HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY RENEWAL APPLICATION

Atlantic Specialty Insurance Company
(Stock company owned by OneBeacon Insurance Group)

OneBeacon MANAGEMENT LIABILITY

Onebeaconml.com

NOTICE: THE LIABILITY COVERAGE SECTIONS OF THE HEALTHCARE MANAGEMENT LIABILITY POLICY PROVIDE CLAIMS MADE COVERAGE, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" WILL BE APPLIED AGAINST THE RETENTION AMOUNT. IN NO EVENT WILL THE UNDERWRITER BE LIABLE FOR "DEFENSE EXPENSES" OR OTHER "LOSS" IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

If additional space is needed to answer the below questions, attach a separate document to this Application to provide complete answers. If the answer to a question is none, state "None" or "0" in the space provided.

Application Instructions:

Whenever used in this Application, the term "Applicant" shall mean the organization identified in response to Question 1 of Section I. of this Application.

I. APPLICANT

1. Name of Applicant:
2. Street Address:
3. City: State: Zip Code:

II. GENERAL INFORMATION

4. Number of Employees at the Applicant and its subsidiaries: Full Time: Part Time: Independent Contractor:

   Of the employees and independent contractors listed above, how many are physicians? _____

5. Please provide the following for the most recent fiscal year end for the Applicant:

   If financial statements are provided as an attachment to this Application, this Question 5. does not need to be completed.

   Total Assets: Revenues: Net Income:

   Long Term Debt: Equity:

6. Has the Applicant or any of its subsidiaries in the past 12 months completed, or is any such entity contemplating completing in the next 12 months, any of the following:

   a. Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No
   b. Facility or subsidiary closings or layoffs? ☐ Yes ☐ No
   c. Mergers, acquisitions or divestures? ☐ Yes ☐ No
   d. Registration for a public or private offering of securities? ☐ Yes ☐ No

   If "Yes" to a., b., c. or d., please provide details:

7. Over the past 12 months has the Applicant or any of its subsidiaries entered into exclusive contracts with any providers? ☐ Yes ☐ No

   If "Yes," please provide details:

8. Over the past 12 months, has the Applicant or any of its subsidiaries controlled more than twenty percent (20%) of the market share in any given geographical area of: a. providers in any given field of practice; b. hospital beds; c. healthcare services; or d. if the Applicant or any of its subsidiaries provides managed care products or services, the market share of health plan members? ☐ Yes ☐ No

If "Yes" to a., b., c. or d., please provide market share percentages by separate attachment.

9. a. Over the past 12 months, has the Applicant or any of its subsidiaries closed or restricted staff admissions and/or privileges of a provider for reasons other than professional competence, including but not limited to, a conflict of interest? ☐ Yes ☐ No

If "Yes," how many? _____

b. Are there any formal plans for future staff admission/privilege closings or restrictions? ☐ Yes ☐ No

If "Yes," please provide details:

III. DIRECTORS AND OFFICERS LIABILITY INFORMATION – Complete if coverage is requested.

10. *If the Applicant is a not-for-profit organization, this Question 10. does not need to be completed.*

Please provide the following information if there has been any change in ownership of the Applicant in the past 12 months:

Total number of common shareholders, partnership interests or LLC units: _____
Common shares outstanding: _____

For any shareholder owning 5% or more of the Applicant's voting shares, complete the following:

Shareholder Name	% Owned	Is this shareholder a private equity or venture capital firm?	Does this shareholder have board representation?
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No
	%	☐ Yes ☐ No	☐ Yes ☐ No

11. Has the Applicant or any of its subsidiaries experienced any changes to key executives (Chairman, President, CEO, CFO) in the past 12 months due to reasons other than death or retirement at the normal retirement age? ☐ Yes ☐ No

If "Yes," please provide details:

12. Is the Applicant or any of its subsidiaries in violation of any debt covenant? ☐ Yes ☐ No

If "Yes," please provide details:

IV. EMPLOYMENT PRACTICES LIABILITY INFORMATION – Complete if coverage is requested.

13. Please provide the following information for the Applicant and its subsidiaries:

Estimated annual remuneration* of all employees, including officers, owners or partners: _____

*Note: Remuneration includes salary, commissions, bonuses and other incentives and does not include dividends or security based distributions.

Employee Turnover: Most Recent 12 months _____%

Number of employees located in CALIFORNIA:

Full Time: Part Time: Independent Contractor:

Of the employees and independent contractors located in CALIFORNIA, how many are physicians? _____

14. Has the Applicant or any of its subsidiaries in the past 12 months completed, or does any such entity contemplate completing during the next 12 months, any layoffs? ☐ Yes ☐ No

If "Yes," please answer the following:

a. How many employees were or will be laid off? _____

b. Did the Applicant or subsidiary consult with outside counsel or will they consult with outside counsel prior to the layoffs? ☐ Yes ☐ No

V. FIDUCIARY LIABILITY INFORMATION – Complete if coverage is requested.

15. Provide the total assets for the benefit plans maintained by the Applicant and its subsidiaries: $ _____

16. Does the Applicant maintain any Defined Benefit Plan(s)? ☐ Yes ☐ No

If "Yes," what is the funded percentage (as shown on Schedule SB of the 5500)? _____%

17. During the past 12 months has (or during the next 12 months will) any plan for which coverage is requested:

a. Been (Be) merged with another plan, terminated or sold? ☐ Yes ☐ No

b. Had (Have) any outstanding or delinquent contributions? ☐ Yes ☐ No

c. Held (Hold) investments in more than 10% of any corporation or partnership, including but not limited to the Applicant? ☐ Yes ☐ No

If "Yes" to a., b. or c., please provide details:

VI. EMPLOYED LAWYERS INFORMATION – Complete if coverage is requested.

18. Number of Lawyers at the Applicant and its subsidiaries:

Employed Lawyers _____ Contract/Leased Attorneys _____

19. Do any Lawyers, in their position with the Applicant, provide legal services for any entity other than the Applicant and its subsidiaries or for individuals who are not employed by the Applicant or its subsidiaries? ☐ Yes ☐ No

If "Yes," please provide details:

VII. INFORMATION RISK AND RECOVERY (CYBER) – Complete if coverage is requested.

20. Does the Applicant store any of the following data records?

	Yes/No	Approximate number of records
Social Security Numbers	☐ Yes ☐ No	
Credit Cards	☐ Yes ☐ No	
Healthcare	☐ Yes ☐ No	
Bank accounts of customers, staff or volunteers	☐ Yes ☐ No	

21. Does the Applicant have (check all that apply):

- ☐ Up-to-date, active firewall technology
- ☐ Intrusion detection software for privileged access
- ☐ Patch management procedures
- ☐ Procedure to test or audit network security
- ☐ Remote access limited to VPN
- ☐ Disaster recovery plan, business continuity plan or equivalent
- ☐ Incident response plan
- ☐ A person or department responsible for information security
- ☐ Anti-virus software active on all computers and networks

22. Are all systems backed up by the Applicant on a daily basis? ☐ Yes ☐ No

23. If credit card payments are accepted by the Applicant or any of its subsidiaries, is the Applicant or any such subsidiary compliant with the Payment Card Industry Data Security Standards (PCI-DSS)? ☐ Yes ☐ No ☐ Not Applicable (credit card payments are not accepted)

VIII. CRIME INFORMATION – Complete if coverage is requested.

24. Total number of locations of the Applicant and its subsidiaries in the United States and Canada: _____

Total number of locations of the Applicant and its subsidiaries outside the United States and Canada: _____

List any countries, outside of the United States and Canada, where the Applicant and its subsidiaries have locations and provide the number of employees in each country:

25. Are at least two signatures required on checks? ☐ Yes ☐ No

If "Yes," above what amount? $_____

26. Does the Applicant:

a. Maintain a list of authorized vendors? ☐ Yes ☐ No

b. Strictly comply with dual recorded authorizations for all outgoing wire transfers? ☐ Yes ☐ No

c. Have internal controls designed so that no employee can control a process from beginning to end (for example, request a check, approve a voucher and sign the check)? ☐ Yes ☐ No

If "No" to a., b. or c., please explain:

27. How many employees handle, have access to or maintain records of money or securities? _____

IX. LOSS HISTORY

Complete Question 28. below if the Applicant is requesting coverage that the Applicant does not currently purchase or is requesting limits of liability that are higher than the Applicant currently purchases.

28. With respect to any liability coverage that the Applicant does not currently purchase or any requested limits of liability that are higher than the Applicant currently purchases, is the Applicant or any individual or entity proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such individual or any such entity has reason to believe may, or could reasonably be foreseen to, give rise to a claim or loss that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please provide details:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM OR LOSS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 28 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. ATTACHMENTS

29. If the Applicant meets any of the below criteria, please submit year-end audited financial statements and the most recent interim financial statements with this Application.

- More than 100 employees
- 2 years or less in operation
- Operating at a net loss
- Directors and Officers Liability coverage is requested

XI. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

ARKANSAS AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

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.

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.

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 any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or 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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

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 civil fines and criminal penalties.

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.

MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

XII. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance. Note this sentence does not apply to Maine Applicants.

NEW YORK 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 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.

REPRODUCED SIGNATURES, INCLUDING PHOTOCOPIES, WILL BE TREATED AS ORIGINAL.

IF THE APPLICANT PREFERS TO ELECTRONICALLY SUBMIT THIS APPLICATION TO THE UNDERWRITER, ITS AUTHORIZED AGENT SHOULD DO SO BY CHECKING THE BELOW BOX AND TYPING HIS/HER NAME AND THE DATE. BY DOING SO, THE APPLICANT AND ITS AUTHORIZED AGENT HEREBY CONSENT AND AGREE THAT SUCH AUTHORIZED AGENT'S USE OF A KEY PAD, MOUSE OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES HIS/HER/ITS SIGNATURE, ACCEPTANCE AND AGREEMENT AS IF ACTUALLY SIGNED BY SUCH AUTHORIZED AGENT IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.

A digital signature is a simple as:

1. Check the box.
2. Type authorized agent's name and the date.

The box must be checked by the chairperson, president, chief executive officer or chief financial officer of the Applicant (or equivalent positions thereof).

☐ **AUTHORIZED AGENT SIGNATURE AND ACCEPTANCE**

Applicant Name	
By (Authorized Signature) *Or Sign/Type/Print the Name of the chairperson, president, CEO or CFO (or equivalent positions thereof) who signed this form electronically by checking the box above.*	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHAIRPERSON, PRESIDENT, CHIEF EXECUTIVE OFFICER OR CHIEF FINANCIAL OFFICER OF THE APPLICANT (OR EQUIVALENT POSITIONS THEREOF) ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: State: Zip: