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 deficiencies within the Applicants organization? ☐ Yes ☐ No

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.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO OKLAHOMA APPLICANTS: WARNING**:** 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.

NOTICE TO KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND PENNSYLVANIA APPLICANTS: 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. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

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. FOR NEW HAMPSHIRE APPLICANTS, THE FOREGOING STATEMENT IS LIMITED TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, AFTER REASONABLE INQUIRY. IN MAINE, THE UNDERWRITERS MAY MODIFY BUT MAY NOT WITHDRAW 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. FOR NORTH CAROLINA, UTAH, AND WISCONSIN APPLICANTS, SUCH APPLICATION MATERIALS ARE PART OF THE POLICY, IF ISSUED, ONLY IF ATTACHED AT ISSUANCE.

WARRANTY:
I warrant 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 this Application is completed in Florida, please provide the Insurance Agent's name and license number as designated. If this Application is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Name of Insurance Agent	License Identification No.
Authorized Representative	

*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

If this Application is completed in Wisconsin, please note the following:

- As a condition precedent to the right to purchase the Optional Extension Period, the total premium for this Policy must have been paid. The right to purchase the Optional Extension Period shall terminate unless written notice together with full payment of the premium for the Optional Extension Period is given to the Insurer within thirty (30) days after the effective date of cancellation or nonrenewal. If such notice and premium payment is not so given to the Insurer, there shall be no right to purchase the Optional Extension Period.

- In the event of the purchase of the Optional Extension Period, the entire premium for the Optional Extension Period shall be deemed earned at its commencement.

- If this Policy is cancelled by the Named Insured, the Insurer shall retain the customary short rate portion of the premium hereon. If this Policy is cancelled by the Insurer, the Insurer shall retain the pro rata portion of the premium hereon. Payment or tender of any unearned premium by the Insurer shall not be a condition precedent to the effectiveness of cancellation.