MANAGEMENT LIABILITY APPLICATION FOR MEDICAL GROUPS

McDONALD INSURANCE GROUP in conjunction with ALEXANDER MORFORD & WOO

General Information:		
1	Name of Applicant Organization:	
2	Address:	
3	Nature of Operations:	
4	Date Established:	
5	Website:	
6	Please list any subsidiaries or affiliates: ***Please be sure to include underwriting information below for all subsidiaries and affiliates for which coverage is desired (including, but not limited to, employee counts and financial information).**	
7	Is the Application Organization or any of its Directors or Officers a partner in a Joint Venture?	Yes ☐ No ☐
	If yes, is coverage being requested for such Joint Venture? ***If yes, please provide a description of the Joint Venture, ownership held by the Applicant and/or its Directors or Officers, employee count controlled by the Applicant, and a copy of the JV's financials.**	Yes ☐ No ☐

Coverage Requested:	Seeking Coverage?	Limit Requested	Retention Requested	Currently Purchased?
D&O	Yes ☐ No ☐	$	$	Yes ☐ No ☐
EPL	Yes ☐ No ☐	$	$	Yes ☐ No ☐
Fiduciary	Yes ☐ No ☐	$	$	Yes ☐ No ☐
Crime	Yes ☐ No ☐	$	$	Yes ☐ No ☐
Billing E&O	Yes ☐ No ☐	$	$	Yes ☐ No ☐

Financial Information:		
8	Current Assets: $	Total Assets: $
9	Long-term Liabilities: $	
10	Annual Revenues: $	
11	Net Income/Loss: $	Positive/Income ☐ Negative/Loss ☐
	***Please attach the most recent income statement and balance sheet, if available.**	

Directors & Officers Liability:		
12	What type of organization is the Applicant? (Corporation, Partnership, LLC, etc)	
	***Please attach an organizational chart, if available.**	
13	Please list all shareholders:	Director, Officer, or Board Representation?
	Name: , %	Yes ☐ No ☐
	Name: , %	Yes ☐ No ☐
	Name: , %	Yes ☐ No ☐
	Name: , %	Yes ☐ No ☐
	Name: , %	Yes ☐ No ☐
	***Please attach a capitalization table, if available.**	
14	Over the past 18 months, or in the next 12 months, has the Applicant been involved in or anticipate any merger, acquisition, divestment, restructuring, or bankruptcy? ***If yes, please provide details on a separate sheet.**	Yes ☐ No ☐
15	a. Over the past 18 months, or in the next 12 months, has the Applicant transacted, attempted to transact, or anticipate any private debt or equity offering?	Yes ☐ No ☐
	b. Any public debt or equity offering? ***If yes, please provide details on a separate sheet**	Yes ☐ No ☐

Employment Practices Liability:			
16	Employee count:		
	Full-time employees:	Seasonal, temporary, or leased employees:	
	Part-time employees:	Independent contractors:	
17	Does the Applicant have written policies and procedures in place which address anti-discrimination, anti-sexual harassment, and handling of employee grievances and complaints?		Yes ☐ No ☐
18	Does the Applicant have written procedures in place for responding to complaints from customers, vendors, or other third parties?		Yes ☐ No ☐
19	Do managers/supervisors attend HR training?		Yes ☐ No ☐
20	Over the past 18 months, or in the next 12 months, has the Applicant been involved in or anticipate any layoffs, staff reductions, or facility closings? ***If yes, please provide details on a separate sheet**		Yes ☐ No ☐
Fiduciary Liability:			
21	Total number of employees enrolled in all plans:		
22	Total combined asset value of all plans:		
23	Please list all pension plans (401k, Defined Contribution, Defined Benefit, Profit Sharing, etc.) and any Employee Stock Ownership Plan that coverage is desired for:		
Crime Coverage:			
24	How many employees handle, have custody, or maintain records of money, securities, or other property?		
25	Are bank accounts reconciled by someone not authorized to make deposits or withdrawals?		Yes ☐ No ☐
26	Are books and accounts audited or reviewed by an independent CPA on an annual basis?		Yes ☐ No ☐
27	Is countersignature of checks required?		Yes ☐ No ☐
Physicians Billing E&O:			
28	Number of physicians in group:		
29	In what states is the Applicant license to practice? Please provide registration/license numbers.		
	State: #	State: #	State: #	State: #
30	Does the Applicant require all Physicians / Providers to carry medical malpractice insurance?		Yes ☐ No ☐
31	Please provide the Entity Medicare Payer I.D.#:		
32	What are the Medicaid/Medicare billings for the past three years?		
	This year: $	Last year: $	Two years ago: $
33	Please provide the date of the last Medicare/Medicaid audit:		
34	Does the Applicant have a compliance program in place?		Yes ☐ No ☐
	If no, would the Applicant be willing to implement one?		Yes ☐ No ☐
35	Does the Applicant have a compliance manager?		Yes ☐ No ☐
	Does the Applicant use an outside compliance consultant?		Yes ☐ No ☐
	Who does the compliance manager and/or outside compliance consultant report to?		
36	Does the Applicant do its own billing?		Yes ☐ No ☐
	If yes, which software system do you use?		
	If no, what third party billing service do you use?		
37	What percentage of billed revenue is to: Government payers: % Private payers: %		
38	Please provide a list of all physicians to be covered.		
Loss History:			
39	Has the Applicant Organization or any Physician Applicant been involved in any claims, losses, lawsuits, EEOC charges (or similar), sanctions, loss of medical practice privileges, or any other administrative or regulatory investigations in the past 5 years, that would fall within the scope of the proposed insurance? ***If yes, please provide details on a separate sheet.**		Yes ☐ No ☐
40	For Physicians Billing E&O: Has any Physician Applicant provided notice to any professional liability carrier providing similar coverage in the past 6 years?		Yes ☐ No ☐

Other Information

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall form the basis of the contract should a Certificate be issued, and this application will be attached to, and become part of such Certificate, if issued. Underwriters are hereby authorized to perform any and all investigations and inquiries in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Certificate and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached), are the basis for the proposed Certificate and are to be considered as incorporated into, and constituting part of, the proposed Certificate.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Certificate, the applicant will notify Underwriters and, at the sole discretion of the Underwriters, any outstanding quotations may be modified or withdrawn.

It is agreed that in the event there is any misstatement or untruth in the answers to the questions contained herein, Underwriters have the right to exclude from coverage any claim based upon, arising out of, or in connection with, such misstatement or untruth.

Disclaimer and Signature

I agree to bind this contract using an electronic signature. (Note: Must be signed by an Executive Officer of the Named Insured)

Name: _____
Please print or type

Capacity: _____

Assured Organization: _____

Date: _____

Submitted by: _____
(Agent)

Date: _____

For purposes of creating a binding contract of insurance by this application or in determining the rights and obligations under such contract in any court of law, the parties acknowledge that an electronic signature reproduced in this form shall have the same force and effect as a script signature.