

5. DOES APPLICANT EMPLOY PHYSICIANS, SURGEONS, DENTISTS, OR OTHER HEALTH CARE PROFESSIONALS, IN ANY MEDICAL CAPACITY EXCEPT TO PERFORM ADMINISTRATIVE DUTIES, PEER REVIEW OR UTILIZATION REVIEW FUNCTIONS? YES _____ NO _____ IF YES, GIVE PARTICULARS:

6. NUMBER OF EMPLOYEES, FULL AND PART TIME AND THEIR FUNCTIONS: _____

7. IS THE APPLICANT ENGAGED IN ANY BUSINESS OR PROFESSION OTHER THAN AS DESCRIBED IN ITEM 3? IF YES, EXPLAIN _____

8. **CREDENTIALING OF CONTRACTED HEALTH CARE PROVIDERS:**

a) HOW OFTEN DOES APPLICANT RE-CREDENTIAL CONTRACTED HEALTH CARE PROVIDERS? _____

b) HOW OFTEN DOES APPLICANT PERFORM ON-SITE VISITS OF CONTRACTED HEALTH CARE PROVIDERS?

c) DO YOU REFER TO OR CHECK ON CONTRACTED HEALTH CARE PROVIDERS WITH ANY AVAILABLE DATA BANKS DURING THE CREDENTIALING PROCESS? _____

d) DO YOU REQUIRE ALL CONTRACTED HOSPITALS TO BE JCAHO ACCREDITED? YES _____ NO _____

DOES APPLICANT REQUIRE ALL CONTRACTED HEALTH CARE PROVIDERS TO HAVE STAFF PRIVILEGES AT A JCAHO ACCREDITED HOSPITAL? YES _____ NO _____

e) ARE ALL CONTRACTED HEALTH CARE PROVIDERS REQUIRED TO MAINTAIN MEDICAL MALPRACTICE INSURANCE? YES _____ NO _____ WHAT MINIMUM LIMITS ARE REQUIRED? _____

- f) ARE ALL CONTRACTED HEALTH CARE PROVIDERS REQUIRED TO WARRANT THAT THEY MAINTAIN THIS INSURANCE IN FORCE DURING THEIR CONTRACT PERIOD WITH YOU? _____
- g) DO THEY PROVIDE YOU WITH CERTIFICATES OF INSURANCE? _____
- h) WHO DOES THE CREDENTIALING? _____

- i) IF THE CREDENTIALING IS SUB-CONTRACTED, DO YOU REVIEW OR AUDIT THE PROCESS? _____
DO YOU REQUIRE THE SUBCONTRACTOR TO CARRY PROFESSIONAL LIABILITY INSURANCE? _____

9. **OPERATIONAL PROCEDURES:**

- a) ARE YOU AWARE OF ANY HIV IMPAIRED PROVIDERS UNDER CONTRACT, AND IF SO, DO YOU HAVE ANY PROCEDURES OR RESTRICTIONS FOR HIV IMPAIRED PROVIDERS? _____
- b) ARE CLAIM DENIAL APPEAL PROCEDURES CLEARLY SPELLED OUT TO PLAN PARTICIPANTS?

- c) DO YOU HAVE A "FAST TRACK" APPEAL SYSTEM REGARDING DENIAL OF BENEFIT OR POSTPONEMENT OF BENEFIT PROCEDURES FOR ORGAN TRANSPLANTS, BONE MARROW TRANSPLANTS, OR ANY PROCEDURE THAT MAY SEVERELY IMPAIR THE QUALITY OF LIFE FOR AN ENROLLEE? _____

- d) DO YOU IDENTIFY TO SUBSCRIBERS THE PERSON WHO MAKES DECISIONS REGARDING APPEALS?

- e) WHO WRITES AND TRANSMITS DENIAL OF BENEFITS? _____
- f) DO YOU HAVE A PROFIT SHARING ARRANGEMENT OR ANY FINANCIAL INDUCEMENT ARRANGEMENTS WITH YOUR CONTRACTED HEALTH CARE PROVIDERS OR CLAIMS HANDLING ORGANIZATION? _____

g) DESCRIBE CLAIM HANDLING PROCEDURES FOR ENROLEES YOU INSURE: _____

10. **ADVERTISING**

- a) DO ALL CONTRACTS, SALES LITERATURE/BROCHURES CLEARLY STATE COVERED AND NON-COVERED PROCEDURES? _____ (PLEASE ENCLOSE SPECIMENS)
- b) DO CONTRACTS, SALES LITERATURE/BROCHURES USE THE TERMS "INVESTIGATIONAL" OR "EXPERIMENTAL"? _____
- c) IF THE ABOVE ANSWER IS YES, DO ALL CONTRACTS, SALES LITERATURE/BROCHURES DEFINE WHAT IS CONSIDERED "INVESTIGATIONAL" OR "EXPERIMENTAL"? _____
- d) DO SUCH CONTRACTS, SALES LITERATURE/BROCHURES CLEARLY STATE THAT YOU HAVE DISCRETIONARY AUTHORITY IN THE INTERPRETATION AND IMPLEMENTATION OF THE PLAN'S PROVISIONS? _____
- e) DO ALL CONTRACTS, SALES LITERATURE/BROCHURES CLEARLY ADDRESS AND DEFINE "ORGAN TRANSPLANTS"? _____
- f) DO YOUR LEGAL REPRESENTATIVES REVIEW AND APPROVE ALL CONTRACTS, SALES LITERATURE/BROCHURES PRIOR TO THEIR USE? _____
- g) ARE ALL CONTRACTED HEALTH CARE PROVIDERS ALWAYS REFERRED TO AS INDEPENDENT CONTRACTORS? _____
- h) DO YOU MAKE ANY BROAD WARRANTIES AS TO QUALITY OF HEALTH CARE, BROADNESS OF PLAN, ETC.? _____

11. **MARKETING OF HEALTH CARE:**

a) NUMBER OF SALES EMPLOYEES _____ NUMBER LICENSED _____

b) HOW ARE APPLICANT'S SERVICES SOLD? _____

c) PLEASE DESCRIBE ALL DUTIES OF SALES EMPLOYEES: _____

d) ARE APPLICANT'S SERVICES SOLD BY NON-EMPLOYEES? IF YES, PLEASE EXPLAIN _____

e) NATURE AND TYPE OF PRODUCT/S SERVICES SOLD:

_____	_____	%
_____	_____	%
_____	_____	%
_____	_____	%
	TOTAL	_____ %

f) ARE ALL SALES EMPLOYEES LICENSED? _____ IF NO, PLEASE DESCRIBE: _____

12. ENROLLMENT:

	<u>LAST 12 MONTHS:</u>	<u>NEXT 12 MONTHS:</u>
TOTAL NUMBER OF ENROLLEES	_____	_____
TOTAL NUMBER OF UR CASES	_____	_____
TOTAL NUMBER OF PATIENT VISITS/ENCOUNTERS	_____	_____

DISTRIBUTION OF ENROLLMENT:	STATE	# OF ENROLLEES	# OF VISITS/ENCOUNTERS
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

h) TOTAL NUMBER OF COMMON SHARES OUTSTANDING _____

i) TOTAL NUMBER OF COMMON STOCK SHAREHOLDERS _____

j) TOTAL NUMBER OF COMMON SHARES OWNED BY DIRECTORS (DIRECT AND BENEFICIAL) _____

k) TOTAL NUMBER OF COMMON SHARES OWNED BY OFFICERS (DIRECT AND BENEFICIAL) NOT DIRECTORS _____

l) IN THE EVENT ANY SHAREHOLDER OWNS 5 PERCENT OR MORE OF THE COMMON SHARES DIRECTLY OR BENEFICIALLY, DESIGNATE NAME AND PERCENTAGE OF HOLDINGS: _____

m) PLEASE DESIGNATE IF THERE ARE ANY OTHER SECURITIES CONVERTIBLE TO COMMON STOCK. IF SO, DESCRIBE FULLY _____

n) ATTACH COMPLETE LIST OF ALL DIRECTORS BY NAME AND AFFILIATIONS WITH OTHER CORPORATIONS.

o) ATTACH COMPLETE LIST OF ALL OFFICERS BY NAME AND AFFILIATIONS WITH OTHER CORPORATIONS.

15. HAS THE APPLICANT OR ANY SUBSIDIARY WITHIN THE PAST 36 MONTHS BEEN INVOLVED IN, OR CONTEMPLATE WITHIN THE NEXT 12 MONTHS BEING INVOLVED IN, ANY OF THE FOLLOWING: (IF YES, PLEASE DESCRIBE THE ESSENTIAL TERMS OF EACH SUCH TRANSACTION AS AN ATTACHMENT TO THIS APPLICATION.)

a) MERGER, ACQUISITION OR CONSOLIDATION WITH ANOTHER ENTITY _____ YES _____ NO

b) SALE, TENDER OFFER, DISTRIBUTION OR DIVESTITURE OF ANY ASSETS OR STOCK, OTHER THAN IN THE ORDINARY COURSE OF BUSINESS _____ YES _____ NO

c) ANY REGISTRATION FOR A PUBLIC OFFERING OR PRIVATE PLACEMENT OF SECURITIES? _____ YES _____ NO

16. HAS ANY DIRECTOR OR OFFICER IN THE PAST FIVE YEARS BEEN CHARGED OR CONVICTED OF ANY CRIMINAL ACT, OR IS ANY DIRECTOR OR OFFICER PRESENTLY THE SUBJECT OF A PENDING CRIMINAL PROCEEDING? _____ YES _____ NO

17. IF YES, PLEASE PROVIDE DETAILS: _____

18. **PRIOR HISTORY AND EXPERIENCE:**

GIVE MANAGED HEALTH CARE E & O / D & O COVERAGE FOR LAST FIVE YEARS FOR THE FIRM:

CARRIER	LIMIT	DEDUCTIBLE	PREMIUM	EXPIRATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

19. IF EXPIRING INSURANCE IS A CLAIMS-MADE POLICY, WHAT IS THE RETROACTIVE DATE? _____

a) LIST ANY MANAGED CARE PROFESSIONAL LIABILITY OR DIRECTORS & OFFICERS LIABILITY CLAIMS ACTUALLY MADE AGAINST YOU OR ANY PREDECESSOR FIRM IN THE PAST FIVE YEARS:

b) LIST ANY KNOWN INCIDENTS WHICH MIGHT GIVE RISE TO A PROFESSIONAL LIABILITY CLAIM:

c) HAS ANY INSURER CANCELLED OR REFUSED TO RENEW ANY SIMILAR INSURANCE DURING THE PAST FIVE YEARS? _____

20. LIMITS OF LIABILITY REQUESTED: _____ DEDUCTIBLE: _____

21. DESIRED TERM OF POLICY FROM: _____ TO: _____

THE APPLICANT DECLARES THAT THE ABOVE STATEMENTS AND REPRESENTATIONS ARE TRUE AND CORRECT AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MISSTATED. THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO SELL NOR THE APPLICANT TO PURCHASE THIS INSURANCE, BUT ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

THE APPLICANT UNDERSTANDS THAT ANY SUBSEQUENT CONTRACT ISSUED BY THE COMPANY WILL BE ISSUED ON A **CLAIMS-MADE FORM**.

DATE

SIGNATURE OF APPLICANT

TITLE

PLEASE INCLUDE THE FOLLOWING ADDITIONAL INFORMATION REQUIRED WITH THE APPLICATION:

9 ARTICLES OF INCORPORATION AND BY-LAWS.

9 SPECIMEN OF EACH TYPE OF CONTRACT AND SERVICE AGREEMENT USED BY THE APPLICANT FOR PROVIDERS, SUBSCRIBERS, OTHER.

9 PEER REVIEW PROCEDURES, UTILIZATION REVIEW PROCEDURES, AND CREDENTIALING PROCESS.

9 LATEST AUDITED FINANCIAL INFORMATION OR FORECASTED BUDGET.

9 ADVERTISING BROCHURES AND MARKETING MATERIALS.

9 CLAIM PROCESSING PROCEDURES, INCLUDING DENIAL OF BENEFITS PROCEDURES.

9 MOST RECENT CLAIM DEPARTMENT AUDIT PERFORMED BY OUTSIDE COUNSEL.

9 BUSINESS PLAN, IF IN BUSINESS LESS THAN THREE YEARS.

9 ORGANIZATIONAL CHART (IF MORE THAN ONE ENTITY).

9 COMPLAINT OR GRIEVANCE PROCESS.