Beazley Remedy Renewal Regulatory Liability Application

THE APPLICABLE LIMITS OF LIABILITY AND ARE SUBJECT TO THE RETENTIONS.
PLEASE READ THIS POLICY CAREFULLY.

Please fully answer all questions and submit all requested information. Terms appearing in bold face in this Application are defined in the Policy and have the same meaning in this Application as in the Policy. If you do not have a copy of the Policy, please request it from your agent or broker. This Application, including all materials submitted herewith, shall be held in confidence.

1. ORGANIZATIONAL INFORMATION:

Applicant Name:		Years in Business	
Principal Address:			
Primary Business Activity:		SIC Code/NAICS Code	
Total Assets			
Annual Revenue			
Number of Employed Physicians			
Number of beds			
Business Organization: For Profit Corporation___ Partnership ___ Limited Liability Corporation ___ Not-For-Profit Tax Exempt Corp___ Not-For-Profit Taxable Corp___ Publicly Traded___ Other ___			

If Applicant is a subsidiary of another company, please provide the name of the Parent Company:

_____

A. Nature of Operations_____

Please list all subsidiaries including ownership by percentage:

Subsidiary Name	Applicant's Ownership Percentage	Nature of Business
	%	
	%	
	%	

Attach additional page if necessary.

B. Is the Applicant a party to any joint venture arrangements or partnership agreements? ☐ Yes ☐ No

If yes, please attach details.

C. 1. Has the Applicant been involved with any mergers or acquisitions within the last 12 months? ☐ Yes ☐ No

If yes, please attach details.

2. Are there any plans for a merger, acquisition or consolidation in the next 12 months? ☐ Yes ☐ No

If yes, please attach details.

D. 1. Is the Applicant managed by an independent healthcare facility management group or similar entity? ☐ Yes ☐ No

If yes, please identify the managing entity and if they are responsible for medical billing.

_____

2. Does the Applicant manage any healthcare facilities or physician groups for any other separate and distinct entity that it doesn't have ownership interest? ☐ Yes ☐ No

If yes, please identify the entity for which the institution provides management services that include medical billings.

_____

2. COMPLIANCE:

A. Have there been any changes to the Medical Billings or Chief Compliance Officer? ☐ Yes ☐ No

If yes, please attach details.

B. 1. Have there been any changes to the formal compliance program? ☐ Yes ☐ No

If yes, please attach details.

2. How many dedicated full time employees does the Applicant have for compliance? _____

3. Has the Applicant had an external compliance effectiveness analysis conducted in the past 12 months? ☐ Yes ☐ No

If yes, please provide the name of the firm and the date of the review?

_____

4. Does the Applicant screen employment applicants and existing healthcare providers rendering services against the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No

5. Does the Applicant screen employment applicants and existing healthcare providers Against the General Services Administration's List of Parties Debarred from Federal Programs? ☐ Yes ☐ No

6. Have there been any changes to the Applicants Annual Compliance Audit/Analysis Work Plan? ☐ Yes ☐ No

If yes, please attach details.

3. BILLING PROCEDURES:

A. 1. Who performs government funded healthcare program billing for the Applicant?

_____

2. If billing is performed in house is the department centralized? ☐ Yes ☐ No

3. Is any billing performed by a third party? ☐ Yes ☐ No

   If yes, please provide the following:

   a. Percentage of total billings performed by third party_____

   b. Third party company's name_____

      Address_____

      City _____State _____ Zip code _____

   c. Describe any common ownership between the Applicant and third party

      _____

   d. Does the third party company have a compliance program? ☐ Yes ☐ No

4. Has the Applicant made any changes to their internal audit and compliance analysis? ☐ Yes ☐ No

   If yes, please attach details.

5. Does the Applicant monitor free and/or discounted samples of medications, equipment and replacement medical devices to guard against co-mingling with purchased inventory or inappropriate billing for items dispensed? ☐ Yes ☐ No

6. Are all contracts and referral relationships reviewed by counsel to ensure they conform to STARK and Anti-kickback statutes? ☐ Yes ☐ No

7. Does the Applicant monitor non-monetary compensation for compliance? ☐ Yes ☐ No

8. Briefly describe the procedure when potential incorrect medical billing is identified:

   _____

   a) To whom, by title, are such potential incidents reported? _____

   b) How are they investigated? _____

   c) What is the disciplinary procedure for personnel performing incorrect medical billings?

      _____

   d) In the past 12 months how many employees have received written warnings, suspensions or terminations for billing coding or documentation infractions? _____

9. Does the Applicant have a hotline or other reporting mechanism to report knowledge or questions concerning incorrect billings procedures or any other compliance concerns? ☐ Yes ☐ No

   a. If yes, what is the average number of complaints per month? _____

   b. If yes, what are the follow up procedures on the complaints?

      _____

10. Are exit interviews performed on all employees including billing and compliance staff? ☐ Yes ☐ No

    If yes, does the interview include a request for information on any known compliance ☐ Yes ☐ No

deficiencies within the Applicants organization?

Is the exiting employee asked to sign the exit interview document? ☐ Yes ☐ No

4. CODING INFORMATION:

A. 1. What is the approximate split between the billing processed performed by credentialed and non-credentialed staff?

Credentialed: _____%

Non-Credentialed: _____%

2. Does the Applicant have written policies and procedures for coders? ☐ Yes ☐ No

If yes, when were they last updated? _____

3. Does the Applicant track and analyze opioid prescriptions to identify outliers for questionable prescribing patterns from all insured entities and employed physicians? ☐ Yes ☐ No

4. Does the Applicant have a Risk Management program that addresses governance, employee training and initiatives surrounding opioid prescriptions? ☐ Yes ☐ No

5. Does the Applicant have in place a quality improvement or peer review committee that addresses clinical and administrative review or monitoring of physician prescribing practices including opioids? ☐ Yes ☐ No

6. Does the Applicant have any physician arrangements with compensation linked to prescription drugs? ☐ Yes ☐ No

5. PAYOR INFORMATION:

Payor Source	Gross Billings for the current year	Collections for the current year
Medicare:	$	$
Medicaid:	$	$
Medicare Advantage:	$	$
Commercial Payor:	$	$
Private Payor:	$	$
All other:	$	$
Total:	$	$

Payor Source	Gross Billings for the 1st year previous	Collections for the 1st year previous
Medicare:	$	$
Medicaid:	$	$
Medicare Advantage:	$	$
Commercial Payor:	$	$
Private Payor:	$	$
All other:	$	$
Total:	$	$

6. COVERAGE INFORMATION:

	Regulatory Liability
Current:	
Limit	
Retention	
Premium	
Insurer	
Policy Period	
Requested:	
Limit	
Retention	
Effective Date	

A. APPLICANTS IN MISSOURI: DO NOT ANSWER THE FOLLOWING QUESTION.

Have any of the Applicant's current liability insurers indicated intent not to offer renewal terms? ☐ Yes ☐ No

If yes, please attach details.

ATTACHMENTS: Attach the following materials regarding the Applicant:
- Audited financial statements
- Compliance effectiveness analysis report and findings performed by external firm
- Individual organizational charts for compliance hierarchy
- Entity organizational chart
- Audit/Analysis work plan
- Compliance Plan

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED EMPLOYEE OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AUTHORIZED EMPLOYEE AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITER OF SUCH CHANGES, AND THE UNDERWRITER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE. NO COVERAGE SHALL BE AFFORDED FOR ANY CLAIMS NOT PROPERLY REPORTED UNDER THE TERMS AND CONDITIONS OF THE APPLICABLE POLICIES.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

REPRESENTATION:
I represent to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by Applicant within 90 days of proposed effective date, or as required by underwriting quote and terms.

Name of Applicant	Title
Signature of Applicant	Date
Name of Applicant	Title
Signature of Applicant	Date

PLEASE MAKE CERTAIN ALL QUESTIONS ARE ANSWERED AND THAT ALL APPLICABLE SUPPLEMENTS IF APPLICABLE ARE COMPLETED. THIS APPLICATION WILL NOT BE PROCESSED UNLESS ALL QUESTIONS ON THIS APPLICATION AND APPLICABLE SUPPLEMENTS ARE ANSWERED.

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance - Producer