ST PAUL TRAVELERS

Healthcare Directors and Officers Protection PLUS+℠ Policy

Healthcare Directors, Officers and Trustees Protection PLUS+℠ Policy

RENEWAL APPLICATION - UTAH and VIRGINIA

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. 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	POLICY NUMBER

GENERAL

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

A. Complete the list of all Subsidiary, and Affiliate Corporations and Partnerships on page 4 of this Application.

2. Limit of Liability requested on renewal: $____

3. 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)

4. Is the Applicant managed or administered by any third party under contract or agreement?
❑Yes *(If "Yes," attach copy of contract)* ❑No

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

6. J.C.A.H.O. Accredited? ❑Yes ❑No

7. Is the Applicant, including all Subsidiaries, Affiliates and Partnerships, involved in, or planning any of the following:
(a) Bankruptcy, receivership, liquidation or reorganization? ❑Yes ❑No
(b) The closure of one or more plants, places of business, or departments with 20 or more Employees?
❑Yes ❑No
(c) Any restructuring that affects 10% of the Employees or 20 Employees, whichever is greater, at any one facility of the Applicant? ❑Yes ❑No
(d) Mergers, acquisitions, affiliations or joint ventures? ❑Yes ❑No

If "Yes", please submit details on a separate sheet. Please include the status of obtaining necessary regulatory approvals.

INSURANCE CARRIED BY THE APPLICANT

Type	Carrier	Policy Period	Retention	Limit 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? ❑Yes ❑No

Is coverage included for alleged Wrongful Employment Practices? ❑Yes ❑No

Type	Carrier	Policy Period	Retention	Limit of Liability
4. Employee Dishonesty Ins.	_______________	_____________	___________	_____________
5. Workers Compensation Ins.	_______________	_____________	___________	_____________

6. Is the HPL or GL above self-insured through a trust or captive? ❑Yes ❑No
   If "Yes" please complete the Supplemental Questionnaire for Self-Insurance and Captive insurance, see page 4.

REQUIRED ATTACHMENTS

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

(1) The Applicant's most recent audited financial statement and any subsequent interim financial statements.
(2) The roster of current Directors, Officers and Trustees, including the Administrator, of the each Applicant.

It is agreed that this Renewal Application is a supplement to the applications on file with the Company and that such applications, together with any supplemental information, constitutes the complete application that shall be the basis for the contract and will be attached to and form part of the policy.

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 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.

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 AR, FL, KY, MN, NJ, NY, OH, OK , 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.

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.

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

____
Title

____
Applicant

____
Date

Attaching to and Forming an integral part of the Application.
Please list all Subsidiary and Affiliate Corporations and Partnerships to be covered

Name	Percent of Ownership	Description of Operations	Corporation		Partnership	
			Non-Profit	For-Profit	General	Limited

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 claims 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 claims 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

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

____
Title

____
Applicant

____
Date

INSURANCE FRAUD WARNINGS

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.