NAS insurance
16501 Ventura Blvd. Suite 200 Encino, CA 91436
LIC #0677191 · NASinsurance.com

APPLICATION for: Miscellaneous Errors and Omissions for Healthcare Professionals Liability

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

Notice: The Policy for which this Application is made, subject to its terms, applies only to any Claim (as defined in the Policy) made against an Insured during the Policy Period. The Limit of Liability available to pay damages or settlements will be reduced and may be exhausted by amounts paid as Claim Expenses (as defined in the Policy). Claim Expenses, damages and settlements will be applied to the retention. Submission of this Application does not guarantee coverage.

1. Name of Applicant: _____
(as it should appear on the policy)

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Website: _____

2. Is firm: ☐ Corporation ☐ Partnership ☐ Individual ☐ LLC ☐ Publicly traded
☐ For Profit ☐ Not for Profit ☐ Other _____

3. Date the Applicant's firm was established: _____

4. Does the Applicant have a Governing Board? ☐ Yes ☐ No ☐ N/A
If "Yes", please provide details including names, primary affiliation and ownership interest in the Applicant, if applicable:

_____

_____

5. Do the major shareholders (either individually or collectively) own any other healthcare related entity, such as a provider of medical services, management/consulting services or any other service? ☐ Yes ☐ No ☐ N/A

6. If coverage is desired for any other entities (subsidiaries, common ownership, joint ventures), please specify below. Please use an additional page, if necessary.

Name and Address	Relationship to Applicant	Description of Operations	Percent Owned by Applicant

7. Total expected revenue for the services Applicant is seeking to cover:

Next Calendar Year: $ _____

Current Calendar Year To Date: $ _____ Last Calendar Year: $ _____

8. Describe the following financial information of the Applicant for the most recent fiscal year end. Not applicable for individual applicants.

a) Total Assets: $ _____

b) Net Income: ☐ or Net Loss: ☐ (check one) $ _____

c) Equity: $ _____

d) Fiscal year ending: 20_____

9. Are other services provided for which coverage is not desired? ☐ Yes ☐ No
If "Yes", please describe services and indicate percent of the Applicant's total revenue:

_____ _____%

10. Services to be Covered:

Services	For own business	For a third party	% of Revenue
Advertising/marketing of healthcare plans/products	☐ Yes ☐ No	☐ Yes ☐ No	%
Billing/Coding/Reimbursement consulting	☐ Yes ☐ No	☐ Yes ☐ No	%
Billing/Coding/Reimbursement services	☐ Yes ☐ No	☐ Yes ☐ No	%
Business valuation or appraisal – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Case management / Coordination of care	☐ Yes ☐ No	☐ Yes ☐ No	%
Claims handling/adjustment of benefits – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Clinical trials consulting and/or research – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Collections	☐ Yes ☐ No	☐ Yes ☐ No	%
Contracting with health care providers and the establishment of health care provider networks	☐ Yes ☐ No	☐ Yes ☐ No	%
Credentialing/peer review	☐ Yes ☐ No	☐ Yes ☐ No	%
Design or implementation of clinical guidelines, practice parameters or protocols	☐ Yes ☐ No	☐ Yes ☐ No	%
Disease management	☐ Yes ☐ No	☐ Yes ☐ No	%
Financial planning, investment advisory – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
HIPAA consulting	☐ Yes ☐ No	☐ Yes ☐ No	%
Human Resources consulting	☐ Yes ☐ No	☐ Yes ☐ No	%
IT services/consulting	☐ Yes ☐ No	☐ Yes ☐ No	%
Managed care contracting	☐ Yes ☐ No	☐ Yes ☐ No	%
Medical Directorship			
a) Hospitals	☐ Yes ☐ No	☐ Yes ☐ No	%
b) Nursing home/skilled nursing facility	☐ Yes ☐ No	☐ Yes ☐ No	%
c) Laboratory	☐ Yes ☐ No	☐ Yes ☐ No	%
d) Other _____	☐ Yes ☐ No	☐ Yes ☐ No	%
Mergers & acquisitions consulting, including due diligence – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Physician practice/office management (please describe services):	☐ Yes ☐ No	☐ Yes ☐ No	%
Physician staffing – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Quality assurance, review or improvement	☐ Yes ☐ No	☐ Yes ☐ No	%
Utilization review – If "Yes", coverage is not available	☐ Yes ☐ No	☐ Yes ☐ No	%
Other (please describe): _____	☐ Yes ☐ No	☐ Yes ☐ No	%

11. Does the Applicant provide any direct patient care in connection with any of the above services? ☐ Yes ☐ No

12. Does the Applicant entity or any persons proposed for coverage provide medical services? ☐ Yes ☐ No

13. Does the Applicant maintain all licenses as required by any federal, state or local government? ☐ Yes ☐ No

14. Within the next 18 months, does the Applicant anticipate any?
    a) private debt equity offering of securities? ☐ Yes ☐ No
    b) public offering of securities? ☐ Yes ☐ No

15. Is the Applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company? ☐ Yes ☐ No
If "Yes", please list all affiliations:

_____

_____

16. Has the name of the firm ever changed, or has any merger or consolidation ever taken place? ☐ Yes ☐ No
If "Yes", please provide details including dates and any liabilities assumed:

_____

_____

17. Does any partner, director, officer or equity owner (or spouse thereof) of the Applicant firm serve as partner, director, officer or equity owner of any client firm to which the Applicant provides services? ☐ Yes ☐ No
If "Yes", please provide explanation: _____

_____

18. Does the Applicant firm use a written contract with clients describing the services provided?

☐ Always ☐ Most of the Time ☐ Some of the Time ☐ Never

19. Does the Applicant ever enter into contracts where the fees for services are contingent upon the client achieving cost reductions or improved operating results? ☐ Yes ☐ No
If "Yes", please attach a detailed description of such arrangements.

20. Staff Information:
(Please include with application all principal and key employee résumés)

Name of all Principals, Partners, Owners and Key Employees	Professional Qualifications	Years with Applicant Firm	Years providing service	Continuing Education (Yes or No)	Position with Firm

21. Number of consultants to be covered: _____

22. Total Number of employees: Full Time: _____ Part Time: _____

23. Has the Applicant provided services to any governmental entities or plan to do so? ☐ Yes ☐ No
If "Yes", please attach an explanation.

24. If the Applicant handles patient data, is there a compliance program in place for HIPAA? ☐ Yes ☐ No

25. a) Total annual billings: $_____

b) Percentage of annual projected billings attributable to Medicare patients: _____%

c) Percentage of annual projected billings attributable to Medicaid patients: _____%

26. Does the Applicant have a billing compliance program in place? ☐ Yes ☐ No

Insurance History

27. a) Please list the Applicant's Professional Liability Insurance Coverage carried during the past three (3) years, including any periods without coverage.

Name of Insurer	Policy Period From: MM/DD/YY To: MM/DD/YY	Limits of Liability	Retention	Premium

b) Has any carrier canceled or non-renewed any of the above? ☐ Yes ☐ No

c) Does the Applicant maintain medical malpractice insurance? ☐ Yes ☐ No

d) Has any person proposed for coverage retired from the practice of medicine? ☐ Yes ☐ No

If "Yes", please provide details: _____

_____

e) Does the current policy have a prior acts limitation or retroactive date? ☐ Yes ☐ No

If "Yes", please indicate date: _____

Claims History

28. Have any claims, suits, or demands been made against the Applicant, a predecessor firm or any past or present principals, partners, officers, or employees within the past five (5) years? ☐ Yes ☐ No
If "Yes", please provide a completed NAS supplemental claim form.

29. After inquiry with all principals, partners and officers, is the Applicant aware of any dispute, error, omission, act or circumstance that is, or could reasonably be expected to become, a claim under the policy for which this application is submitted to the Underwriters? ☐ Yes ☐ No

30. Has the Applicant even been audited, investigated, sanctioned or accused of billing errors by any local, state or federal government agency or private payor? ☐ Yes ☐ No

31. Limits of Liability requested: $_____ / $_____

Deductible (each Claim): $_____

Proposed Effective Date: _____

To complete the submission, please include the following:

- Résumés of the Applicant's principals or key employees.
- Claim Supplement(s), if applicable.

NOTICE TO APPLICANT: PLEASE READ CAREFULLY

The undersigned declares that 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 and any materials submitted herewith (which shall be retained of files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto) shall be the basis of the contract should a Policy be issued, and this Application will be attached to and become a part of such Policy, if issued. Underwriters are hereby authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

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 Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

_____	_____
Print Name of Insured, Owner, Partner or Principal	Title
_____	_____
Signature	Date