

**NEW YORK APPLICATION**

**NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO ANY "CLAIM" FIRST MADE OR DEEMED MADE AGAINST THE "INSURED" DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED BY THE AMOUNTS INCURRED AS "DEFENSE EXPENSES" AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.**

The term "Applicant" means all corporations, organizations or entities proposed for this insurance.

AGENCY/ BROKER	CODE	NAME LICENSE NUMBER	POLICY NUMBER
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**GENERAL**

1. Name and address of Applicant : \_\_\_\_\_  
(to be shown on Declarations) \_\_\_\_\_

Complete the list of all Subsidiary and Affiliate Corporations and Partnerships to be covered by the proposed insurance on page 5 of this Application

2. Limit of Liability requested: \$ \_\_\_\_\_

3. The Applicant has continually been in operation since: \_\_\_\_\_

4. A. Has the Applicant merged with or acquired any other entity within the last three years? Yes No  
If "Yes", please submit details on a separate sheet of paper.

B. Is the Applicant, including all Subsidiaries, Affiliates and Partnerships, involved in or planning in the next 12 months, any:

- 1. Bankruptcy, receivership, liquidation or reorganization? Yes No
- 2. The closure of one or more plants, places of business, or departments with 20 or more Employees? Yes No
- 3. Any restructuring that affects 10% of the Employees or 20 Employees, whichever is greater, at any one facility of the Applicant? Yes No
- 4. Mergers, acquisitions, affiliations or joint ventures? Yes No  
If "Yes", please submit details on a separate sheet of paper. Please include the status of obtaining necessary regulatory approvals.

C. Has the Applicant made, in the last 18 months, or does it anticipate making in the next 12 months, any new offering of securities or any registration of securities, under the Securities Act of 1933 or qualification of securities under Regulation A? Yes No (If "Yes," give details and submit prospectus).

5. The following officer of the Applicant is designated to receive any and all notices from the Insurer or their authorized representative(s) concerning this insurance:

\_\_\_\_\_

(Name) (Title)

6. Previous Directors and Officers Liability Insurance carried during the last two years:

Insurer	Amount of Policy	Deductible	Policy Period	Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If cancelled or non-renewed, was any discovery period or extended reporting period obtained? Yes No  
If "Yes", please provide details below.

\_\_\_\_\_

7. Has similar insurance on behalf of the Applicant for any Professional Liability, Directors and Officers Liability or similar coverage been declined, cancelled or non-renewed in the last three years? Yes No  
If answer is "None", so state; if "Yes", please provide details on a separate sheet of paper.

\_\_\_\_\_

8. Does the Applicant's Charter or By-laws limit or eliminate the personal liability of the proposed Insured Persons to the broadest extent permitted by law? Yes No (Coverage may not be available if the answer is "NO".)

9. Ownership of Applicant to be named on Declarations:

Governmental-nonfederal	Nongovernmental not-for-profit	Investor Owned
<input type="checkbox"/> State	<input type="checkbox"/> Church	<input type="checkbox"/> Individual
<input type="checkbox"/> County	<input type="checkbox"/> Mutual	<input type="checkbox"/> Partnership
<input type="checkbox"/> City	<input type="checkbox"/> Public-Benefit	<input type="checkbox"/> Corporation
<input type="checkbox"/> City-County	<input type="checkbox"/> Other	

10. Complete if investor-owned:

- a. Total number of common Stockholders: \_\_\_\_\_
- b. Total number of common shares outstanding: \_\_\_\_\_
- c. Total number of common shares owned by officers: \_\_\_\_\_
- d. Total number of shares owned by directors who are not officers: \_\_\_\_\_
- e. If any shareholder owns 5% or more of shares, designate name and percentage:

\_\_\_\_\_

11. Who names Directors and Trustees?

- Membership Vote  Appointed by: \_\_\_\_\_
- Other: \_\_\_\_\_

12. Is Applicant managed or administered by any third party under contract or agreement?

- Yes No (If "Yes," attach copy of contract) No

13. Does the Applicant manage or provide administrative services for any medical and/or non-medical facility under any contract or agreement? Yes No (If "Yes," attach copy of contract)

14. Applicant's Affiliation and Accreditation:

- American Hospital Association  State Hospital Association
- J.C.A.H.  Other: \_\_\_\_\_

**LOSS HISTORY**

1. Have any claims such as would come within the scope of the proposed insurance been made against any entity or person proposed for this insurance during the last three (3) years?  
 If answer is "None", so state. \_\_\_\_\_  
 If "Yes", provide on a separate attachment full details concerning the nature and status of such proceedings, including the costs of defense and amount of any settlements or judgments, whether any insurance responded to any aspect of the claims, and any corrective procedures implemented.
2. Has the Applicant been involved in any anti-trust, price fixing, tax litigation or governmental, regulatory or administrative proceedings, within the last five years? Yes No  
 If "Yes", attach details as noted above.
3. Are there any facts or circumstances which may result in a claim under this policy? Yes No  
 If "Yes", attach details as noted above.

**It is agreed that if such facts or circumstances exist, whether or not disclosed, any claim arising therefrom is excluded from this proposed insurance.**

**INSURANCE CARRIED BY APPLICANT**

Type	Carrier	Policy Period	Retention	Limits of Liability
1. Healthcare Professional Liability (HPL)	_____	_____	_____	_____
2. Any Other Professional Liability, Errors & Omissions or Umbrella/Excess Insurance	_____	_____	_____	_____
3. General Liability (GL)	_____	_____	_____	_____
Personal Injury Liability included?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is coverage included for alleged Wrongful Employment Practices?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Employee Dishonesty Ins.	_____	_____	_____	_____
5. Workers Compensation Ins.	_____	_____	_____	_____
6. Have any of the above carriers indicated an intent not to offer renewal terms?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

If "Yes", please provide details on a separate sheet of paper.

7. Is the HPL or GL self-insured? Yes No Insured through a Captive? Yes No  
 If "Yes," please complete the Supplemental Questionnaire for Self-Insurance or Captive on page 6.

It is warranted that all the above insurance/self insurances (or equivalent replacements) will be maintained in full force and effect throughout the entire period of any policy that may be issued by or on behalf of the Insurer, unless the prior approval of the Insurer is obtained.

**REQUIRED ATTACHMENTS**

As part of this Application, submit the following materials for each of the corporations, organizations and entities that comprise the Applicant:

- (1) Audited Annual Reports for the last 3 years and any subsequent interim financial statements
- (2) Corporate Bylaws
- (3) Roster of current Directors, Officers and Trustees for each proposed Named Insured.
- (4) List of Subsidiaries, Affiliates and Partnerships to be covered. (See Question 1.)

And for proprietary corporations only:

- (5) Applicant's latest notice to shareholders, if applicable
- (6) Applicant's latest Offering Memorandum, if applicable.

**THE UNDERSIGNED AUTHORIZED AGENT OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND COMPLETE. IF THE INFORMATION IN THIS APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.**

**THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.**

ALL COVERAGE FOR THE POLICY CEASES UPON THE POLICY TERMINATION DATE, EXCEPT FOR THE AUTOMATIC EXTENDED REPORTING PERIOD, UNLESS THE ADDITIONAL EXTENDED REPORTING PERIOD IS PURCHASED. SUCH ADDITIONAL EXTENDED REPORTING PERIOD, INCLUDING THE AUTOMATIC EXTENDED REPORTING PERIOD, IS LIMITED TO ONE YEAR FROM THE POLICY TERMINATION DATE; POTENTIAL COVERAGE GAPS MAY ARISE UPON EXPIRATION OF THE EXTENDED REPORTING PERIOD. NOTICE: THIS POLICY, SUBJECT TO ALL TERMS, CONDITIONS AND LIMITATIONS, APPLIES ONLY TO ANY CLAIM FIRST MADE OR DEEMED MADE PURSUANT TO THE TERMS HEREOF AGAINST THE **INSURED** DURING THE **POLICY PERIOD** OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

G.J. Sullivan Co. Excess and Surplus Lines Brokers, on behalf of the Insurer, is hereby authorized to make any investigation and inquiry in connection with this application as they may deem necessary.

At the sole discretion of the Insurer, any outstanding quotation may be modified or withdrawn.

**Attention NY Insureds:**

**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.**

\_\_\_\_\_  
Signature (Must be signed by Chairman of the Board, President or Administrator.)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date



**Supplemental Questionnaire For Self-Insurance and Captive Insurance**

1. If the Applicant's Healthcare Professional Liability Insurance or General Liability Insurance is self-insured, or if the Applicant is a self-insured trust, attach the following:
  - (a) Latest annual certified statement from independent actuary as to soundness of fund
  - (b) Copy of the Trust Agreement
  - (c) Financial Statement of the Trust
  - (d) Details of loss control and claim services
  - (e) Details of any excess insurance carried by the Insured Applicant
  - (f) Copy of document which sets forth the coverage afforded under the self-insurance program
  - (g) What recommended confidence level has been funded? \_\_\_\_\_
  
2. If the Applicant's Healthcare Professional Liability Insurance or General Liability Insurance is provided through a captive, or if the applicant is a captive, attach the following:
  - (a) Latest annual certified statement as to the financial condition of the captive
  - (b) Latest annual report of the independent actuary to the captive
  - (c) Details of loss control and claim services
  - (d) Details of any excess insurance carried by the Applicant
  - (e) Copy of the policy supplied by the captive
  - (f) Details of ownership of the captive
  - (g) Details of reinsurance for the captive
  - (h) What recommended confidence level has been funded? \_\_\_\_\_
  
3. Does the self-insurance trust or captive provide primary coverage for Employment Practice Claims including but not limited to claims alleging sexual harassment, discrimination of any kind, violations of any state, local or federal laws pertaining to employment matters, wrongful termination or constructive discharge?  
Yes No  
If yes, are there any limitations to coverage? If so, please specify; and please identify the specific policy provisions providing the primary coverage.
  
4. Is there a defense obligation under the self insurance trust or captive for Employment Practice Claims?  
Yes No  
  
Are there any limitations or qualifications to the defense obligation? Yes No
  
5. Does the self insurance trust or captive provide primary coverage for claims related to the Organization's Peer Review and Credentialling process? Yes No  
  
If yes, are there any limitations to coverage? If so, please specify; and  
Please identify the specific policy provisions providing the primary coverage.
  
6. Is there a defense obligation under the self insurance trust or captive for Peer Review and Credentialling?  
Yes No  
Are there any limitations or qualifications to the defense obligation? Yes No

**Attention NY Insureds:**

**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.**

\_\_\_\_\_  
Signature (Must be signed by Chairman of the Board, President or Administrator.)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

*Attention: Insureds in AR, DC, FL, KY, ME, MN, NJ, OH, and PA*

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.

*Attention: Insureds in NY*

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.

*Attention: Insureds in CO*

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.

*Attention: Insureds in TN and VA*

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.

*Attention: Insureds in LA and NM*

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.

*Attention: Insureds in OK*

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.