



# NAS

Insurance Services, inc.

## APPLICATION for: Managed Care Organizations and Healthcare Consultants Errors & Omissions Liability

**Notice: The Policy for which this Application is made, subject to its terms, applies only to any Claim (as applicable in the Coverage Section for which application is made) made against any of the Insureds during the Policy Period. The Limit of Liability available to pay damages or settlements shall be reduced and may be exhausted by amounts incurred as Costs, Charges and Expenses (as defined in the Coverage Section for which application is made), and Costs, Charges and Expenses shall be applied to the retentions. Submission of this Application does not guarantee coverage.**

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

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Web Site: \_\_\_\_\_

Is firm:  Corporation  Partnership  Individual  LLC  Other \_\_\_\_\_  
 For Profit  Not for Profit  Publicly traded

2. Date the Applicant's firm was established: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. If the firm is a Managed Care organization, please specify what type:  
 PHO  IPA  Medical Group  MSO  HMO  TPA

4. 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

5. Total Expected Revenue for the upcoming policy period: \$ \_\_\_\_\_

Current Year: \$ \_\_\_\_\_ Last Year: \$ \_\_\_\_\_

6. Describe the following financial information of the Applicant for the most recent fiscal year end.

- a) Total Assets: \$ \_\_\_\_\_
- b) Net Income:  or Net Loss:  \$ \_\_\_\_\_  
(check one)
- c) Equity: \$ \_\_\_\_\_

Fiscal year ending: 200 \_\_\_\_\_

**Please attach the latest year's full financial statements, and a current profit/loss statement including a balance sheet, if the audit is not available.**

7. Services to be Covered:

Services	No	Yes	% of Revenue
Medical billing	<input type="checkbox"/>	<input type="checkbox"/>	
Billing/Coding/Reimbursement consulting	<input type="checkbox"/>	<input type="checkbox"/>	
Claims handling/adjustment of benefits	<input type="checkbox"/>	<input type="checkbox"/>	
Case management	<input type="checkbox"/>	<input type="checkbox"/>	
Disease management	<input type="checkbox"/>	<input type="checkbox"/>	
Utilization review	<input type="checkbox"/>	<input type="checkbox"/>	
Credentialing/ peer review	<input type="checkbox"/>	<input type="checkbox"/>	
Advertising/marketing of healthcare plans/products	<input type="checkbox"/>	<input type="checkbox"/>	
Expert Witness services	<input type="checkbox"/>	<input type="checkbox"/>	
Healthcare, wellness education	<input type="checkbox"/>	<input type="checkbox"/>	
Development/implementation of clinical guidelines	<input type="checkbox"/>	<input type="checkbox"/>	
Actuarial analysis	<input type="checkbox"/>	<input type="checkbox"/>	
Independent medical exams	<input type="checkbox"/>	<input type="checkbox"/>	
Physician practice/office management (please describe):	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other (please describe):			

8. Are the above services provided to others for a fee?  Yes  No

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. Does the Applicant have any direct patient contact?  Yes  No

11. 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



**If the Applicant EMPLOYS OR INDEPENDENTLY CONTRACTS PHYSICIANS, please complete the following section:**

23. Does the Applicant employ physicians?  Yes  No  
 If "Yes", are they involved in: Direct patient care?  Yes  No  
 Non-patient care services?  Yes  No

24. Please specify the number of: Last 12 months Next 12 Months  
 Independent contractor physicians \_\_\_\_\_  
 Employed physicians \_\_\_\_\_  
 Hospitals/healthcare facilities \_\_\_\_\_

25. Does the Applicant require its providers to maintain Medical Malpractice insurance?  Yes  No  
 Minimum limits of liability \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_

26. In any of the Applicant's marketing regions:  
 a) Do Applicant's exclusive participating providers constitute greater than 20% of the market for such providers?  Yes  No  
 b) Do Applicant's non-exclusive participating providers constitute greater than 30% of the market for such providers?  Yes  No

27. Are insufficient patient encounters, excessive utilization or any other economic factors grounds to disqualify or remove a provider from the Applicant's panel?  
 Yes  No  
 a) Have any providers been terminated from the Applicant's provider panel in the past 12 months?  Yes  No  
 If the answer is "Yes", please indicate how many were terminated and for what reasons, on a separate page.

b) Were the terminated providers notified of their due process rights, as applicable?  Yes  No

28. Have any providers who applied, been denied membership to the panel in the last twelve (12) months?  Yes  No  
 If the answer is "Yes", please indicate how many were denied, and for what reasons, on a separate page.

**If the Applicant performs MEDICAL BILLING, please complete the following section:**

29. a. Total annual billings: \$ \_\_\_\_\_  
 b. Percentage of annual projected billings attributable to Medicare patients: \_\_\_\_\_ %  
 c. Percentage of annual projected billings attributable to Medicaid patients: \_\_\_\_\_ %

30. Does the Applicant have a compliance program in place?  Yes  No

**If the Applicant performs CLAIMS SERVICES, please complete the following section:**

31. Total revenue for claims handling and adjusting Last 12 Months Next 12 Months  
 services performed for others for a fee: \$ \_\_\_\_\_ \$ \_\_\_\_\_

32. a) Number of claims processed: \_\_\_\_\_  
 b) Number of FTE claim adjusters: \_\_\_\_\_  
 c) Number or percentage of PTE claim adjusters: \_\_\_\_\_  
 d) Number or percentage of claims denied: \_\_\_\_\_

33. What is the average error rate for the Applicant's claim handlers? \_\_\_\_\_ %

34. Please indicate whether the Applicant performs the following services:

- Administers health/welfare plans  Yes  No
- Administers pension or profit sharing plans  Yes  No
- Adjusts claims  Yes  No
- Reviews claim denials  Yes  No
- Issuance of denial of claims  Yes  No
- Administers Section 125 Reimbursement or COBRA benefits  Yes  No
- Acts as an insurance agent or broker  Yes  No
- Designs benefit plans (without actuarial analysis)  Yes  No
- Designs benefit plans (with actuarial analysis)  Yes  No

35. **For TPAs:** What kinds of plans are being administered?

- Single employers \_\_\_\_\_ %
- Multi-Employers (METs) \_\_\_\_\_ %
- Multi-Employer Welfare Arrangements (MEWAs) \_\_\_\_\_ %
- Taft-Hartley Plans \_\_\_\_\_ %
- Public/Government Plans \_\_\_\_\_ %
- Partially Self-Funded Minimum Premium Plans \_\_\_\_\_ %

**If the Applicant performs UTILIZATION REVIEW, FILE REVIEW or CASE MANAGEMENT, please complete the following section.**

36. Does the Applicant perform:

- Prospective utilization review  Yes  No
- Concurrent utilization review  Yes  No
- Retrospective utilization review  Yes  No
- Case management  Yes  No

37. Does the Applicant utilize guidelines such as Milliman and Robertson and/or InterQual for its utilization decisions?

- Yes  No

38. In any of the Applicant's contracts, does the Applicant have the responsibility to make the final determination as to whether or not a procedure is covered?

- Yes  No

**Insurance History**

39. 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

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

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

If "Yes", please indicate date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Claims History**

40. Have any claims, suits, or demands been made against the Applicant, a predecessor firm, any past or present principals, partners, officers, or employees within the past **five (5) years**?  Yes  No

If "Yes", please provide a claim summary for each claim consisting of:

- Name of claimant
- Type of service provided
- Date of claim
- Demand amount
- Indemnity and expenses paid/reserved
- Final disposition of claim

41. 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

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

43. Limits of Liability requested: \$ \_\_\_\_\_ / \_\_\_\_\_

Deductible (each Claim): \$ \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

To complete the submission, please include the following:

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

---

**NOTICE TO APPLICANT: PLEASE READ CAREFULLY**

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 be the basis of the contract should a policy be issued, and this application will be attached and become a part of such policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this application as they deem necessary.

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

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.

For purposes of creating a binding contract of insurance by this application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

\_\_\_\_\_  
Print Name of Insured, Owner, Partner or Principal

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date