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| Healthcare/Hospital Facilities Liability Application |
| Managed Care Organizations’ Errors & Omissions Liability Supplement |
| * Ace American Insurance Company * Illinois Union Insurance Company * Westchester Surplus Lines Insurance Company |
|  |

**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly. Use 🗷 for Yes or No answers and other selections.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice: This supplement is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions.* All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Coverage Requested, Loss Adjustment, Loss Experience, Exposures (prospective and historical Professional Liability, General Liability, Helipad Liability, Aircraft Liability, Automobile Liability, Watercraft Liability, Employee Benefits Liability, and Employer’s Liability), Risk Management, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – Applicant & Retroactive Dates

1. Legal name of the entity or entities providing managed care services to be insured exactly as it shall be shown on the policy. Include location information and requested retroactive date(s).

|  |  |
| --- | --- |
| Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |
| Managed Care Organizations’ Errors & Omissions Liability Retroactive Date: | |
| Description of Operations: |  |

1. Parent entity:

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |

1. Applicant is:

|  |  |
| --- | --- |
| Partnership  Corporation  Joint Venture | Limited Liability Company  Profit  Non-Profit |

| Partners, Stockholders, or Members of the Applicant: | % of Ownership/Control: |
| --- | --- |
|  | % |
|  | % |
|  | % |
|  | % |

1. Date in incorporation or formation:
2. Type of Organization:

|  |  |
| --- | --- |
| HMO  PPO  PHO  IPA | MSO/TPA  Peer Review Organization (PRO)  Utilization Review Organization (URO)  Disease Management/Case Management/Health Management |

1. Number of years in the managed care business:

# Section B. – Licensure & Accreditation

|  |  |
| --- | --- |
| 1. Does the applicant comply with all federal, state or local licensing requirements? If No, explain: | Yes  No |
| 1. Is the applicant accredited by: |  |
| National Committee for Quality Assurance (NCQA): | Yes  No |
| URAC: | Yes  No |
| Any state or federal agency: | Yes  No |
| 1. Has the applicant’s license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? | Yes  No |
| If Yes, explain: |  |

# Section C. Enrollment And Revenue

|  |  |  |
| --- | --- | --- |
| 1. Prospective number of enrollees/members insured (whenever used, enrollees means covered lives): | | |
| Type | Projections for Current or Expiring Year *(Annualized Data)* | Projections for Requested Coverage Period *(Annualized Data)* |
| Dental (not included in enrollment below): |  |  |
| Vision (not included in enrollment below): |  |  |
| Life (not included in enrollment below): |  |  |
| Disability (STD/LTD – not included in enrollment below): |  |  |
| Pharmacy/Pharmacy Benefit Management (not included in enrollment below): |  |  |
| HMO – Medicaid: |  |  |
| HMO – All Other: |  |  |
| PPO – Network Access Only/Non-Risk: |  |  |
| PPO – All Other: |  |  |
| Point of Service: |  |  |
| Administrative Service Only (ASO): |  |  |
| Indemnity: |  |  |
| Consumer Directed Health Plan: |  |  |
| Medicare Supplement: |  |  |
| Medicare Advantage: |  |  |
| Medicare Part D: |  |  |
| Other: |  |  |
| Total Gross Revenue: | $ | $ |

1. Historical number of total enrollees/members insured:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Total Enrollees/Members - Years Prior to the Prospective Coverage Period (Annualized Data) | | | | | | | | | | |
| 2 Years Prior | 3 Years Prior | 4 Years Prior | 5 Years Prior | 6 Years Prior | 7 Years Prior | 8 Years Prior | 9 Years Prior | 10 Years Prior | 11 Years Prior | 12 Years Prior |
|  |  |  |  |  |  |  |  |  |  |  |

# Section D. – Type of Services Provided

|  |  |
| --- | --- |
| 1. Does the applicant provide any of the following services: | |
| Credentialing or Peer Review of Health Care Providers: | Yes  No |
| Utilization Review: | Yes  No |
| Handling and Adjusting Enrollee Benefit Claims: | Yes  No |
| Drafting Practice Guidelines/Clinical Pathways: | Yes  No |
| Case Management: | Yes  No |
| Disease Management: | Yes  No |
| Application or Enrollment Processing for Enrollees of Health Care Plans: | Yes  No |
| Billing or Other Processing of Enrollee Claims Under Health Care Plans: | Yes  No |
| Establishing Health Care Provider Networks: | Yes  No |
| Nurse Call Line That Provides Health and Wellness Information and/or Advice: | Yes  No |
| Ownership of Indemnity Insurance Company: | Yes  No |
| Advertising, Marketing or Selling Health Care Plans or Products: | Yes  No |
| HSA/FSA/HRA Administration: | Yes  No |
| Applicant Owns Physician Practices or Employs Physicians: | Yes  No |
| If Yes, Number of Full-Time Equivalents: |  |
| Applicant Owns or Operates Any Type of Health Care Facility: | Yes  No |
| If Yes, describe: |  |
| Other – describe: | Yes  No |

1. Does the applicant provide any of the following services for third parties:

|  |  |  |  |
| --- | --- | --- | --- |
| Services for Third Parties | | Annual Income Projections for the Current or Expiring Year | Annual Income Projections for the Prospective Coverage Period |
| Agency and Brokerage Operations for Third Parties: | Yes  No | $ | $ |
| Insurance Consulting for Third Parties | Yes  No | $ | $ |
| Actuarial Services for Third Parties | Yes  No | $ | $ |
| Claim Handling for Third Parties: | Yes  No | $ | $ |
| Utilization Review for Third Parties: | Yes  No | $ | $ |
| Case Management Services for Third Parties | Yes  No | $ | $ |
| Disease Management Services for Third Parties | Yes  No | $ | $ |
| Electronic Data Processing or Computer Software Development for Third Parties: | Yes  No | $ | $ |
| Loss Control or Safety Engineering for Third Parties | Yes  No | $ | $ |
| Benefits Stop Loss Placement for Third Parties | Yes  No | $ | $ |
| Ownership of an Indemnity Insurance Company Rented To or Services Shared With Third Parties: | Yes  No | $ | $ |
| Premium Financing for Third Parties | Yes  No | $ | $ |
| Rehabilitation Services for Third Parties | Yes  No | $ | $ |
| Peer Review/Credentialing for Third Parties | Yes  No | $ | $ |
| Lease, Franchise or Rent Physician Network to Third Parties | Yes  No | $ | $ |
| Other – describe |  | $ | $ |

# Section E. – Claim Handling and TPA Services

|  |  |
| --- | --- |
| 1. Does the applicant settle or coordinate the settlement of managed care organizations’ errors and omissions liability claims made against the applicant? | Yes  No |
| If Yes, who handles the claims:  Self-Administered Third Party Claim Administrator – Firm: | |
| 1. Does the applicant provide claim handling services for third parties?   If No, disregard the remaining questions in this section. | |

If Yes, provide:

| Claim Handling Services for Third Parties | | | |
| --- | --- | --- | --- |
|  | Annual Projections for the Current or Expiring Year | Annual Projections for the Prospective Coverage Period | |
| Total Number of Customers: |  |  | |
| Number of Enrollees Covered for Claim/TPA Services: |  |  | |
| Number of Enrollees Participating In Benefit Plans Governed by ERISA: |  |  | |
| Applicant Administers:  Managed Care Plans:  Health and Welfare Plans:  Pension Plans:  Workers’ Compensation:  Multiple Employer Trusts:  Municipal, State or Federal Government Plans:  Self-Funded Plans:  Other – describe: | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No  Yes  No | |
| Applicant Owns or Operates Any Type of Health Care Facility: | Yes  No | | |
| Number of Claims Processed: |  | |  |
| Percentage of Claims Denied: | % | | % |
| 1. Does the applicant outsource (subcontract) any of these services to third parties?  If Yes, percentage of claims handled by independent adjusters:      % | | | Yes  No |
| If Yes, what minimum limits of Errors and Omissions Liability insurance are required for claim handling services: $     Each Occurrence/$     Annual Aggregate | | | |
| If Yes, does the applicant review or audit this process? | | | Yes  No |
| 1. Is the applicant authorized to set claim reserves and/or have settlement authority on behalf of third parties? If Yes, explain in detail: | | | Yes  No |
| 1. Briefly describe any hold harmless agreements in effect with any independent adjusters or others doing work on behalf of the applicant for claim handling/TPA services: | | | Not Applicable |
| If applicable: | | |  |
| 1. Does the applicant indemnify or hold harmless any clients or customers? If Yes, explain in detail: | | | Yes  No |

# Section F. – Utilization Review

|  |  |  |
| --- | --- | --- |
| 1. Does the applicant perform utilization review? *If No, disregard all questions in this section.* | Yes  No | |
| If Yes, provide: | | |
|  | For Applicant’s Own Enrollees | For Others For a Fee |
| Number of Enrollees: |  |  |
| Projected Number of Cases Reviewed in the Current or Expiring Year: |  |  |
| Number of Cases Reviewed in the Past 12 Months Where Payment or Treatment Was Denied: |  |  |
| Number of Cases Where Denials Were Appealed to the External Review Process: |  |  |
| Percentage of Decisions Which Go Through the External Review Process Ultimately Decided in Favor of the Enrollee: |  |  |
| Number of Full-Time Equivalent Physician Reviewers: |  |  |
| Number of Full-Time Equivalent Nurse Reviewers: |  |  |

|  |  |
| --- | --- |
| 1. Does the applicant outsource (subcontract) any utilization review services for its enrollees or covered lives to third parties? | Yes  No |
| If Yes, name of firm and relationship to the applicant: | |
| If Yes, what minimum limits of Errors and Omissions Liability insurance are required for utilization review services: $     Each Occurrence/$     Annual Aggregate | |
| If Yes, does the applicant review or audit this process? | Yes  No |
| 1. Are physician and nurse reviewers credentialed by an entity in the applicant’s organization? | Yes  No |
| 1. Are claim denial appeal procedures clearly stated to participants of managed care organizations for which the applicant provides utilization review? | Yes  No |
| 1. Does the applicant have written policies and procedures for utilization review including denials and appeals? | Yes  No |
| If Yes, do such policies and procedures follow NCQA and URAC standards and comply with applicable laws? | Yes  No |
| 1. Are claim denial and appeal procedures explained in writing to enrollees including the identity of the person who makes decisions regarding appeals? | Yes  No |
| 1. Does the applicant have a “fast track” appeals system regarding denial of benefits for postponement of benefits procedures for organ transplants or any other procedure which may severely impair the quality of life of the enrollee if not performed? | Yes  No |
| 1. Does the applicant have an external review process in all states where it operates? | Yes  No |

# Section G. – Health Care Provider Service Network Selection And Credentialing

1. Participating Network Providers:

| Provider | Annual Projections for the Current or Expiring Year | Annual Projections for the Prospective Coverage Period |
| --- | --- | --- |
| Total Number of Physicians |  |  |
| Total Number of Hospitals |  |  |
| Total Number of Facilities Other Than Hospitals – describe: |  |  |
| Total Number of Other Providers – describe: |  |  |

|  |  |
| --- | --- |
| 1. How often are health care providers credentialed? | |
| 1. Does the applicant managed care organization credential health care providers | Yes  No |
| 1. Does the applicant outsource credentialing of health care providers to third parties? | Yes  No |
| If Yes, name of firm and relationship to the applicant: | |
| If Yes, what minimum limits of Errors and Omissions Liability insurance are required? $     Each Occurrence/$     Annual Aggregate | |
| If Yes, does the applicant audit or review this process? | Yes  No |
| 1. Does the applicant require all contracted hospitals and other facilities to be accredited by: | |
| The Joint Commission: | Yes  No |
| Commission on Accreditation of Rehabilitation Facilities: | Yes  No |
| Other(s) – describe: | Yes  No |
| 1. Are all contracted health care providers required to maintain Professional Liability insurance? | Yes  No |
| If Yes, what minimum limits of Professional Liability insurance are required? | |
| $     Each Professional Incident/$     Annual Aggregate If No, explain: | |
| 1. Are all health care providers required to provide the applicant with current certificates of Professional Liability insurance as evidence of coverage? | Yes  No |
| 1. Does the applicant have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which could adversely affect a provider? | Yes  No |
| If Yes, do the written credentialing procedures follow The Joint Commission or NCQA standards and comply with all applicable laws? | Yes  No |
| If Yes, are the procedures given to health care providers? | Yes  No |
| If Yes, is legal counsel consulted before any recommendation or decision which could adversely affect a provider becomes final? | Yes  No |
| If Yes, are all providers offered a hearing or appeal prior to termination? | Yes  No |
| 1. Does the applicant have any provider agreements that contain “most favored” clauses? | Yes  No |
| 1. Does the applicant have any provider agreements that contain non-compete clauses? | Yes  No |

# Section H. – Advertising And Marketing

|  |  |
| --- | --- |
| 1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state covered and non-covered services, procedures, and treatments, etc.? | Yes  No |
| 1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state out-of-pocket financial responsibilities? | Yes  No |
| 1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures contain exclusions or clarifications with regard to investigational or experimental procedures? | Yes  No |
| If Yes, do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures define what is considered investigational or experimental? | Yes  No |
| 1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly state pre-certification requirements, emergency department access requirements, network provider access, i.e. referrals needed for specialists? | Yes  No |
| 1. Do all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures clearly address and define organ transplants? | Yes  No |
| 1. Does the applicant’s legal representative review and approve all contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures prior to their use? | Yes  No |
| 1. Do all provider directories clearly state that all contracted health care providers are independent contractors? | Yes  No |
| 1. Are all contracted health care providers always referred to as independent contractors | Yes  No |
| 1. Are claim denial procedures clearly stated in the applicant’s contracts, plan summary, benefit documents, complete plan documents, sales literature, and brochures, etc.? | Yes  No |
| 1. Are the applicant’s customer service representatives and sales representatives trained to clearly explain benefits, denial procedures, out-of-pocket financial responsibilities, investigational or experimental procedures, emergency department access requirement, network provider access, and | Yes  No |
| 1. Are unsolicited facsimiles, e-mails or other communications disseminated to actual or prospective customers or any other third party? If Yes, explain: | Yes  No |

# Section I. – Supplemental Materials As Attachments

|  |  |
| --- | --- |
| The most current versions of the following documents must be submitted, if applicable: | |
| Audited Financial Statements (1) | Included  Not Applicable |
| If Applicant is Newly-Formed – Business Plan including Pro-Forma Financial Statements | Included  Not Applicable |
| Corporate Organizational Chart (2) | Included  Not Applicable |
| Names, Occupation, Affiliations of Directors and Officers | Included  Not Applicable |
| Utilization Review Procedures Including Procedures for Denials of Benefits and Appeals | Included  Not Applicable |
| Credentialing and Peer Review Procedures | Included  Not Applicable |
| Sample Contracts With Health Care Providers (Physicians, Hospitals, and Others) | Included  Not Applicable |
| Sample Contracts with Enrollees or Member Handbook | Included  Not Applicable |
| Sample TPA or ASO Contracts | Included  Not Applicable |
| Sample Sales Literature, Brochures, Advertisement or Other Marketing Materials | Included  Not Applicable |
| Privacy Policies and Procedures | Included  Not Applicable |
| Sample Consent Forms | Included  Not Applicable |

1. *If not consolidated with the Financial Statements submitted with the main Chubb Healthcare/Hospital Facilities Liability Application. If consolidated with the Financial Statements submitted with the main Chubb Healthcare/Hospital Facilities Application indicate “Not Applicable”.*
2. *If not consolidated with the document submitted with the main Chubb Healthcare/Hospital Facilities Liability Application.*

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions.**

|  |  |
| --- | --- |
| Signature of Applicant | Date |
|  |  |
| Title |  |
|  |  |