

MANAGED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

INSTRUCTIONS:

1. Please type or print clearly
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a principal of the business.

REQUIRED INFORMATION:

1. Loss History for the last five years. The loss run should be updated within the last 30 days and include claim descriptions, breakdown of total incurred losses (paid and reserves for indemnity and expense), respective deductibles or retentions and full details on all losses paid or outstanding in excess of \$25,000. Any non-Lexington loss runs must include open claim reserve amounts. If reserves are not disclosed, the applicant must provide full details on the claim. Details should include an evaluation from outside counsel with potential claim estimates and estimated defense costs.
2. Most Recent **Audited** Financials or Interim Financials with Treasurers Warranty.
3. Specimen copy of provider and service agreements.
4. Any marketing brochures.
5. Credentialing and Utilization Management Procedures.

SECTION 1 GENERAL INFORMATION

1) a. Name of Applicant: _____

(Applicant should include all entities listed in Question 3)

b. Address: _____

c. City: _____ State: _____ Zip: _____

d. Contact Person _____
Risk Manager (if different): _____

e. Web Address: _____

- 2) APPLICANT IS:
- | | | |
|--|---|--|
| <input type="checkbox"/> For Profit Corp. | <input type="checkbox"/> Not for Profit (taxable) | |
| <input type="checkbox"/> TAX STATUS Not for profit (non taxable) | <input type="checkbox"/> Joint Venture | |
| <input type="checkbox"/> MEWA or MET | <input type="checkbox"/> OTHER (Describe): | |
- _____

- b. **ORGANIZATION TYPE**
- | | |
|---|---|
| <input type="checkbox"/> Publicly Traded | <input type="checkbox"/> Privately Held Company |
| <input type="checkbox"/> HMO ___IPA Model ___Staff Model ___Mixed Model ___Provider Owned | |
| <input type="checkbox"/> PPO | <input type="checkbox"/> IPA |
| <input type="checkbox"/> PHO | <input type="checkbox"/> MSO |
| <input type="checkbox"/> Peer Review Organization | <input type="checkbox"/> TPA |
| <input type="checkbox"/> Utilization Review Organization | <input type="checkbox"/> Consumer Driven Provider |
| <input type="checkbox"/> OTHER (Describe): _____ | |

c. Date of Incorporation: _____ Date Operations Began: _____

d. States of Operation: _____

- 3) Do you desire coverage for subsidiaries, joint venture or partnerships? Yes No
 If yes, please provide the following details listed below. Please provide attachment if necessary.
Please be sure to include the respective exposure information in question below.

Name and Address	Relationship to Applicant	Description of Operations	Tax Status	% Owned	Date Acquired/Formed

- 4) Does the applicant own, operate, or supervise a hospital, inpatient or outpatient clinic, pharmacy, dispensary, or any other medical facility? Yes No
 If yes, please provide details: _____
-
- 5) Does the applicant employ physicians, surgeons, dentists or other health care professionals, in any medical capacity except to perform administrative duties, peer review or utilization functions? Yes No
 If yes, please provide details: _____
-
- 6) Are medical services provided under a written contract between health care providers and the applicant? **Please attach a sample copy.** Yes No
 If no, please provide details: _____
-
- 7) How are providers compensated? Please check all that apply: Capitated Non-Capitated Withhold
Fee For Service Other: _____
-
- 8) Are there any plans being considered for a merger, an acquisition or a consolidation of or by the applicant or any of its subsidiaries? Yes No
 a) If "Yes", have such plans been approved by the Board of Directors (or equivalent governing board) of the applicant and such entity? Yes No
 Date of Approval? _____
 b) If "Yes", have such plans been submitted to the shareholders/members of the applicant and such entity for approval? Yes No
 Date of Approval? _____
-
- 9) Is the applicant currently or ever been under any supervision order, receivership, bankruptcy or similar protection? If yes, please explain in detail. Yes No

-
- 10) Is the applicant currently or ever been subject to administrative proceedings, fines, penalties, sanctions or like punishments? If yes, please explain in detail. Yes No

-
- 11) Does the applicant or any of its subsidiaries anticipate any registration of securities under the Securities Act of 1933 (or any similar state or foreign rule or law) or any other offering of securities or private placement within the next twenty-four months? Yes No
 If yes, give details and submit offering materials if available. _____
-
- 12) Do you manage any plans, including any minority owned plans? Yes No
 If yes, please explain. _____

SECTION 2 DESCRIPTION OF SERVICES

- 1) Please attach a written narrative describing your operations, including any services you provide to others for a fee.
The narrative is required for underwriting consideration.

SECTION 3 EXPOSURE INFORMATION

Covered Lives/Enrollment	This Year _____	Last Year _____	Est. Next Year _____
Commercial (non-government) employer plans, Unions and Trusts, including dependents & retirees			
Government Employer			
Medicare/Medicaid			
Individual Coverage			
PPO/POS			
Dental*			
Vision*			
Behavioral Health*			
Consumer-Driven Options			

*If only offered as a part of standard medical coverage, please state "included".

PROVIDERS	This Year _____	Last Year _____	Est. Next Year _____
Contracted (a) Physicians (b) Other			
Contracted Hospitals			
Contracted Facilities			

FEE BASED SERVICES:

EXTERNAL CREDENTIALING	This Year _____	Last Year _____	Est. Next Year _____
Revenue			
# of Cases Reviewed			

UTILIZATION REVIEW COST CONTAINMENT	This Year _____	Last Year _____	Est. Next Year _____
Revenue			
# of Cases Reviewed			
% of Cases sent to Independent Review			
% of Cases Upheld			

List top 3 reasons cases were overturned: _____

CLAIMS ADMINISTRATION	This Year _____	Last Year _____	Est. Next Year _____
Revenue			
Claim Volume (number)			
Claim Volume (\$ amt)			
# of Claim Handlers			

*Please attach specimen service agreement

STOP LOSS REINSURANCE	This Year _____	Last Year _____	Est. Next Year _____
Gross Written Premium by Carrier (list):			
Commission Earned			

EMPLOYEE ASSISTANCE PROGRAM	This Year _____	Last Year _____	Est. Next Year _____
Revenues			
Client Contact Hours			

OTHER SERVICES (Included, but not limited to benefit management, financial planning, accounting services, actuarial services, facilities management, staffing and purchasing)

SERVICE DESCRIPTION	This Year _____	Last Year _____	Est. Next Year _____

STATE BREAKDOWN:

Please provide enrollment and required physician medical malpractice limits by state. Please use attachment, if necessary.

State	Total Enrollment	Required Physician Limits
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4 ADVERTISING

- 1) Do all contracts, sales literature/brochures clearly state covered and non-covered procedures? Yes No
Please enclose specimens
- 2) Do contracts, sales literature/brochures use the term(s) "investigational" , "experimental" or "medically necessary"? Yes No
- 3) If the above answer is YES, do contracts, sales literature/brochures and certificate of coverage define what is considered "investigational", "experimental" or "medically necessary"? Yes No
- 4) Are all contracted health care providers always referred to as independent contractors or participating providers? Yes No
- 5) Do you conduct satisfaction surveys? Yes No
If yes, how often? _____ **Please provide details on latest results.**
- 6) Do all contracts and certificate of coverage provide details or instructions for your internal appeal process or state mandated external review process? Yes No
Please provide details: _____
- 7) Do your legal representatives review and approve all contracts, sales literature/brochures prior to their use, including any amendments or revisions? Yes No
If no, are your marketing materials subject to state approval? Yes No

SECTION 5 MARKETING AND SALES

- 1) Number of employees selling insurance products _____ Number of those employees licensed _____
- 2) How are applicant's services sold? _____
- 3) Please describe all duties of sales employees: _____
- 4) Are applicant's services sold by non-employees? _____
- 5) If YES, please describe: _____
- 6) Nature and type of products/services sold:
_____ %
_____ %
_____ %
Total: _____ %

SECTION 6 HIPAA COMPLIANCE

- 1) Does applicant take appropriate measures to assure that client's plans comply with HIPAA? Yes No
If yes, please explain: _____

- 2) Have you complied with the Electronic Transactions Standards Yes No
If no, have you filed and been approved for an extension? Yes No
Extension date: _____
- 3) Have you established privacy policies and procedures to comply with the Health Insurance Portability and Accountability Act (HIPAA)? Yes No
Please describe: _____

- 4) Has your legal representative reviewed all materials related to the rule? Yes No
- 5) Do marketing materials and enrollee plan documents explain the HIPAA rule and the impact on enrollees, including consent procedures and protected health information? Yes No
Please describe: _____
- 6) Have "firewalls" been established in claim handling for employees to ensure proper privacy? Yes No
Please describe: _____

- 7) Has a compliance officer and training staff been established? Yes No
Please describe: _____
- 8) Have amendments to employee handbooks been drafted to explain HIPAA and outlined violations and sanctions? Yes No
Please describe: _____

SECTION 7 CREDENTIALING

INTERNAL PROCEDURES:

- 1) Do you follow NCQA guidelines for credentialing? **If no, please provide details.** Yes No
If yes, what is your procedure for quality and disciplinary review between scheduled credential reviews? _____

- 2) How often does applicant recredential contracted health care providers? _____
- 3) How often does applicant perform on-site visits of contracted health care providers? _____
- 4) Do you refer to or check on contracted health care providers with any available data banks during the credentialing process? Yes No
- 5) Do you require all contracted hospitals to be JCAHO accredited? If no, please explain. Yes No
- 6) Does applicant require all contracted health care providers to have staff privileges at a JCAHO accredited hospital? Yes No

- 7) Are all contracted health care providers required to maintain medical malpractice insurance? Yes No
What minimum limits are required? _____
- 8) Are all contracted health care providers required to warrant that they maintain this insurance in force during their contract period with you? Yes No
- 9) Do they provide you with certificates of insurance? Yes No
- 10) Do you provide details on the appeal process to providers who are not approved /accepted into your network as part of the credentialing process? Yes No
Please provide a sample non-acceptance letter.
- 11) Who does the credentialing? _____
- 12) If the credentialing is sub-contracted, do you review or audit the process? Yes No
- 13) Do you require the subcontractor to carry Professional Liability Insurance? Yes No
What minimum limits are required? _____

EXTERNAL CREDENTIALING (Services to others for a fee):

- 1) Do you use the same criteria as outlined in SECTION 3? Yes No
- 2) Does the client have the final authority to approve or deny a provider's status? Yes No
- 3) Do you provide details on the appeal process to providers who are not approved /accepted into your network as part of the credentialing process? Yes No
Please provide a sample letter.
- 4) Does the applicant notify enrollees that a provider has been decredentialed? Yes No
Please provide a sample letter.

SECTION 8 UTILIZATION REVIEW AND COST CONTAINMENT

A. UTILIZATION REVIEW/COST CONTAINMENT:

- 1) Number of full-time reviewers: _____
- 2) Number of part-time reviewers: _____
- 3) Does the applicant have written policies and procedures for utilization review, including processes for denials, appeals and independent and external review? Yes No
If yes, do the procedures comply with NCQA or URAC standards and comply with all applicable law? Yes No
If no, please provide details. _____
- 4) Are denial, appeals and grievance procedures explained to enrollees in writing and include the identity of the person making the decisions? Yes No
- 5) Does the applicant use an independent external review process? Yes No
- 6) Does the applicant abide by independent review decisions? Yes No
If no, please describe in detail: _____
- 7) Does the denial letter identify all applicable internal or external review procedures, including any state mandated review organizations? Yes No
- 8) Does a physician or specialist review all proposed denial of benefits prior to an issuance of a denial? Yes No
- 9) Does the applicant use practice guidelines as a part of the utilization review process? Yes No
If yes, do the guidelines state that the physician's judgement may override a guideline? Yes No
- 10) Does the applicant have profit sharing or other financial incentives in its compensation arrangements with utilization reviewers? Yes No
Please describe: _____
- 11) Does the applicant use same specialty reviewers for high risk or life-threatening benefit/coverage denials? Yes No

B. CLAIMS ADMINISTRATION/MISC. MANAGEMENT:

- 1) Do you apply the same criteria as outlined in Section 9 to fee based utilization review and cost containment services? Yes No
If no, please provide details. _____
- 2) Does the applicant, its partners, directors, officers or employees act as Trustee for any clients? Yes No
If yes, please explain: _____

- 3) a. Does the contract between the applicant and client require that the applicant be the “named fiduciary” or “designated decision maker”? Yes No
Please attach a specimen contract.
b. Who has the final authority on denial of benefit? _____
- 4) Does applicant take appropriate measures to assure that client’s plans comply with ERISA? Yes No
If yes, please explain: _____
- 5) Are you insured elsewhere for any exposures you identified above? Yes No
If yes, please describe: _____
- 6) Is 50% or more of applicants' income from all sources derived from providing claims administration services? Yes No
- 7) What percentage of your clients are:
Self Funded with Stop Loss Coverage _____
Self Funded with no Stop Loss Coverage _____
Fully Insured _____
- 8) Does the applicant administer any self-funded Multiple Employer Trusts (METs) or Multiple Employer Welfare Arrangements (MEWAS)? Yes No
If yes, please explain: _____
- 9) Please outline below the applicant’s Standard of Practice (Practice Protocols):
a. How do you comply with individual administration guidelines? _____
b. How do you determine denials of coverage? _____
c. What are the protocols for denying a benefit or coverage? _____
d. How are claimants informed of a denial of coverage or benefit? _____
e. What is the appeal process for a denial? _____
f. Do you inform the claimants on the procedures and instructions for appeals or Independent External Review in all denial letters? _____
g. What are the procedures for notifying a stop loss carrier of a claim (please provide written procedure, if available)? _____
- 10) How often do you perform internal audits? _____
- 11) What situations are the audit guidelines designed to reveal? _____
- 12) Do you provide warranties or guarantees on savings or on any other service? Yes No
If yes, please explain: _____
- 13) What percentage of the applicants business is involved in subcontracting work to others? _____%
Please explain: _____
- 14) Do you place insurance for customers, including stop loss coverage? Yes No
- a. Are bids solicited from at least 3 reinsurance carriers with a grade A or above? Yes No
b. Are the agents soliciting the coverage appropriately licensed? Yes No
c. Does the agent assist the client in completing the application for insurance? Yes No
d. Do you have a hold harmless agreement or similar release stating you are not responsible for adequacy of insurance or level of insurance purchased? Yes No
e. Is coverage ever placed with a subsidiary or affiliate? Yes No
f. Are you responsible for tracking claim experience for the stop loss? Yes No
g. Are you responsible for remitting claims to the stop loss carrier? Yes No
h. Is the employer or trustee the policyholder of the stop loss coverage? Yes No
i. Does the employer or trustee submit stop loss premium directly to the carrier? Yes No

- 15) Do you determine, contractually or otherwise, assist in the determination of an adequate level of funding for partially or fully self insured plans? Yes No
- a. Does an outside actuary sign off on the final funding amount? Yes No
- b. Does the funding level always equal at least 125% of anticipated covered services? Yes No
- c. Do you require a hold harmless agreement or similar release stating you are not responsible for the adequacy or inadequacy of the funding level? Yes No
- 16) Do you have check writing authority for your managed clients? Yes No
If yes, what is the maximum check amount you are authorized to issue: _____
- 17) Are co-signatures required on all checks? Yes No
- 18) Do you carry fiduciary liability insurance? Yes No
If yes, what is the limit? _____ Insuring Co. _____
- 19) Do you have fund management authority for any clients? Yes No
If yes, please describe duties: _____

20) Please attach any copies of advertising materials related to any of these services.

SECTION 9 EMPLOYEE ASSISTANCE PROGRAMS (EAP)

- 1) Do you provide EAP services or mental health/chemical dependency counseling services? Yes No
If yes, do you provide it to other for a fee? Yes No
- 2) a. number of employed counselors: _____
Describe services below:
- a. assessment and referral Yes No
- b. short term counseling (10 visits or less) Yes No
- c. longer term counseling (_____ visits) Yes No
- d. M.D./Psychiatrist clinical services (as employees of applicant), including drug prescriptions. Yes No
- 3) Do you apply your internal utilization review procedures to this service? Yes No

SECTION 10 SUPPLEMENTAL INFORMATION

- 1) In the past 5 (five) years, has any claim been made against the Applicant, or any director, officer or employee of the Applicant, arising out of any of the operations of the Applicant described in this Application that is not set forth on the Loss History of the Applicant submitted with this Application? Yes No
If yes, please explain. _____
- 2) Does any principal, owner, partner, or employee know of any incident, act, error or omission that is reasonably likely to result in a claim or suit against the Applicant or any of its predecessor firms, if any? Yes No
If yes, please explain. _____

If you answer "Yes" to question 1 or 2, please attach full details.

It is agreed that with respect to questions 1 and 2 above, of such knowledge, information or involvement exists, any claim or action arising therefrom is excluded from the proposed coverage.

- 3) Have all matters in Questions 1 and 2 been reported to the Applicant's former or current insurer(s)? Yes No
If no, please explain. _____
- 4) Are you involved in any operations that are not specifically addressed herein? Yes No
If yes, please explain: _____
- 5) Are you currently insured for managed care professional liability? Yes No
If yes, please provide: Company/limits/retro date/deductible or SIR/annual premium _____
- 6) To what trade groups or associations do you belong? _____

7) Name and address of law firm(s) acting as counsel to the applicant: _____

8) Name and address for firm(s) employed as accountants: _____

Notice to Arkansas 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" (23-66-503).

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 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" (10-1-127).

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" (22-3825.9).

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" (817.234).

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 Maine 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS" (24-A § 2186).

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" (Bulletin 95-16, citing P.L. 1995, c. 132).

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" (59A-16C-8).

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."

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" (3999.21).

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" (18-4117).

Notice to Tennessee Applicants:

"IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS' COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS" (56-47-112).

Notice to Virginia 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" (52-40).

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT ME TO ORDERING COVERAGE. IF INSURANCE COVERAGE IS DESIRED FOR DIRECTORS AND OFFICERS INSURANCE OR INSURANCE COMPANY PROFESSIONAL LIABILITY THE UNDERSIGNED MUST COMPLETE A SEPARATE APPLICATION.

THIS APPLICATION IS VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE.

SIGNATURE OF PRESIDENT/EXECUTIVE DIRECTOR

DATE