitoring compliance with security measures by staff?
____

16. Is there an Incident Response Plan in place? ☐ Yes ☐ No

X. EMPLOYMENT PRACTICES INFORMATION

(Please provide the following information for the Applicant and all Subsidiaries for which coverage is being requested.)

1. Enter the **TOTAL** (**Inclusive of California**) number of employees in the boxes below.
Note: Seasonal, Temporary and Leased Employees to be included as Part-Time employees
Number of Employees in ALL STATES/JURISDICTIONS:

Full Time:	
Part Time:	
Total Number of Independent Contractors:	
Total Number of Employed Physicians	

2. Please provide a breakdown of employees located in the states in which the Applicant operates:

State	**Percentage of Employees**

3. Enter the **TOTAL** number of **California** employees in the boxes below.
   Note: Seasonal, Temporary and Leased Employees to be included as Part-Time employees
   Number Employees in CALIFORNIA ONLY:

Full Time:	
Part Time:	
Total Number of Independent Contractors:	
Total Number of Employed Physicians	

4. For the past 3 years, what has been the annual percentage turnover rate of employees (all locations)?
   Year _____, _____%   Year _____, _____%   Year _____, _____%

5. What percentage of employees currently have an annual salary, including projected bonus amounts, of:

Salary Amount	**Percentage**
Less than $50,000	
$50,000 - $100,000	
$100,000 - $250,000	
Greater than $250,000	

6. What percentage of employees are:

	Percentage
Union	
Non-Union	

7. Does the Applicant have a full-time Human Resources manager or the equivalent? ☐ Yes ☐ No

8. Does the Applicant have written procedures in place for the following:
   - Hiring / interviewing? ☐ Yes ☐ No
   - Employment at-will statement? ☐ Yes ☐ No
   - Discrimination? ☐ Yes ☐ No
   - Progressive discipline policies and procedures? ☐ Yes ☐ No
   - Employment evaluations? ☐ Yes ☐ No
   - Accommodating the disabled? ☐ Yes ☐ No
   - Employee grievances or complaints? ☐ Yes ☐ No
   - Sexual harassment? ☐ Yes ☐ No
   - Workplace harassment? ☐ Yes ☐ No
   - Employee terminations? ☐ Yes ☐ No
   - Orientation of all new employees? ☐ Yes ☐ No

9. Does the Applicant distribute the above-listed procedures to all employees at all locations? ☐ Yes ☐ No

10. Does the Applicant implement the above-listed procedures at all locations? ☐ Yes ☐ No

11. Does the Applicant track, monitor and react to pay equity studies and promotional practice studies? ☐ Yes ☐ No

12. Does the Applicant review terminations to look at trends which might indicate a practice of discrimination? ☐ Yes ☐ No

13. Does the Applicant perform self-critical analysis of workforce diversity? ☐ Yes ☐ No

14. Does the Applicant use outside counsel for employment advice? ☐ Yes ☐ No

15. Is the Applicant or any of its Subsidiaries currently undergoing or does the Applicant or any of its Subsidiaries contemplate undergoing during the next twelve (12) months, any employee layoff or early retirements programs (including ones resulting from any type of company restructuring, or office, plant or store closing)?
(If "Yes", please provide details in an attachment.) ☐ Yes ☐ No

    a. Have there been any structured layoffs in the past twenty four (24) months? ☐ Yes ☐ No
    If "Yes," please answer the following:

    What percentage of total employees were laid off? ☐1-10% ☐11-25% ☐Over 25%

    Did the Applicant or its Subsidiary consult with an outside counsel during the layoff procedure?
    ☐ Yes ☐ No

    Were severance packages offered in exchange for releases not to sue? ☐ Yes ☐ No
    (*If "No," please attach complete details.)*

    b. Please provide the number of layoffs that have taken place to date (including those which are planned and about to occur: ____________________

    c. Does the Applicant and its Subsidiaries have procedures in place to assist terminated or laid off employees find work? ☐ Yes ☐ No

16. Does the Applicant have a procedure in place to ensure compliance with the federal Fair Labor Standards Act and similar state laws? ☐ Yes ☐ No

17. Has the Applicant been the subject of any wage and hour investigations or audits by any governmental agency? ☐ Yes ☐ No
If "Yes" what was the outcome? ____

18. Has the Applicant conducted any internal, voluntary wage and hour audits? ☐ Yes ☐ No
If "Yes" were the audits conducted by a third party, such as outside legal counsel or a professional human resources consultant? ☐ Yes ☐ No

19. What percentage of the Applicant's employees are classified as "Exempt" (versus "Non-Exempt")?
____%

20. How many of the Applicant's employees are classified as Exempt under each of the following exemption categories?

    Administrative: _____
    Professional: ____
    Executive: ____
    Computer Professional: ____
    Other (Please Specify): ____ ____

21. Does the Applicant maintain records regarding the number of hours worked by Non-Exempt Employees? ☐ Yes ☐ No

If “Yes” please explain the method used (weekly time sheets, time clock, electronic records, etc.):
____

22. Are such records verified by both the employee and their manager on a weekly basis?
☐ Yes ☐ No

23. Does the Applicant maintain records regarding the number of hours worked by Exempt employees?
☐ Yes ☐ No
If “Yes” please explain the method used (weekly time sheets, time clock, electronic records, etc.):
____

24. Are Non-Exempt employees paid on an hourly or salaried basis? ______________________________

25. Are any deductions taken from Exempt employees’ wages based upon the number of hours worked?
☐ Yes ☐ No

26. Do you provide compensatory time off to any employees? ☐ Yes ☐ No
If “Yes” please explain: ____

27. Are independent contractors paid in accordance with the Applicant’s standard payroll practices for employees? ☐ Yes ☐ No

28. Are Non-Exempt employees paid for time spent to prepare for work, such as changing into a uniform on site, traveling from one job site to another, or traveling in connection with work duties (please do not consider when answering, time spent by employees for a customary commute)? ☐ Yes ☐ No

XII. FIDUCIARY LIABILITY INFORMATION

1. Please provide the following information for each Plan to be covered:

Plan Name and Plan Number	Type of Plan *	Number of Participants	Plan Assets	Plan Status**

* Welfare (W), Defined Benefit (DB), Defined Contribution (DC), ESOP (ESOP), Other (O)
** Active (A), Merged (M), Sold (S), Terminated (T), Frozen (F)

2. Are any of the Plans assets invested in the Applicant’s own securities? ☐ Yes ☐ No
If “Yes”, are the investments ‘Company Directed’ or invested at the discretion of the employee?
☐ Yes ☐ No

3. Have any Plan benefits been modified within the last two years? ☐ Yes ☐ No

4. Are any Plans managed by an independent third-party administrator? ☐ Yes ☐ No
If “Yes,” how often is the third-party administrator’s performance reviewed? :____________

5. Does the Applicant plan on terminating, suspending, merging or dissolving any Plans within the next twelve (12) months? ☐ Yes ☐ No
   (If "Yes," please provide complete details in an attachment.)

6. Please answer the following questions should coverage for an ESOP plan be requested.
   What percent of the Company stock does the ESOP own? :____________________
   Who votes the shares of the ESOP? :____________________
   How often are the shares of the Company valued for purposes of the ESOP? :_________________

XIII. EMPLOYED LAWYERS INFORMATION

1. Number of full-time Lawyers employed by the Applicant (including Subsidiaries):________________
   Number of part-time Lawyers employed by the Applicant (including Subsidiaries):________________

2. Describe the type of work including types of Pro Bono and moonlighting work performed by Employed Lawyers. (Please provide complete details in an attachment.)

3. If the Applicant's (including any subsidiary's) securities are publicly traded or subject to public reporting under the Securities Exchange Act of 1934, please answer the following:

   Does any Employed Lawyer prepare, review, comment on, sign, or approve financial statements, registration statements, prospectuses, annual or quarterly reports, or other reports filed with federal or state agencies or released to shareholders or the public, regarding the Applicant or its Subsidiaries? ☐ Yes ☐ No

4. Does any Employed Lawyer serve on the Board of Directors or the equivalent governing/oversight body of the Applicant or its Subsidiaries? ☐ Yes ☐ No

5. Does the Applicant or its Subsidiaries anticipate any registration of securities under the Securities Act of 1933 (or any similar federal, state or foreign rule or law), or any other offering of securities within the next twelve (12) months? ☐ Yes ☐ No

6. Does the Applicant or its Subsidiaries permit or require any Employed Lawyer to issue any written legal opinion to an outside party, in connection with a sale, acquisition, merger, consolidation or other similar transaction? ☐ Yes ☐ No

7. Does any Employed Lawyer serve on a due diligence committee or perform legal services regarding any proposed sale, merger, acquisition, consolidation or other similar transaction involving the Applicant or its Subsidiaries? ☐ Yes ☐ No
   (If "Yes," please provide a narrative description of the role and process in an attachment.)

8. Does any Employed Lawyer appear in court for or on behalf of the Applicant or its Subsidiaries or any proposed insured person, in the course of his or her employment for the Applicant? ☐ Yes ☐ No

9. Does any Employed Lawyer provide personal legal services, including but not limited to legal services relating to criminal, civil, matrimonial, intellectual property law or estate/financial planning matters, to any proposed insured person or any third party? ☐ Yes ☐ No

10. Does any Employed Lawyer issue written legal opinions to or for the use of, the Board of Directors or the equivalent governing/oversight body, of any entity other than the Applicant or its Subsidiaries, in which the Applicant or any Subsidiary has an equity or other interest in such entity? ☐ Yes ☐ No

11. Has any Employed Lawyer been the subject of any disciplinary proceeding or investigation, or been disciplined by, any state organization or agency charged with the licensing or discipline of attorneys, or been refused admission to practice by any state or federal bar, court or administrative agency? (If "Yes," please provide complete details in an attachment.) ☐ Yes ☐ No

XIV. CRIME INFORMATION

1. Has the Applicant experienced any of the following losses in the past six years, or if in business less than six years, since the date of formation (whether insured or not):
   - Employee Theft? ☐ Yes ☐ No
   - Forgery or Alteration? ☐ Yes ☐ No
   - Theft of Money and Securities (Inside/Outside)? ☐ Yes ☐ No
   - Any Other Crime or Fidelity related losses? ☐ Yes ☐ No

   (If "Yes" to any of the above please provide complete details in an attachment.)

2. Please provide the Applicant's (including its Subsidiaries) total number of locations:____________________

   Please indicate the number of Locations by State:
   State __________ Number of Locations_____________
   State __________ Number of Locations_____________
   (Please provide additional details in an attachment if necessary.)

3. Please provide the Applicant's (including its Subsidiaries) total number of employees:____________________

   U.S. :____________Canadian:___________Foreign:_____________

4. Of the total employees listed above, what percent handles, has access to or maintains records of, money, securities or other property of the Applicant or any third party, including, but not limited to, directors, officers, trustees or any persons handling or having access to employee welfare or benefit plan assets? _______%

5. Does the Applicant currently have cash exposures that exceed the lowest deductible amount of its current Crime or Fidelity Policy? ☐ Yes ☐ No

6. Does the Applicant have precious metals or stones, or articles containing such materials, artwork, or any other valuable items, the total value of which exceeds the lowest deductible amount of the Applicant's current Crime or Fidelity Policy? ☐ Yes ☐ No

7. Are corporate credit, debit, charge or purchasing cards used by the Applicant's employees? ☐ Yes ☐ No
   If "Yes," please indicate the following:
   a. Total number of cards issued: __________
   b. Maximum credit limit allowed under each card: __________
   c. Briefly describe the controls in place for preventing and identifying unauthorized transactions:
   ____________________ ______________________________

CHECK HANDLING AND DISBURSEMENT CONTROLS

8. Does the Applicant have access to client's funds or property (including money, securities, inventory, high value property, banking systems, wire transfer systems, computer systems or sensitive data, etc.)? ☐ Yes ☐ No
   If "Yes," please indicate the following:

a. Type of funds or property, and dollar amount or value:____________________
b. Number of employees who will be performing work for your client(s):____________________
c. Total number of clients:_________________

9. Do all checks issued by the Applicant require a physical (handwritten) signature? ☐ Yes ☐ No
If "No," please indicate the maximum amount that a check may be issued for, using an electronic or other "automated" signature: $_________________

10. Do checks issued by the Applicant sometimes require two authorized signatures? ☐ Yes ☐ No

a. If "Yes," over what amount is a second signature required? $__________
b. If there is no second signature required, who is authorized to sign the Applicant's checks? ______________

11. Are checks signed only by the owner(s) of the Company? ☐ Yes ☐ No

12. How often is blank check stock inventoried? ___________________

13. Are those persons authorized to sign checks instructed to require that all checks be accompanied by properly approved vouchers or invoices? ☐ Yes ☐ No

14. Are systems designed so that no single person can control a process from beginning to end (i.e. request a check, approve a voucher and sign a check)? ☐ Yes ☐ No

15. Are bank accounts reconciled on a monthly basis? ☐ Yes ☐ No
a. If "No," how often are they reconciled? _________________

16. Are those who reconcile the Applicant's bank accounts prohibited from:
a. handling deposits to or withdrawals from the accounts they reconcile? ☐ Yes ☐ No
b. signing checks? ☐ Yes ☐ No

AUDIT FUNCTIONS AND CONTROLS

17. Does a second person review the reconciliation of an account with supporting documentation, and initial their approval of the information? ☐ Yes ☐ No

18. How often, and by whom, are audits of cash and accounts performed? _______________

19. How often, and by whom, are inventory counts conducted? ________________

20. Is there a CPA letter to management relating to internal control weaknesses? ☐ Yes ☐ No
(If "Yes," please provide a copy of the most recently issued letter.)

21. If no CPA letter to management was issued, did the CPA make recommendations for improvement in internal control procedures informally? ☐ Yes ☐ No
(If "Yes," please provide complete details in an attachment.)

22. Does the Applicant have an internal audit department? ☐ Yes ☐ No
a. Are all of Applicant's locations audited by the internal audit staff? ☐ Yes ☐ No
(If "No", please explain in an attachment.)
b. If "Yes," how often is each location audited? _______________

STAFFING AND VENDOR CONTROLS

23. Are background checks performed on all new hires? (Check all that apply.)
☐ Criminal ☐ Prior Employment ☐ Credit History ☐ References ☐ Drug Testing

24. Are mid-employment screenings performed when employees are promoted to sensitive positions?
☐ Yes ☐ No

25. Are all employees' building access cards cancelled immediately upon termination and are all procurement, credit cards, etc. cancelled? ☐ Yes ☐ No ☐ N/A

26. Are all employees' credit, debit, charge or purchasing cards cancelled immediately upon termination?
☐ Yes ☐ No ☐ N/A

27. Are employees provided with a copy of the organization's Anti-Fraud Policy at least annually? ☐ Yes ☐ No
    a. Is there a system in place that allows for the reporting of suspicious or fraudulent activity or unauthorized transactions confidentially? ☐ Yes ☐ No
    b. If "Yes," describe the procedure for investigating these reports in an attachment.

28. Are employees provided with written guidelines or policies on other prohibited activities or behavior?
☐ Yes ☐ No

29. Are employees required to complete Conflict of Interest disclosure forms at least annually? ☐ Yes ☐ No

30. Are background and credit checks performed on vendors in order to determine ownership and financial capability, prior to doing business with them? ☐ Yes ☐ No
    a. If "Yes," is there dual control over this process so a single employee cannot set up a fictitious vendor in the system without it being detected? ☐ Yes ☐ No

31. Is an authorized vendor list utilized by the Applicant and updated annually for all purchases, with competitive bidding required over stated amounts? ☐ Yes ☐ No

32. Are all vendors provided with the Applicant's policy on gifts and entertainment (prohibiting gifts or entertainment of any significant value)? ☐ Yes ☐ No

WIRE TRANSFER AND COMPUTER CONTROLS

33. What is the daily average number of, and dollar value of, wire transfers to and from the Applicant's accounts?
______________ $ _______________

34. What is the maximum dollar value that may be transferred per day? ______________

35. Is approval by more than one authorized person required to initiate a wire transfer? ☐ Yes ☐ No

36. Does the Applicant's financial institution receive authorization from an employee, other than one who requested the wire transfer, before acting on the request? ☐ Yes ☐ No

37. Does the Applicant receive hard copy confirmations on all wire transfers? ☐ Yes ☐ No
    a. If "Yes are confirmations sent directly to a department or individual which is not authorized to initiate a wire transfer? ☐ Yes ☐ No

38. Are computer system access codes and passwords changed at least every sixty (60) days? ☐ Yes ☐ No

39. Do any third parties, other than employees, have access to the Applicant's computer systems? ☐ Yes ☐ No
(If Yes, please explain in an attachment.)

40. Does the Applicant sponsor any employee welfare or retirement plan(s) for its employees? ☐ Yes ☐ No
    a. If "Yes," please list all sponsored employee welfare or retirement plan(s) that are required to be bonded by ERISA. (Please provide in an attachment.)

41. Are all entities for which the Applicant is seeking Crime Coverage listed in Section IV.1. of this Application? If not, please provide complete listing in an attachment.

    a. Are all such entities owned, controlled or operated by the Applicant, directly or through its Subsidiaries? ☐ Yes ☐ No
    b. Does the information provided in this Application, or any attachment, include information for all joint ventures proposed to be covered? ☐ Yes ☐ No
    If "No," to questions a. or b. above, please provide details in an attachment.

XV. KIDNAP AND RANSOM/EXTORTION

1. List total number of proposed insured persons which are based outside the United States or Canada, by country:

Country	City	Number of Employees	Number of Locations	Operations

2. List any planned travel in the next twelve (12) months outside the United States or Canada, by country:

Country	City	Number of Insured Persons Traveling	Frequency	Duration

3. Describe any preventative measures taken for employees located or traveling outside the United States or Canada:____

4. Has the Applicant or any person proposed for coverage ever been involved in an attempted, threatened or actual kidnapping, extortion, detention or hijacking? ☐ Yes ☐ No

5. Please list contact information for Director of Security and/or Risk Management (or equivalent position):

    Name:______________________ Email Address:_______________

    Title:_______________________ Telephone Number:_______________

XVI. CLAIMS HISTORY *(Renewal Applicants do not need to complete this section.)*

1. Does any person or entity for whom coverage is sought under the proposed insurance have any knowledge of any fact, circumstance, situation, or information of any error, misstatement, misleading statement, act, omission, neglect, breach of duty or other matter that may give rise to a Claim which may fall within the scope of coverage under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A
   Employed Lawyers Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

2. Has any Claim been made or legal proceeding been brought against any person or entity for whom coverage is sought under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A
   Employed Lawyers Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

3. Does any person or entity for whom coverage is sought under the proposed insurance have knowledge of any inquiry, investigation or communication that he/she/it has reason to believe might give rise to a Claim that might fall within the scope of the coverage under the proposed insurance?

   Directors and Officers Liability ☐ Yes ☐ No ☐ N/A
   Employment Practices Liability ☐ Yes ☐ No ☐ N/A
   Fiduciary Liability ☐ Yes ☐ No ☐ N/A
   Employed Lawyers Liability ☐ Yes ☐ No ☐ N/A

   If "Yes," please provide complete details in an attachment.

4. Has the Applicant or any of its Subsidiaries, or any director or officer thereof:
   a. Been named as a party in, or otherwise involved in any antitrust, copyright or patent litigation? ☐ Yes ☐ No
   b. Been charged in any civil or criminal action or administrative proceeding, with a violation of any federal or state antitrust or unfair trade practices law? ☐ Yes ☐ No
   c. Been charged in any civil or criminal action or administrative proceeding, with a violation of any federal or state securities law or regulation? ☐ Yes ☐ No
   d. Been named as a party in, or otherwise involved in any representative actions, class actions, or derivative suits? ☐ Yes ☐ No
   e. Been charged in any civil or criminal action or administrative proceeding with a violation of any federal or state anti-harassment or anti-discrimination law? ☐ Yes ☐ No

   If "Yes," please provide complete details in an attachment.

IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS WITH REGARD TO ANY QUESTIONS IN THIS SECTION XVI., REGARDLESS OF WHETHER IT IS DISCLOSED IN THIS APPLICATION, ANY CLAIM BASED ON, ARISING FROM, OR IN ANY WAY RELATING TO SUCH MATTER OF WHICH THERE IS KNOWLEDGE OR INFORMATION SHALL BE EXCLUDED FROM COVERAGE UNDER THE INSURANCE BEING APPLIED FOR, AND THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS OR DEFENSE EXPENSES OR OTHER COSTS RESULTING THEREFROM, AND TO THE EXTENT THIS POLICY PROVIDES DUTY TO DEFEND COVERAGE, THE INSURER SHALL HAVE NO DUTY TO DEFEND ANY CLAIM, SUIT OR OTHER LEGAL PROCEEDING ARISING OUT OF SUCH MATTER.

XVII. PRIOR INSURANCE COVERAGE

Please provide the following details regarding the Applicant's current Insurance programs:

Coverage	Carrier	Limit of Liability	Retention	Premium	Policy Period
Directors and Officers					
Employment Practices					
Errors and Omissions					
Medical Malpractice					
Fiduciary					
Stop Loss/ Provider Excess					
Employed Lawyers					
Crime					
Kidnap and Ransom					

If Applicant does not currently have such coverage in place, please indicate "N/A."

1. What is the Retroactive Date of the current Directors and Officers Liability Policy? _______________

2. What is the Retroactive Date of the current Employment Practices Liability Policy? _______________

MISSOURI APPLICANTS, DO NOT ANSWER QUESTION 3.

3. Have any of the Applicant's prior carriers cancelled coverage or indicated an intent to not offer renewal terms?
   (If "Yes," please provide complete details in an attachment.) ☐ Yes ☐ No

XVIII. REPRESENTATIONS OF AND NOTICES TO THE APPLICANT

The undersigned authorized representative of the Applicant declares that the statements set forth herein are true, and reasonable effort has been made to obtain sufficient information from all persons proposed for this insurance to facilitate the accurate completion of the Application.

The undersigned authorized representative 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 Insurer of such changes, and the Insurer may withdraw or modify any outstanding quotations or agreement to bind insurance.

The submission of this Application by the Applicant to the Insurer or signing of this Application by or on behalf of the Applicant does not obligate the Insurer to issue the insurance requested. It is agreed that this Application shall be the basis of the contract if a policy is issued and shall be deemed to be attached to, incorporated into and become a 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. 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.

NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, DISTIRCT OF COLUMBIA 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 FINES AND CONFINEMENT IN PRISON.

NOTICE TO 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 CLAIMING 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

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.

NOTICE TO KANSAS APPLICANTS: 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 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.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA 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 FINES AND CONEFINEMENT IN PRISON.

NOTICE TO MAINE, MISSOURI, 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW MEXICO 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.

NOTICE TO 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.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO 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.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

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.

XII. DECLARATION AND SIGNATURE

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE HEREBY ACKNOWEDGES THAT HE OR SHE IS MAKING THE REPRESENTATIONS IN THIS APPLICATION ON BEHALF OF THE APPLICANT AND ALL ENTITIES OR PERSONS PROPOSED FOR COVERAGE UNDER THE POLICY.

Signed: ________________________________

Print Name: ________________________________

Title: ________________________________
(President, CEO or CFO)

Date: ________________________________