

SERFF Tracking Number: CHUB-125753977 State: Arkansas
Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: DO AR0043810F01
TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
Product Name: Health Care Portfolio
Project Name/Number: HCP/438

Filing at a Glance

Company: Federal Insurance Company

Product Name: Health Care Portfolio

TOI: 17.1 Other Liability - Claims Made Only

Sub-TOI: 17.1006 Directors & Officers Liability

Filing Type: Form

Effective Date Requested (New): On Approval

Effective Date Requested (Renewal): On Approval

State Filing Description:

SERFF Tr Num: CHUB-125753977 State: Arkansas

SERFF Status: Closed

Co Tr Num: DO AR0043810F01

Co Status:

Authors: Donna Daigle, Desirae
Bartlett, Christina Cresenzi

Date Submitted: 09/10/2008

State Tr Num: EFT \$50

State Status: Fees verified and
received

Reviewer(s): Betty Montesi, Edith
Roberts

Disposition Date: 09/23/2008

Disposition Status: Approved

Effective Date (New):

Effective Date (Renewal):

General Information

Project Name: HCP

Project Number: 438

Reference Organization: n/a

Reference Title: n/a

Filing Status Changed: 09/23/2008

State Status Changed: 09/23/2008

Corresponding Filing Tracking Number:

Filing Description:

In accordance with the laws of the State of Arkansas, we are filing the enclosed endorsement and applications applicable to the above product. This product was approved by the Department effective September 22, 2004 under our filing designation number DO AR0023101F01.

The revised endorsement is optional and premium bearing.

Status of Filing in Domicile: Pending

Domicile Status Comments:

Reference Number: n/a

Advisory Org. Circular: n/a

Deemer Date:

SERFF Tracking Number: CHUB-125753977 State: Arkansas
 Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
 Company Tracking Number: DO AR0043810F01
 TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
 Product Name: Health Care Portfolio
 Project Name/Number: HCP/438

Enclosed are the following components:

Required State Forms (if applicable)
 Forms Listing and Forms
 Comparison of Revised Endorsements

Company and Contact

Filing Contact Information

Donna Daigle, State Filing Analyst
 82 Hopmeadow Street
 Simsbury, CT 06070-7683

ddaigle@chubb.com
 (800) 464-7965 [Phone]
 (860) 408-2047[FAX]

Filing Company Information

Federal Insurance Company
 202 Hall's Mill Road
 P.O. Box 1650
 Whitehouse Station, NJ 08889-1650
 (908) 572-4422 ext. [Phone]

CoCode: 20281
 Group Code: 38

State of Domicile: Indiana
 Company Type:

Group Name:
 FEIN Number: 13-1963496

State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 50.00 flat
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federal Insurance Company	\$50.00	09/10/2008	22409200

SERFF Tracking Number: CHUB-125753977 State: Arkansas
Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: DO AR0043810F01
TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
Product Name: Health Care Portfolio
Project Name/Number: HCP/438

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	09/23/2008	09/23/2008

SERFF Tracking Number: CHUB-125753977 *State:* Arkansas
Filing Company: Federal Insurance Company *State Tracking Number:* EFT \$50
Company Tracking Number: DO AR0043810F01
TOI: 17.1 Other Liability - Claims Made Only *Sub-TOI:* 17.1006 Directors & Officers Liability
Product Name: Health Care Portfolio
Project Name/Number: HCP/438

Disposition

Disposition Date: 09/23/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CHUB-125753977 State: Arkansas
 Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
 Company Tracking Number: DO AR0043810F01
 TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
 Product Name: Health Care Portfolio
 Project Name/Number: HCP/438

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	14-02-10173 marked up copy	Approved	Yes
Supporting Document	438 Forms list HCP	Approved	Yes
Form	Health Care Portfolio for Health Care New Business Application with LOGO (For organizations with more than 250 employees)	Approved	Yes
Form	Health Care Portfolio for Health Care New Business Application with LOGO (For organizations with up to 250 employees)	Approved	Yes
Form	Health Care Portfolio for Health Care Renewal Application with LOGO	Approved	Yes
Form	Regulatory Claim Coverage Endorsement	Approved	Yes

SERFF Tracking Number: CHUB-125753977 State: Arkansas
 Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
 Company Tracking Number: DO AR0043810F01
 TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
 Product Name: Health Care Portfolio
 Project Name/Number: HCP/438

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Health Care Portfolio for Health Care New Business Application with LOGO (For organizations with more than 250 employees)	14-03-0742LOG	07/2008	Application/ New Binder/Enrollment		0.00	14-03-0742LOGO.pdf
Approved	Health Care Portfolio for Health Care New Business Application with LOGO (For organizations with up to 250 employees)	14-03-0743LOG	07/2008	Application/ New Binder/Enrollment		0.00	14-03-0743LOGO.pdf
Approved	Health Care Portfolio for Health Care Renewal Application with LOGO	14-03-0744LOG	07/2008	Application/ New Binder/Enrollment		0.00	14-03-0744LOGO.pdf
Approved	Regulatory Claim Coverage Endorsement	14-02-10173	09/2008	Endorsement/Amendment/Conditions	Replaced Form #: 14-02-10173 (10/2005) Previous Filing #:	0.00	14-02-10173.pdf



Chubb Group of Insurance Companies
 15 Mountain View Road
 Warren, New Jersey 07059

Health Care PortfolioSM
New Business Application

(For organizations with more than 250 employees)

Insert Logo Here

**BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH
 FEDERAL INSURANCE COMPANY (THE "COMPANY")**

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

APPLICATION INSTRUCTIONS:

Whenever used in this Application, the term "**Applicant**" means the Parent Organization and all of its subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____
2. Address of **Applicant**: _____
 City: _____ State: _____ Zip Code: _____ Telephone: _____
 Website: _____
3. State and Date of Incorporation: _____
4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____
5. Individual responsible for Human Resources or employment law matters:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which coverages are being requested and complete supplemental questionnaires if required.
- Note: The requested coverage is not automatically provided; the terms and conditions of the coverage section, if issued, will determine actual coverage.**



Projected next twelve (12) months: _____

(ii) Employees: Previous twelve (12) months: _____

Projected next twelve (12) months: _____

(iii) Total Assets: _____

4. Does the **Applicant** have any subsidiaries, joint ventures or affiliates or control any other entity or organization? Yes No

If "Yes," please attach a description of the operations, ownership, and the tax status of each such entity, and indicate whether coverage is requested for each such entity.

5. **Applicant's** Affiliation and Accreditation (note all that apply):

- American Hospital Association JCAHO
 NCQA Other: _____

(a) Has any **Applicant's** license, certification or accreditation ever been investigated, denied, suspended, revoked or granted subject to any contingencies or recommendations? Yes No

If "Yes," please explain: _____

(b) Has the JCAHO, NCQA or any other certifying or accrediting body found any **Applicant** to be out of substantial compliance with its certifying or accrediting standards? Yes No

If "Yes," please provide details by separate attachment.

(c) Has any federal or state regulatory authority criticized or noted deficiencies in any of the **Applicant's** operations, procedures or finances? Yes No

If "Yes," please provide details by separate attachment.

6. Is any of the **Applicant's** medical malpractice/health care professional liability exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk-sharing arrangement or pool? Yes No

If "Yes," please describe that insurance program by separate attachment, state how the program is administered and attach a copy of the most recent actuarial study. If a funded trust, captive or subsidiary is used:

(a) Does the funded trust, captive or subsidiary provide insurance other than to the **Applicant**? Yes No

(b) Is the program funded in accordance with annually determined actuarial requirements? Yes No

MISSOURI APPLICANTS: DO NOT ANSWER QUESTIONS 7 AND 8.

7. Has the **Applicant** been declined, canceled or non-renewed for any of the liability insurance mentioned above? Yes No

If "Yes," please attach an explanation.

8. Has any insurer under any other coverages listed above indicated an intent not to offer renewal terms to the **Applicant**? Yes No



III. DIRECTORS AND OFFICERS AND OPTIONAL ENTITY LIABILITY INFORMATION:

1. Who names the **Applicant's** directors and trustees?
 Membership Vote Appointed by: _____
 Other: _____

2. (a) How many board members does **Applicant** have? _____
 (b) How often does the **Applicant's** board meet? _____
 (c) Have any **Applicant** board members resigned or terminated in the last two (2) years for reasons other than expiration of their term? Yes No
 If "Yes," please describe: _____

3. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? Yes No
 If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? Yes No
 If "Yes," please explain: _____

4. Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

	<u>Organization</u>	<u>Persons</u>
(a) Anti-trust, copyright or patent litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Any other criminal actions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to any of the above in Question 4, please attach a full description of the details.

5. Other than those identified in your response to Question 4, has any civil proceeding been brought at any time during the last five (5) years against (a) any **Applicant** or (b) any proposed insured individual in his or her capacity as a director, officer, trustee or member of any duly constituted committee of any entity? Yes No
 If "Yes," please attach a full description of the details.

6. Does the **Applicant** render any professional services, including but not limited to providing any standard setting, accrediting, credentialing or licensing activities, management or administration for others for a fee? Yes No
 If "Yes," please describe: _____

BUSINESS PRACTICES:

To answer questions in this section, you may want to consult with the Applicant's legal counsel, or with the individual(s) responsible for administering or overseeing the Applicant's provider selection practices, which include peer review and credentialing practices.



7. Does the **Applicant** perform provider selection? Yes No

If "Yes," please complete the following questions. If "No," skip to Question 8.

(a) Does the **Applicant** have written policies and procedures in place for provider selection, including credentialing, re-credentialing, and making decisions that adversely affect a provider's credentials? Yes No

For Self? _____ For Others for a fee? _____

8. (a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department 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 closings or restrictions? Yes No

If "Yes," provide details by separate attachment.

If the answer to any part of this Question 8 is "Yes," has the **Applicant** consulted with legal counsel regarding proper procedures and safeguards in such instance? Yes No

9. Does the **Applicant** control more than twenty percent (20%) in any given geographical area of:
 (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? Yes No

If "Yes," to Question 9 (a), (b), (c) or (d), please provide market share percentages by separate attachment.

10. Does the **Applicant** have any exclusive contracts with any providers? Yes No

If "Yes," provide details by separate attachment.

11. Does the **Applicant** have a plan for ongoing training on HIPAA and other privacy laws? Yes No

12. Does the **Applicant** have a conflict of interest policy in place applicable to all directors, officers, trustees, staff and employees? Yes No

13. Are all directors, officers, trustees, staff and employees required to disclose any potential financial or other conflicts of interest annually? Yes No

14. (a) Are all compensation arrangements and business transactions evaluated annually for compliance with Excess Benefit Transaction rules as defined Section 4958 of the Internal Revenue Code of 1986? Yes No

If "No," please provide details by separate attachment.

(b) Has the **Applicant** been subject to an investigation or paid a fine for an Excess Benefit Transaction violation? Yes No

TRANSACTIONAL INFORMATION:

15. In the past seven (7) years has the **Applicant** merged into, been acquired by, consolidated with or affiliated with another entity? Yes No



If "Yes," answer the following questions, otherwise proceed to Question 16.

- (a) Did the **Applicant** seek an outside attorney's opinion on antitrust matters? Yes No

Please provide details as a separate attachment.

- (b) After such merger or acquisition did the **Applicant's** market share (whether of hospital beds, providers, health care services provided or membership in a network) exceed 20%? Yes No

16. Has the **Applicant** in the past two (2) years completed or agreed to, or does it contemplate within the next twelve (12) months, any of the following, whether or not such transactions were or will be completed?

If "Yes," please describe the essential terms of each such transaction as an attachment to this Application.

Also, if the **Applicant** answers "Yes" to Question 16 (b) or (c) below, attach a copy of any applicable prospectus.

- (a) Sale, distribution or divestiture of any assets or stock other than in the ordinary course of business? Yes No
- (b) Registration for a public offering or any private placement of securities? Yes No
- (c) Issuance of debt? Yes No
- (d) Reorganization or arrangement with creditors under federal or state law, whether or not such reorganization or arrangement was or will be completed? Yes No
- (e) Entering into new governmental contracts? Yes No
- (f) Conversion from non-profit to for-profit status? Yes No
- (g) Undertaking new areas of business? Yes No
- (h) Branch, location, facility, office or subsidiary closings, consolidations or layoffs? Yes No
- (i) Acquisitions of any type? Yes No

IV. EMPLOYMENT PRACTICES LIABILITY AND THIRD PARTY LIABILITY INFORMATION:
Complete if coverage is requested.

1. Number of Employees and Independent Contractors:	Current year	Previous year
(a) Full-time employees (include employed physicians):	_____	_____
(b) Part-time employees (include leased and seasonal, and employed physicians):	_____	_____
(c) Employed Physicians (full and part-time):	_____	_____
(d) Volunteers:	_____	_____
(e) Independent Contractors:	_____	_____
(f) Employees located in California:	_____	_____



2. Does the **Applicant**:

- (a) Distribute and document the receipt of its employee handbook to all employees? Yes No
 If "Yes," is the employee required to sign and acknowledge receipt of the handbook?
- (b) Have written procedures in place that are distributed to each employee regarding:
 - (i) Employment-at-will? Yes No
 - (ii) EEO statement and ADA accommodation statement? Yes No
 - (iii) Progressive discipline and termination? Yes No
 - (iv) Anti-discrimination and anti-harassment policies? Yes No
 - (v) Complaint resolution and internal grievance procedures? Yes No
 - (vi) Bonus compensation programs? Yes No
 - (vii) Employee conduct when dealing with third parties including non-discrimination and non-harassment statements? Yes No
 - (viii) Response to complaints of harassment, discrimination or civil rights violations from third parties? Yes No
- (c) Have a full-time human resources manager or department? Yes No
 If "No," who is responsible for this function? _____
- (d) Confer with human resources department or in-house legal counsel prior to any terminations? Yes No
- (e) Have a manual of its human resources procedures? Yes No
 If "Yes," please indicate the date it was last revised: _____
- (f) Provide formal training for its supervisors in administering these procedures? Yes No
 Who provides this training? _____
- (g) Provide formal anti-discrimination and anti-harassment training for all of its employees? Yes No

3. Please list any specific locations in California where the **Applicant** has employees: _____

Number of employees at each location _____

4. During the past 3 years, has any **Applicant** or any person proposed for coverage been involved in any capacity in any of the following matters?

- (a) EEOC, NLRB or other similar administrative proceeding? Yes No
- (b) Employment-related civil suit? Yes No

If "Yes" to either of the above in Question 4, please provide a full description of the details by separate attachment.



ADDITIONAL QUESTIONS FOR APPLICANTS WITH 1,000 OR MORE EMPLOYEES:

If the **Applicant** employs **more than 1,000 employees** on either a full-time or a part-time basis, **or has 5% or more of its employees in California**, and is requesting Employment Practices Liability (with or without Third Party Liability) coverage, complete this Section and submit the following documents as part of this Application:

- Employee handbook;
- Employment application form;
- Most recent EEO-1 (s); and
- Third-party policies and statements (if applying for Third Party Liability coverage).

5. Percentage of employees that are: Union _____% Non-union _____%

List name(s) of union(s): _____

6. What was the annual employee turnover rate for the last three (3) years?

Past year _____% One (1) year previous _____% Two (2) years previous _____%

7. State the **Applicant's** percentage of each:

Involuntary terminations: Past year: _____ One (1) year previous: _____

Voluntary terminations: Past year: _____ One (1) year previous: _____

8. Percentage (%) of employees with salaries (including bonuses):

Less than \$50,000: _____%

\$50,000 - \$100,000: _____%

\$100,000 - \$250,000: _____%

Greater than \$250,000: _____%

9. Is a written application required from all applicants? Yes No

10. Is outside counsel used to review:

- Layoffs, staff reductions or downsizings? Yes No
- Terminations? Yes No
- Written policies and procedures? Yes No

11. Is Alternative Dispute Resolution used? Yes No

12. Has the **Applicant** been audited by the EEOC or DOL? Yes No

13. During the last three (3) years, has any **Applicant** in any capacity been involved in a conciliation, settlement or consent agreement with either the EEOC or the OFCCP? Yes No

If "Yes," provide details by separate attachment. Please include: (a) date, (b) type, (c) allegation(s), (d) current status, (e) judgment or settlement amount, and (f) defense costs incurred.



14. Does the **Applicant** have established policies or procedures:
- (a) Outlining employee conduct when dealing with third parties, including non-discrimination and non-harassment statements? Yes No
 - (b) For responding to complaints of harassment, discrimination or civil rights violations from third parties? Yes No
15. Does the **Applicant** have a grievance or complaint hotline or other type of communication process? Yes No

If "Yes," how are complaints or grievances investigated? _____

16. What percentage of the **Applicant's** employees perform a majority of their functions off-site? _____%

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

1. Please list the names and types of **Applicant's** employee benefits plan(s). Attach additional pages if needed.

Plan names (Do not include health & welfare plans)	Plan assets (current year)	Plan assets (previous year)	Type of plan*	Under funded by more than 25%? (DB only)	Number of plan participants
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

2. Does the **Applicant** handle any investment decisions in-house? Yes No
 If "Yes," please describe: _____

3. In the past two (2) years, has the **Applicant** merged or terminated any plan(s)? Yes No
 If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.

4. Are any plans NOT in compliance with plan agreements or ERISA? Yes No
 If "Yes," please describe: _____

5. Past activities:

- (a) Has any fiduciary been:
 - (i) accused, found guilty or held liable for a breach of trust? Yes No
 - (ii) convicted of criminal conduct? Yes No
- (b) Have any claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries? Yes No



- (c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? Yes No

If "Yes" to any of the above in Question 5, please attach a full description of the details.

VI. CRIME COVERAGE INFORMATION: – Complete if coverage is requested.

1. Does the **Applicant**:
- (a) Allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? Yes No
- (b) Does an independent CPA provide a Management Letter to the **Applicant**? Yes No

If "Yes," please attach the most recent copy and management's response to the letter.

2. What is the limit above which the **Applicant** requires countersignature for their checks? \$_____
3. Please describe the services the **Applicant** provides for clients (including, but not limited to, accounting, payroll or purchasing functions):
- _____

4. Does an annual external audit include all subsidiaries and joint ventures? Yes No
5. Do the **Applicant's** external audits include all of its locations? Yes No

If "No," please explain _____

6. (a) How often does the **Applicant** perform a physical inventory check of stock and equipment? _____
- (b) Who performs these reconciliations? _____

7. Does the **Applicant** have procedures in place to verify the existence and ownership of all new vendors prior to adding them to the authorized master vendor list? Yes No

8. Does the **Applicant** verify invoices against a corresponding purchase order, receiving report and the authorized master vendor list prior to issuing payment? Yes No

9. Number of: domestic locations: _____; foreign locations: _____ and countries _____

10. Are international and domestic purchasing, inventory and payable procedures and controls consistent? Yes No

If "No," please attach an explanation.

11. Does the **Applicant** perform pre-employment reference checks for all its potential employees? Yes No

If "No," please attach an explanation.

Client Services

12. Do any of the **Applicant's** clients require the **Applicant** to carry crime insurance or to be bonded? Yes No

If "Yes," please explain and specify amount _____



13. List all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last 5 years, itemizing each loss separately. Include date of loss, description and total amount of loss. (Attach additional pages if necessary.)

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION: – Complete if coverage is requested.

1. Please complete the following regarding **Applicant's** risk profile:

List countries in which you have operations	Type of operation	Number of locations	Number of employees	Revenues
U.S. and Canada	_____	_____	_____	\$_____
_____	_____	_____	_____	\$_____
_____	_____	_____	_____	\$_____
TOTAL:		_____	_____	\$_____

2. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Please identify:

- (a) any precautions taken to protect those individuals or facilities noted in Questions 1 and 2, above:

- (b) the individual responsible for the **Applicant's** corporate security:

Name: _____ Title: _____

Email Address: _____

4. Please provide details on all network security precautions taken to secure sensitive client data that exists on your corporate networks or databases. If you do not keep client data on your networks or databases, check none:

5. Does the **Applicant** have a nursery, pediatric floor and/or an on-site child care/day care center? Yes No

If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.



6. Has the **Applicant** had any incidents or threats with respect to infant abductions during the past five (5) years? Yes No

If "Yes," please provide details by separate attachment.

7. List all kidnapping, extortion threat, cyber extortion, hijacking, wrongful detention or political threat events discovered by the **Applicant** in the last five (5) years, which would have been covered under the policy for which this **Application** is made, itemizing each loss separately. Include date of loss, threat or event; description of the loss, threat or event; and total amount of each loss. Attach additional pages if necessary.

VIII. CURRENT INSURANCE INFORMATION:

Coverage Sections	The Applicant currently purchases this coverage		Current Limit of Liability	Current Retention	Premium	Current Carrier
	Yes	No				
Directors & Officers And Entity Liability	_____	_____	\$_____	\$_____	\$_____	_____
Employment Practices Liability and Third Party Liability	_____	_____	\$_____	\$_____	\$_____	_____
Fiduciary Liability	_____	_____	\$_____	\$_____	\$_____	_____
Crime	_____	_____	\$_____	\$_____	\$_____	_____
Kidnap Ransom & Extortion	_____	_____	\$_____	\$_____	\$_____	_____
Medical Professional Liability	_____	_____	\$_____	\$_____	\$_____	_____
Managed Care Errors & Omissions	_____	_____	\$_____	\$_____	\$_____	_____

IX. CLAIMS AND REPRESENTATIONS/PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES:

1. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement, except as follows:

If the answer is none, so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.



2. Neither the **Applicant** nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows:

If the answer is none, so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

XI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES:

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, any coverage section. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the contract should any coverage section providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such coverage section; and that the Company will have relied on all such materials in issuing any such coverage section.

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

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 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.

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 and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to 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 material fact thereto, commits a fraudulent insurance act which is a crime.

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 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.

Notice to 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.

Notice to 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.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to 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.

This Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
_____	_____	<u>Chief Executive Officer</u>
_____	_____	<u>Chief Financial Officer</u>

XII. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- Most recent CPA-audited financial statements (last two (2) fiscal years with notes, schedules);
- Most recent CPA Letter to Management and management’s response (if this Letter is not issued, so indicate);
- Interim financial statements including balance sheet(s), income statement(s) and cash flow statement(s), if audited financial statements are six (6) months or older;
- Current organizational chart of the organization, listing each subsidiary, joint venture or affiliate, including the ownership percentage and tax status of each;



- Loss runs for the past five (5) years from any carrier for which the coverage requested is a direct or indirect replacement;
- A summary and status report of any litigation filed within the last two (2) years by or against any person(s) or entity(ies) proposed for this insurance (including any litigation that has been resolved) which is not included in the loss runs but may be covered under the coverage section(s) requested;
- Copies of the **Applicant's** current charter, by-laws, medical staff by-laws and other operating agreements;
- If **Applicant** has defined benefit plan(s), most recent audited pension financial statements for each plan;
- Fiduciary Liability: if **Applicant** has an ESOP, include most recent stock valuation report.

Complete the Regulatory Supplemental Application to the Executive Liability, Entity Liability and Employment Practices Liability Coverage Section, if Regulatory coverage is requested.

Complete the Outside Directorship Liability Application, if a separate limit for such liability is desired.

<u>Produced By:</u>	
Agent: _____	Agency: _____
Agency Taxpayer ID or SS No.: _____	Agent License No.: _____
Address: _____	
City: _____	State: _____ Zip: _____
<u>Submitted By:</u>	
Agency: _____	
Agency Taxpayer ID or SS No.: _____	Agent License No.: _____
Address: _____	
City: _____	State: _____ Zip: _____



Chubb Group of Insurance Companies
 15 Mountain View Road
 Warren, New Jersey 07059

Health Care Portfolio SM
New Business Application

(For organizations with up to 250 employees)

Insert Logo Here

**BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH
 FEDERAL INSURANCE COMPANY (THE "COMPANY")**

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

APPLICATION INSTRUCTIONS:

Whenever used in this Application, the term "**Applicant**" shall mean the Parent Organization and all subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____
2. Address of **Applicant**: _____
 City: _____ State: _____ Zip Code: _____ Telephone: _____
 Website: _____
3. State and Date of Incorporation: _____
4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____
5. Individual responsible for Human Resources or employment law matters:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which coverages are being requested and complete supplemental questionnaires if required.

Note: The requested coverage is not automatically provided; the terms and conditions of the coverage section, if issued, will determine actual coverage.



Coverage Requested	Limit of Liability Requested	Retention Requested
<input type="checkbox"/> Directors & Officers Liability	\$ _____	\$ _____
<input type="checkbox"/> Optional Entity Liability	\$ _____	\$ _____
<input type="checkbox"/> Optional Employment Practices Liability	\$ _____	\$ _____
<input type="checkbox"/> Optional Third Party Liability	\$ _____	\$ _____
<input type="checkbox"/> Fiduciary Liability	\$ _____	\$ _____
<input type="checkbox"/> Optional Separate Defense Costs Coverage	\$ _____	\$ _____
<input type="checkbox"/> Crime	\$ _____	\$ _____
<input type="checkbox"/> Kidnap/Ransom & Extortion	\$ _____	\$ _____

2. Describe nature of **Applicant's** business: _____

3. **Applicant** is a: Not-For-Profit Tax Exempt Corp. For-Profit Corp.
 Not-For-Profit Taxable Corp. Limited Liability Company
 Partnership Other (describe): _____

4. Please complete the following information:
 (a) Revenues: Previous twelve (12) months: _____ Projected next twelve (12) months: _____
 (b) Employees: Previous twelve (12) months: _____ Projected next twelve (12) months: _____
 (c) Total Assets: _____

5. Does the **Applicant** have any subsidiaries, joint ventures or affiliates or control any other entity or organization? Yes No

If "Yes," please attach a description of the operations, ownership, and the tax status of each such entity, and indicate whether coverage is requested for each such entity.

6. **Applicant's** Accreditation (note all that apply): JCAHO NCQA Other _____

7. Has the **Applicant** in the past eighteen (18) months completed or agreed to, or does it contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:

- (a) Reorganization or arrangement with creditors under federal or state law? Yes No
- (b) Branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes No
- (c) Mergers or acquisitions? Yes No

If "Yes" to any part of Question 7, please describe the essential terms of each such transaction as an attachment.



III. DIRECTORS AND OFFICERS LIABILITY INFORMATION:

1. (a) Number of: members on board of directors; trustees; member managers; or equivalent: _____
 (b) Are they elected or appointed? _____

2. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? Yes No

If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? Yes No

If "Yes," please explain: _____

3. Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

	<u>Organization</u>	<u>Persons</u>
(a) Anti-trust, copyright or patent litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Any other criminal actions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to any of the above in Question 3, please attach a full description of the details.

4. Other than those identified in your response to Question 3, has any civil proceeding been brought at any time during the last five (5) years against (a) any **Applicant** or (b) any proposed insured individual in his or her capacity as a director, officer, trustee or member of any duly constituted committee of any entity? Yes No

If "Yes," please attach a full description of the details.

5. Complete if **Applicant** has stock or other equivalent ownership instrument:

- (a) Total number of common shareholders: _____
 (b) Total number of common shares outstanding: _____
 (c) Total number of common shares owned by officers: _____
 (d) Total number of shares owned by directors who are not officers: _____
 (e) If any shareholder owns 5% or more of shares, designate name and percentage: _____

6. In the next twelve (12) months (or during the past two (2) years) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) any public or private offering of securities or issuance of debt? Yes No

If "Yes," please attach a full description of the details, including a copy of any prospectus.

7. Does the **Applicant** have written policies and procedures in place for provider selection, including credentialing, re-credentialing, and making decisions that adversely affect a provider's credentials?



- (a) for self? Yes No
- (b) for others for a fee? Yes No
- (c) are such policies and procedures in compliance with JCAHO or NCQA guidelines? Yes No

If "No," provide details by separate attachment.

8. (a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department 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 closings or restrictions? Yes No

If "Yes," provide details by separate attachment.

9. Does the **Applicant** have any exclusive contracts with any providers? Yes No

If "Yes," provide details by separate attachment.

10. Does the **Applicant** control more than twenty percent (20%) in any given geographical area of:
 (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? Yes No

If "Yes" to Question 10(a), (b), (c) or (d), please provide market share percentages by separate attachment.

**IV. EMPLOYMENT PRACTICES LIABILITY AND THIRD PARTY LIABILITY INFORMATION:
 Complete if coverage is requested.**

- | | Current Year | Previous Year |
|--|---------------------|--|
| 1. Number of Employees and Independent Contractors: | | |
| (a) Full-time employees: | _____ | _____ |
| (b) Part-time employees (include leased and seasonal): | _____ | _____ |
| (c) Volunteers: | _____ | _____ |
| (d) Employed Physicians: | _____ | _____ |
| (e) Independent Contractors: | _____ | _____ |
| (f) Employees located in California: | _____ | _____ |
| 2. Does the Applicant have written procedures in place regarding: | | |
| (a) Equal Opportunity Employment: | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) Anti-discrimination: | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) Anti-harassment: | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If "No" to any of the above, please attach a full explanation.



3. If "Yes" to any of the above in Question 2:
- (a) Are the written procedures distributed to each employee? Yes No
 - (b) If "Yes" to Question 3(a), does the **Applicant** document the distribution? Yes No
4. Does the **Applicant**:
- (a) Confer with human resources department or in-house legal counsel prior to any terminations? Yes No
 - (b) Have a manual of its human resources procedures? Yes No
 If "Yes," please indicate the date it was last revised: _____
 - (c) Provide formal training for its supervisors in administering these procedures? Yes No
 Who provides this training? _____
 - (d) Provide formal anti-discrimination and anti-harassment training for all of its employees? Yes No
5. During the past 3 years, has any **Applicant** or any person proposed for coverage been involved in any capacity in any of the following matters?
- (a) EEOC, NLRB or other similar administrative proceeding? Yes No
 - (b) Employment-related civil suit? Yes No
- If "Yes" to either of the above in Question 5, please attach a full description of the details.

V. FIDUCIARY LIABILITY COVERAGE INFORMATION:

1. Please list the names and types of **Applicant's** employee benefits plan(s). Attach additional pages if needed.

Plan names (Do not include health & welfare plans)	Plan assets (current year)	Plan assets (previous year)	Type of plan*	Under funded by more than 25%? (DB only)	Number of plan participants
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat EBP)

2. Does the **Applicant** handle any investment decisions in-house? Yes No
 If "Yes," please describe: _____
3. In the past two (2) years, has the **Applicant** merged or terminated any plan(s)? Yes No
 If "Yes," please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.



4. Are any plans NOT in compliance with plan agreements or ERISA? Yes No

If "Yes," please explain: _____

5. Past activities:

(a) Has any fiduciary been:

(i) accused, found guilty or held liable for a breach of trust? Yes No

(ii) convicted of criminal conduct? Yes No

(b) Have any claims (other than for benefits) been made during the past three (3) years against any benefit program or any current or past fiduciaries? Yes No

(c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? Yes No

If "Yes" to any of the above in Question 5, please attach a full description of the details.

VI. CRIME COVERAGE INFORMATION:

1. Does the **Applicant** allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? Yes No

If "Yes," please explain: _____

2. What is the limit above which the **Applicant** requires countersignature for their checks? \$_____

3. Please describe the services the **Applicant** provides for clients (including, but not limited to, accounting, payroll or purchasing functions):

4. Number of: domestic locations: _____; foreign locations: _____ and countries _____

5. Does the **Applicant** perform pre-employment reference checks for all its potential employees? Yes No

6. List all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last 5 years, itemizing each loss separately. Include date of loss, description and total amount of loss. (Attach additional pages if necessary.)

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION:

1. Please complete the following regarding **Applicant's** risk profile:

List countries in which you have operations	Type of operation	Number of locations	Number of employees	Revenues
U.S. and Canada	_____	_____	_____	\$_____



_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
TOTAL:		_____	_____	\$ _____

2. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Does the Applicant have a nursery, pediatric floor and/or an on-site child care/day care center? Yes No

If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.

4. Has the **Applicant** had any incidents or threats with respect to infant abductions during the past five (5) years? Yes No

If "Yes," please provide details by separate attachment.

5. List all kidnapping, extortion threat, cyber extortion, hijacking, wrongful detention or political threat events discovered by the **Applicant** in the last five (5) years, which would have been covered under the policy for which this **Application** is made, itemizing each loss separately. Include date of loss, threat or event; description of the loss, threat or event; and total amount of each loss. Attach additional pages if necessary.

VIII. CURRENT INSURANCE INFORMATION:

Coverage Sections	The Applicant currently purchases this coverage		Current Limit of Liability	Current Retention	Premium	Current Carrier
	Yes	No				
Directors & Officers And Entity Liability	_____	_____	\$ _____	\$ _____	\$ _____	_____
Employment Practices Liability and Third Party Liability	_____	_____	\$ _____	\$ _____	\$ _____	_____
Fiduciary Liability	_____	_____	\$ _____	\$ _____	\$ _____	_____
Crime	_____	_____	\$ _____	\$ _____	\$ _____	_____
Kidnap Ransom & Extortion	_____	_____	\$ _____	\$ _____	\$ _____	_____
Medical Professional Liability	_____	_____	\$ _____	\$ _____	\$ _____	_____
Managed Care Errors & Omissions	_____	_____	\$ _____	\$ _____	\$ _____	_____



IX. CLAIMS AND REPRESENTATIONS/PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES:

1. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement, except as follows:

If the answer is none, so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 1 IS EXCLUDED FROM THE PROPOSED INSURANCE.

2. Neither the **Applicant** nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows:

If the answer is none, so state: _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 2 IS EXCLUDED FROM THE PROPOSED INSURANCE.

X. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

XI. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES:

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, any coverage section. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the contract should any coverage section providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such coverage section; and that the Company will have relied on all such materials in issuing any such coverage section.

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



Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 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.

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 and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to 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 material fact thereto, commits a fraudulent insurance act which is a crime.

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 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.

Notice to 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.

Notice to 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.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to 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.



This Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
_____	_____	<u>Chief Executive Officer</u>
_____	_____	<u>Chief Financial Officer</u>

XII. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- When requesting Executive Liability, Entity Liability, Employment Practices Liability or Fiduciary Liability coverage, the most recent annual financial statements, audited if outside audits are performed.

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____



Insert Logo Here

**BY COMPLETING THIS RENEWAL APPLICATION YOU ARE APPLYING FOR COVERAGE WITH
 FEDERAL INSURANCE COMPANY (THE "COMPANY")**

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

RENEWAL APPLICATION INSTRUCTIONS

Whenever used in this Renewal Application, the term "**Applicant**" shall mean the Parent Organization and all subsidiaries, unless otherwise stated.

I. GENERAL INFORMATION:

1. Name of **Applicant**: _____
2. Address of **Applicant**: _____
 City: _____ State: _____ Zip Code: _____ Telephone: _____
 Website: _____
3. State and Date of Incorporation: _____
4. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____
5. Individual responsible for human resources or employment law matters:
 Name: _____ Title: _____
 E-Mail Address: _____ Phone: _____ Fax: _____

II. SPECIFIC INFORMATION:

1. Please indicate below which Health Care PortfolioSM coverages for which the **Applicant** seeks renewal:
 - Directors & Officers Liability
 - Optional Entity Liability
 - Optional Employment Practices Liability
 - Optional Third Party Liability
 - Fiduciary Liability
 - Optional Separate Defense Costs Coverage
 - Crime
 - Kidnap/Ransom & Extortion



- Outside Directorship Liability (additional applications are required)
- Supplemental Regulatory Coverage (an additional application is required)

2. **Applicant's** total revenue as of the most recent fiscal year end: \$ _____

3. **Applicant's** total assets as of the most recent fiscal year end: \$ _____

4. Cash flow from operations as of the most recent fiscal year end: \$ _____

5. Has the **Applicant** in the past twelve (12) months completed or agreed to, or does it contemplate during the next twelve (12) months, any of the following, whether or not such transactions were or will be completed:

- a) Reorganization or arrangement with creditors under federal or state law? Yes No
- b) Branch, location, facility, office, or subsidiary closings, consolidations or layoffs? Yes No
- c) Mergers and/or acquisitions? Yes No
- d) Entering into new governmental contracts? Yes No
- e) Conversion from non-profit to for-profit status? Yes No
- f) Undertaking new areas of business? Yes No

If "Yes" to any part of Question 5, please describe the essential terms of each such transaction as an attachment.

III. DIRECTORS AND OFFICERS LIABILITY INFORMATION:

1. In the next twelve (12) months (or during the past twelve (12) months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) any public or private offering of securities or issuance of debt? Yes No

If "Yes," please attach a full description of the details, including a copy of any prospectus.

- 2. a) Over the past twelve (12) months, has there been any change in the board of directors? Yes No
- b) Current number of: members on board of directors; trustees; member managers; or equivalent _____
- c) Current total outstanding shares, units, or interest _____

If "Yes" to Question 2(a) above, please explain: _____

3. Please list all non-director and non-officer shareholders who directly or beneficially hold common stock and the percentage owned by each (if none, so indicate).

Non director or non officer shareholders: Number of voting shares owned:

4. Does the **Applicant** now have tax exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code of 1986, as amended? Yes No

If "Yes," is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? Yes No

If "Yes," please explain: _____

5. Has there been any change in the **Applicant's** ownership structure within the last 12 months? Yes No

If "Yes," attach a full description of ownership structure.



6. a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department 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 closings or restrictions? Yes No
- If "Yes," provide details by separate attachment.
7. Over the past twelve (12) months has **Applicant** entered into any exclusive contracts with any providers? Yes No
- If "Yes," provide details by separate attachment.
8. Over the past twelve (12) months has **Applicant** controlled more than twenty percent (20%) in any given geographical area of:
- (a) providers in any given field of practice; (b) hospital beds; (c) health care services; or (d) if the **Applicant** provides managed care products or services, the market share of health plan members? Yes No
- If "Yes" to Question 8(a), (b), (c) and/or (d), please provide market share percentages by separate attachment.

IV. EMPLOYMENT PRACTICES INFORMATION:

1. Employee & Independent Contractor count: **Current Year**
- (a) Full-time employees: _____
- (b) Part-time employees (include leased and seasonal): _____
- (c) Volunteers: _____
- (d) Employed Physicians: _____
- (e) Independent Contractors: _____
- (f) Employees located in California: _____
2. Within the last year has the **Applicant** updated its employment practices handbook, or human resources policies and procedures or department? Yes No
- If the **Applicant** answered "Yes," please attach a copy of updated materials and a description of changes.
3. Number of employees who have left the **Applicant** over the past 12 months:
- Voluntary _____ Involuntary _____

V. FIDUCIARY LIABILITY COVERAGE INFORMATION:

1. Please list the names and types of **Applicant's** employee benefits plan(s)



Plan names (Do not include health & welfare plans)	Plan assets (current year)	Plan assets (previous year)	Type of plan*	Under funded by more than 25%? (DB only)	Number of plan participants
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

* Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

2. In the next 12 months is the **Applicant** contemplating (or has the **Applicant** completed within the last year) merging or terminating any plan(s)? Yes No

If "Yes," please explain: _____

VI. CRIME COVERAGE INFORMATION:

1. Does the **Applicant** allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? Yes No

If "Yes," please explain: _____

2. Does the **Applicant** have procedures in place to verify the existence and ownership of all new vendors prior to adding them to the authorized master vendor list? Yes No

3. Does the **Applicant** verify invoices against a corresponding purchase order, receiving report and the authorized master vendor list prior to issuing payment? Yes No

4. How often does the **Applicant** perform a physical inventory check of stock and equipment? _____

5. What is the limit above which the **Applicant** requires countersignature for their checks? \$ _____

VII. KIDNAP/RANSOM & EXTORTION COVERAGE INFORMATION:

1. Please complete the following information regarding the foreign travel of the **Applicant's** employees:

Travel destination by country	Number of annual trips	Average length of stay	Number of employees traveling
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Describe the **Applicant's** security precautions taken for foreign travel: _____

3. Does the **Applicant** have a nursery, pediatric floor and/or an on-site child care/day care center? Yes No

If "Yes," provide a brief description by separate attachment of the security measures used to ensure their safety.

VIII. MATERIAL CHANGE:

If any information provided in this Renewal Application changes materially before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.



IX. DECLARATIONS, FRAUD WARNINGS AND SIGNATURE:

The **Applicant's** submission of this Renewal Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Renewal Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Renewal Application.

The undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance declares that to the best of his or her knowledge and belief, after reasonable inquiry, that the statements made in this Renewal Application and in any attachments or other documents submitted with this Renewal Application are true and complete. The undersigned agrees that this Renewal Application, such attachments and other documents, and all other signed applications submitted by the **Applicant** to the Company for the proposed insurance or any other insurance contract of which the proposed insurance is a direct or indirect renewal or replacement shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

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

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico 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, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 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.

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 and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).

Notice to 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 material fact thereto, commits a fraudulent insurance act which is a crime.

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 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.

Notice to 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.

Notice to 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.



Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to 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.

This Renewal Application must be signed by the chief executive officer and chief financial officer of the Parent Organization acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
_____	_____	<u>Chief Executive Officer</u>
_____	_____	<u>Chief Financial Officer</u>

X. PLEASE ATTACH A COPY OF THE FOLLOWING REQUIRED INFORMATION FOR EVERY APPLICANT SEEKING COVERAGE:

- Most recent annual financial statements, audited if outside audits are performed;
- Most recent audited pension financial statements for each defined benefit plan (applicable to Fiduciary Liability coverage only);
- Most recent CPA Letter to Management and management's response (if this Letter is not issued, so indicate);
- Most recent EEO-1 Report (applicable to Employment Practices Liability coverage only).

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

ENDORSEMENT/RIDER

<COVSECT>

Effective date of
this endorsement/rider: <TRXEFFDATE>

<CARRNAME>

Endorsement/Rider No. <EN>

To be attached to and
form a part of Policy No. <POLICYNO>

Issued to: <ACCTNAME>

REGULATORY CLAIM COVERAGE ENDORSEMENT

In consideration of the premium charged, it is agreed that:

- (1) The following Insuring Clause is added to the Insuring Clauses of this coverage section:

Regulatory Claim Coverage Insuring Clause 6

6. The Company shall pay, on behalf of the **Insureds**, **Loss** which the **Insureds** become legally obligated to pay on account of any **Regulatory Claim** first made against such **Insureds** during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Regulatory Wrongful Act** committed, attempted, or allegedly committed or attempted by such **Insureds** before or during the **Policy Period**, but only if such **Regulatory Claim** is reported to the Company in writing in the manner and within the time provided in Subsection 18 of this coverage section.

- (2) The term **Claim**, as defined in Subsection 6 Definitions of this coverage section, is amended to include, when used in reference to the coverage provided by Insuring Clause 6, a **Regulatory Claim**.

- (3) The term **Loss**, as defined in Subsection 6 Definitions of this coverage section, is amended to include the following:

(c) the amount that any **Insured** (for purposes of Insuring Clause 6) becomes legally obligated to pay on account of any covered **Regulatory Claim**, including but not limited to:

(i) damages;

(ii) judgments;

(iii) settlements;

(iv) pre-judgment and post-judgment interest;

(v) fines and penalties levied against an **Insured** for violation of the Federal False Claims Act or any similar federal, state, or local statutory law or common law anywhere in the world, any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world, or amendments to or regulations promulgated under any such law; and

(vi) **Defense Costs**.

- (4) The term **Loss**, as defined in Subsection 6 Definitions of this coverage section, shall not include, when used in this coverage section:
- (a) any bond or surety requirement;
 - (b) any amount of overpayment or restitution that is identified as such in any document or instrument effecting any settlement; or
 - (c) fees, profits, or other revenue lost, or any costs incurred, by an **Insured** in connection with the termination, suspension, or limitation of such **Insured's** right to participate in any program of a federal, state or local governmental, regulatory or administrative agency or entity.
- (5) The term **Wrongful Act**, as defined in Subsection 6 Definitions of this coverage section, is amended to include, when used in reference to the coverage provided by Insuring Clause 6, a **Regulatory Wrongful Act**.
- (6) Subsection 6 Definitions of this coverage section is amended to include the following terms:

Regulatory Claim means:

- (a) a written demand for monetary damages or non-monetary relief;
- (b) a search warrant, subpoena, notice of investigation, or contact letter;
- (c) a civil proceeding commenced by the service of a complaint or similar pleading;
- (d) a criminal proceeding commenced by the return of an indictment or information;
- (e) a civil administrative or civil regulatory proceeding commenced by the filing of a demand or notice of charges; or
- (f) a qui tam action or a relator lawsuit commenced by the service of a complaint or similar pleading,

brought by or on behalf of a federal, state or local governmental, regulatory or administrative agency or entity against an **Insured** for a **Regulatory Wrongful Act**, including any appeal therefrom.

Regulatory Claim shall not include any customary or routine audit or reconciliation involving an **Insured** by any federal, state or local governmental, regulatory or administrative agency or entity.

Except as may otherwise be provided in Subsection 15, Subsection 16(j), or Subsection 18(b) of this coverage section, a **Regulatory Claim** will be deemed to have first been made when, with respect to any civil, criminal, or civil administrative or civil regulatory proceeding or qui tam action or relator lawsuit described in (c) - (f) above, such **Regulatory Claim** is commenced as set forth in this definition or, in the case of any written demand search warrant, subpoena, notice of investigation, or contact letter described in (a) or (b) above, when such demand is first received by an **Insured**.

Regulatory Wrongful Act means any actual or alleged violation by an **Insured** of the responsibilities, obligations or duties imposed by the Federal False Claims Act or any similar federal, state, or local statutory law or common law anywhere in the world, any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world, or amendments to or regulations promulgated under any such law; provided that **Regulatory Wrongful Act** shall not include any **Employment Practices Wrongful Act** or **Third Party Wrongful Act**.

- (7) Solely with respect to any coverage available under Insuring Clause 6, Exclusion 7(a) of this coverage section is amended to read in its entirety as follows:
- (a) based upon, arising from, or in consequence of any fact, circumstance, situation, transaction, event or **Wrongful Act** that, before <PRIORNOTICEDT>, was the subject of any notice given under any policy or coverage section of which this coverage section is a direct or indirect renewal or replacement;

(8) Solely with respect to any coverage available under Insuring Clause 6, Exclusion 7(b) of this coverage section is amended to read in its entirety as follows:

(b) based upon, arising from, or in consequence of any:

- (i) demand, suit or other proceeding which was pending against any **Insured**;
- (ii) search warrant, subpoena, notice of investigation or contact letter which was pending against any **Insured**; or
- (iii) order, decree, or judgment entered for or against any **Insured**;

on or prior to the applicable Pending or Prior Date set forth in Item 7 of the Declarations for this coverage section, or the same or substantially the same fact, circumstance, or situation underlying or alleged therein, including but not limited to any such **Claim** which is brought by or on behalf of the original claimant in any matter set forth in (i) or (ii) above or any other claimant.

(9) Exclusion 7(l) of this coverage section shall not apply to **Loss** on account of any **Regulatory Claim** under Insuring Clause 6 of this coverage section.

(10) No coverage will be available under Insuring Clause 6 of this coverage section for **Loss** on account of any **Regulatory Claim** made against any **Insured** based upon, arising from, or in consequence of:

- (a) the committing in fact of any dishonest or fraudulent act or omission or any willful violation of any statute or regulation by such **Insured**, if a judgment or other final adjudication establishes such dishonest or fraudulent act or omission or willful violation of any statute or regulation; or
- (b) such **Insured** having gained in fact any profit, remuneration or advantage to which such **Insured** was not legally entitled.

(11) Solely with respect to any coverage available under Insuring Clause 6, Subsection 24 Acquisition/Creation of Another Organization of this coverage section is amended to read in its entirety as follows:

24. If before the **Policy Period** any **Organization**:

- (a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or
- (b) acquires another organization by merger into or consolidation with an **Organization** such that the **Organization** is the surviving entity,

such other organization and its **Insured Persons** shall be **Insureds** under this coverage section, but only with respect to **Wrongful Acts** committed, attempted, or allegedly committed or attempted after such acquisition or creation unless the Company agrees, after presentation of a complete application and all other appropriate information, to provide coverage by endorsement for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by such **Insureds** before such acquisition or creation. Notwithstanding the foregoing, no such coverage will be available under this coverage section for the following such acquired or created organizations:

<EXCLUENTITY>

If during the **Policy Period** any **Organization**:

- (a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or
- (b) acquires another organization by merger into or consolidation with an **Organization** such that the **Organization** is the surviving entity,

such other organization and its directors, officers, and employees shall not be **Insureds** under this coverage section and no coverage shall be available to such other organization and its directors, officers, and employees unless the Company agrees, after presentation of a complete application and all other appropriate information, to provide coverage by endorsement for such other organization and its directors, officers, and employees.

- (12) If any **Regulatory Claim** is filed under seal, the **Insureds** shall, as a condition precedent to exercising any right to coverage under this coverage section, immediately upon becoming aware of such **Regulatory Claim** petition the applicable court, agency, or entity to allow such sealed information be provided to the Company.
- (13) The Company's maximum aggregate liability for all **Loss** on account of all **Regulatory Claims** shall be <SUBLIMIT>, which amount is part of and not in addition to the Company's maximum aggregate Limit of Liability for all **Loss** on account of all **Claims** first made during the **Policy Period** as set forth in Item 2(J) of the Declarations for this coverage section.
- (14) Item 5 Retention of the Declarations for this coverage section is amended to include the following:
 - (I) Insuring Clause 6 – Each **Regulatory Claim**: <RETENTION>
- (15) Item 7 Pending or Prior Date of the Declarations for this coverage section is amended to include the following:
 - (E) Insuring Clause 6: <PPLITDATE>

The title and any headings in this endorsement/rider are solely for convenience and form no part of the terms and conditions of coverage.

All other terms, conditions and limitations of this Policy shall remain unchanged.

<ENDSIG>

Authorized Representative

SERFF Tracking Number: CHUB-125753977 *State:* Arkansas
Filing Company: Federal Insurance Company *State Tracking Number:* EFT \$50
Company Tracking Number: DO AR0043810F01
TOI: 17.1 Other Liability - Claims Made Only *Sub-TOI:* 17.1006 Directors & Officers Liability
Product Name: Health Care Portfolio
Project Name/Number: HCP/438

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CHUB-125753977 State: Arkansas
Filing Company: Federal Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: DO AR0043810F01
TOI: 17.1 Other Liability - Claims Made Only Sub-TOI: 17.1006 Directors & Officers Liability
Product Name: Health Care Portfolio
Project Name/Number: HCP/438

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty	Review Status: Approved	09/23/2008
Comments:		
Attachments:		
AR P&C 438.pdf		
AR form schedule 438.pdf		
Satisfied -Name: 14-02-10173 marked up copy	Review Status: Approved	09/23/2008
Comments:		
Attachment:		
14-02-10173 comparison.pdf		
Satisfied -Name: 438 Forms list HCP	Review Status: Approved	09/23/2008
Comments:		
Attachment:		
HCP Forms List 438.pdf		

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

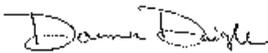
3. Group Name	Group NAIC #
Chubb Group of Insurance Companies	0038

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Federal Insurance Company	IN	20281	13-1963496	

5. Company Tracking Number	DO AR0043810F01
-----------------------------------	-----------------

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Donna M. Daigle 82 Hopmeadow St., P.O. Box 2002 Simsbury CT 06070-7683	State Filing Analyst	800-464-7965	860-408-2047	ddaigle@chubb.com

7. Signature of authorized filer	
8. Please print name of authorized filer	Donna M. Daigle

Filing Information (see General Instructions for descriptions of these fields)

9.	Type of Insurance (TOI)	17.1
10.	Sub-Type of Insurance (Sub-TOI)	17.1006
11.	State Specific Product code(s) (if applicable) [See State Specific Requirements]	N/A
12.	Company Program Title (Marketing Title)	Health Care Portfolio
13.	Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14.	Effective Date(s) Requested	New: 10/10/2008 Renewal:
15.	Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16.	Reference Organization (if applicable)	N/A
17.	Reference Organization # & Title	N/A
18.	Company's Date of Filing	9/10/08
19.	Status of filing in domicile	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

FORM FILING SCHEDULE

(This form must be provided **ONLY** when making a filing that includes forms)
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	DO AR0043810F01
-----------	--	-----------------

2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	N/A
-----------	---	-----

3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or Withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Health Care Portfolio SM for Health Care New Business Application with LOGO (For organizations with more than 250 employees)	14-03-0742LOGO (07/2008)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
02	Health Care Portfolio SM for Health Care New Business Application with LOGO (For organizations with up to 250 employees)	14-03-0743LOGO (07/2008)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03	Health Care Portfolio SM for Health Care Renewal Application with LOGO	14-03-0744LOGO (07/2008)	<input checked="" type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04	Regulatory Claim Coverage Endorsement	14-02-10173 (09/2008) rev.	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	14-02-10173 (10/2005)	
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
11			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

ENDORSEMENT/RIDER

<COVSECT>

Effective date of this endorsement/rider: <TRXEFFDATE>

<CARRNAME>

Deleted: .

Endorsement/Rider No. <EN>

To be attached to and form a part of Policy No. <POLICYNO>

Issued to: <ACCTNAME>

Deleted: .

_____↑

REGULATORY CLAIM COVERAGE ENDORSEMENT

In consideration of the premium charged, it is agreed that:

(1) The following Insuring Clause is added to the Insuring Clauses of this coverage section:

Regulatory Claim Coverage Insuring Clause 6

6. The Company shall pay, on behalf of the **Insureds**, **Loss** which the **Insureds** become legally obligated to pay on account of any **Regulatory Claim** first made against such **Insureds** during the **Policy Period** or, if exercised, during the Extended Reporting Period, for a **Regulatory Wrongful Act** committed, attempted, or allegedly committed or attempted by such **Insureds** before or during the **Policy Period**, but only if such **Regulatory Claim** is reported to the Company in writing in the manner and within the time provided in Subsection 18 of this coverage section.

(2) The term **Claim**, as defined in Subsection 6 Definitions of this coverage section, is amended to include, when used in reference to the coverage provided by Insuring Clause 6, a **Regulatory Claim**.

(3) The term **Loss**, as defined in Subsection 6 Definitions of this coverage section, is amended to include the following:

(c) the amount that any **Insured** (for purposes of Insuring Clause 6) becomes legally obligated to pay on account of any covered **Regulatory Claim**, including but not limited to:

(i) damages;

(ii) judgments;

(iii) settlements;

(iv) pre-judgment and post-judgment interest;

Deleted: and

(v) fines and penalties levied against an **Insured** for violation of the Federal False Claims Act or any similar federal, state, or local statutory law or common law anywhere in the world, any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world, or amendments to or regulations promulgated under any such law; and

Deleted: the Social Security Act,

Deleted: .

(vi) Defense Costs.

- (4) The term **Loss**, as defined in Subsection 6 Definitions of this coverage section, shall not include, when used in this coverage section:
- (a) any bond or surety requirement;
 - (b) any amount of overpayment or restitution that is identified as such in any document or instrument effecting any settlement; or
 - (c) fees, profits, or other revenue lost, or any costs incurred, by an **Insured** in connection with the termination, suspension, or limitation of such **Insured's** right to participate in any program of a federal, state or local governmental, regulatory or administrative agency or entity.
- (5) The term **Wrongful Act**, as defined in Subsection 6 Definitions of this coverage section, is amended to include, when used in reference to the coverage provided by Insuring Clause 6, a **Regulatory Wrongful Act**.
- (6) Subsection 6 Definitions of this coverage section is amended to include the following terms:

Regulatory Claim means:

- (a) a written demand for monetary damages or non-monetary relief;
- (b) a search warrant, subpoena, notice of investigation, or contact letter;
- (c) a civil proceeding commenced by the service of a complaint or similar pleading;
- (d) a criminal proceeding commenced by the return of an indictment or information;
- (e) a civil administrative or civil regulatory proceeding commenced by the filing of a demand or notice of charges; or
- (f) a qui tam action or a relator lawsuit commenced by the service of a complaint or similar pleading,

brought by or on behalf of a federal, state or local governmental, regulatory or administrative agency or entity against an **Insured** for a **Regulatory Wrongful Act**, including any appeal therefrom.

Regulatory Claim shall not include any customary or routine audit or reconciliation involving an **Insured** by any federal, state or local governmental, regulatory or administrative agency or entity.

Except as may otherwise be provided in Subsection 15, Subsection 16(j), or Subsection 18(b) of this coverage section, a **Regulatory Claim** will be deemed to have first been made when, with respect to any civil, criminal, or civil administrative or civil regulatory proceeding or qui tam action or relator lawsuit described in (c) - (f) above, such **Regulatory Claim** is commenced as set forth in this definition or, in the case of any written demand search warrant, subpoena, notice of investigation, or contact letter described in (a) or (b) above, when such demand is first received by an **Insured**.

Regulatory Wrongful Act means any actual or alleged violation by an **Insured** of the responsibilities, obligations or duties imposed by the Federal False Claims Act or ~~any similar federal, state, or local statutory law or common law~~ anywhere in the world, any federal, state, or local anti-kickback, self-referral or healthcare fraud and abuse law anywhere in the world, or amendments to or regulations promulgated under any such law; provided that **Regulatory Wrongful Act** shall not include any **Employment Practices Wrongful Act** or **Third Party Wrongful Act**.

Deleted: the Social Security Act,

- (7) Solely with respect to any coverage available under Insuring Clause 6, Exclusion 7(a) of this coverage section is amended to read in its entirety as follows:
- (a) based upon, arising from, or in consequence of any fact, circumstance, situation, transaction, event or **Wrongful Act** that, before <PRIORNOTICEDT>, was the subject of any notice given under any policy or coverage section of which this coverage section is a direct or indirect renewal or replacement;

(8) Solely with respect to any coverage available under Insuring Clause 6, Exclusion 7(b) of this coverage section is amended to read in its entirety as follows:

(b) based upon, arising from, or in consequence of any:

- (i) demand, suit or other proceeding which was pending against any **Insured**;
- (ii) search warrant, subpoena, notice of investigation or contact letter which was pending against any **Insured**; or

(iii) order, decree, or judgment entered for or against any **Insured**;

Deleted: ¶

on or prior to the applicable Pending or Prior Date set forth in Item 7 of the Declarations for this coverage section, or the same or substantially the same fact, circumstance, or situation underlying or alleged therein, including but not limited to any such **Claim** which is brought by or on behalf of the original claimant in any matter set forth in (i) or (ii) above or any other claimant.

(9) Exclusion 7(l) of this coverage section shall not apply to **Loss** on account of any **Regulatory Claim** under Insuring Clause 6 of this coverage section.

(10) No coverage will be available under Insuring Clause 6 of this coverage section for **Loss** on account of any **Regulatory Claim** made against any **Insured** based upon, arising from, or in consequence of:

- (a) the committing in fact of any dishonest or fraudulent act or omission or any willful violation of any statute or regulation by such **Insured**, if a judgment or other final adjudication establishes such dishonest or fraudulent act or omission or willful violation of any statute or regulation; or
- (b) such **Insured** having gained in fact any profit, remuneration or advantage to which such **Insured** was not legally entitled.

(11) Solely with respect to any coverage available under Insuring Clause 6, Subsection 24 Acquisition/Creation of Another Organization of this coverage section is amended to read in its entirety as follows:

24. If before the **Policy Period** any **Organization**:

- (a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or
- (b) acquires another organization by merger into or consolidation with an **Organization** such that the **Organization** is the surviving entity,

such other organization and its **Insured Persons** shall be **Insureds** under this coverage section, but only with respect to **Wrongful Acts** committed, attempted, or allegedly committed or attempted after such acquisition or creation unless the Company agrees, after presentation of a complete application and all other appropriate information, to provide coverage by endorsement for **Wrongful Acts** committed, attempted, or allegedly committed or attempted by such **Insureds** before such acquisition or creation. Notwithstanding the foregoing, no such coverage will be available under this coverage section for the following such acquired or created organizations:

<EXCLUENTITY>

If during the **Policy Period** any **Organization**:

- (a) acquires securities or rights in another organization or creates another organization, which as a result of such acquisition or creation becomes a **Subsidiary**; or
- (b) acquires another organization by merger into or consolidation with an **Organization** such that the **Organization** is the surviving entity,

such other organization and its directors, officers, and employees shall not be **Insureds** under this coverage section and no coverage shall be available to such other organization and its directors, officers, and employees unless the Company agrees, after presentation of a complete application and all other appropriate information, to provide coverage by endorsement for such other organization and its directors, officers, and employees.

- (12) If any **Regulatory Claim** is filed under seal, the **Insureds** shall, as a condition precedent to exercising any right to coverage under this coverage section, immediately upon becoming aware of such **Regulatory Claim** petition the applicable court, agency, or entity to allow such sealed information be provided to the Company.
- (13) The Company's maximum aggregate liability for all **Loss** on account of all **Regulatory Claims** shall be <SUBLIMIT>, which amount is part of and not in addition to the Company's maximum aggregate Limit of Liability for all **Loss** on account of all **Claims** first made during the **Policy Period** as set forth in Item 2(J) of the Declarations for this coverage section.
- (14) Item 5 Retention of the Declarations for this coverage section is amended to include the following:
 - (I) Insuring Clause 6 – Each **Regulatory Claim**: <RETENTION>
- (15) Item 7 Pending or Prior Date of the Declarations for this coverage section is amended to include the following:
 - (E) Insuring Clause 6: <P&PLITDATE>

The title and any headings in this endorsement/ rider are solely for convenience and form no part of the terms and conditions of coverage.

Deleted: ¶
¶

All other terms, conditions and limitations of this Policy shall remain unchanged.

<ENDSIG>

Authorized Representative

Health Care PortfolioSM

Federal Insurance Company (14-02-9524)

Forms Listing

Form Number / Edition Date	Title of Endorsement	Applicable Policy	Form Usage
14-03-0742LOGO (07/2008)	Health Care Portfolio SM for Health Care New Business Application with LOGO (For organizations with more than 250 employees)	Health Care Portfolio SM 14-02-9524	Mandatory if purchased
14-03-0743LOGO (07/2008)	Health Care Portfolio SM for Health Care New Business Application with LOGO (For organizations with up to 250 employees)	Health Care Portfolio SM 14-02-9524	Mandatory if purchased
14-03-0744LOGO (07/2008)	Health Care Portfolio SM for Health Care Renewal Application with LOGO	Health Care Portfolio SM 14-02-9524	Mandatory if purchased
14-02-10173 (09/2008) rev.	Regulatory Claim Coverage Endorsement <i>replaces previously approved form 14-02-10173 (10/2005)</i>	Health Care Portfolio SM 14-02-9524	Optional