APPLICATION FOR MANAGED CARE
ERRORS AND OMISSIONS LIABILITY POLICY

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE APPLIES, SUBJECT TO ITS TERMS, ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND ARE REPORTED TO THE UNDERWRITER IN WRITING DURING THE "POLICY PERIOD" OR WITHIN THE TIME PERIOD SET FORTH IN THE POLICY, OR TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE, AND REPORTED TO THE UNDERWRITER IN WRITING DURING THE EXTENDED REPORTING PERIOD OR WITHIN THE TIME PERIOD SET FORTH IN THE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS, OR JUDGMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE EXPENSES," AND "DEFENSE EXPENSES" SHALL BE APPLIED AGAINST THE RETENTION. READ THE ENTIRE APPLICATION BEFORE SIGNING.

ALL APPLICANTS MUST COMPLETE PART I OF THIS APPLICATION.

PART I. GENERAL INFORMATION, OPERATIONS, AND STRUCTURE

1. a) Name of Applicant: _________________________________________________________
   (Note: Wherever used, "Applicant" means this entity and any other entities listed in response to Question 3.)
   b) Address:____________________________________________________________________
      City: __________________________________________ State: ______ ZIP:________________
      Website:_________________________________ Telephone Number(____)________________
   c) Contact person and title: _____________________________________________________
      Email address:_____________________________ Telephone Number(____)________________
   d) Name of risk manager (if different than contact person): __________________________
      Email address:_____________________________ ______________________________

2. a) Applicant is:  □ For-Profit Corp.   □ Not-for-Profit Tax-Exempt Corp.
   □ Not-for-Profit Taxable Corp.   □ Limited Liability Company
   □ Partnership   □ Joint Venture
   □ Other (describe):____________________________________________________________
   b) Date of incorporation: ______________________ Date operations began: ______________
   c) State(s) where Applicant operates: ____________________________________________

3. If coverage is desired for any other entities (e.g., subsidiaries, joint ventures, or partnerships), please list each such entity below. If required, list additional entities on a separate attachment. (Attach additional information, if necessary.) Please note that coverage for such entities is not automatically available; the terms and conditions of the policy, if issued, will determine actual coverage.

<table>
<thead>
<tr>
<th>Name and Address</th>
<th>Relationship to Applicant</th>
<th>Description of Operations</th>
<th>Tax Status</th>
<th>Percent Owned</th>
</tr>
</thead>
<tbody>
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4. **Applicant** is:

- [ ] HMO (If so, please indicate: □ Staff Model □ Network or IPA Model □ Combined [both])
- [ ] PPO  □ PHO □ IPA □ MSO □ Medical Group or Clinic □ Third Party Administrator □ Utilization Review Organization □ Peer Review Organization □ Other (describe): __________________________

5. a) Is the **Applicant** licensed by federal, state, or local government? □ Yes □ No
   If “Yes,” identify the licensing government: __________________________

   b) Is the **Applicant** accredited or certified by any organization such as the National Committee for Quality Assurance (NCQA), URAC or any state or federal agency? □ Yes □ No
   If “Yes,” identify the accrediting or certifying organization(s) and expiration date of the accreditation: __________________________

   c) Has the **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: __________________________

6. **REVENUES:**

   a) Total Gross Revenues: __________________________  __________________________
   If this revenue number does not match that in the attached audited financials, please explain why.

   b) Total Gross Revenues from ASO/TPA enrollees: __________________________  __________________________

   c) Percent of Gross Revenues from “at risk” agreements: __________________________  __________________________
   (Note: Wherever used, “at risk” means capitation, withhold or bonus.)

7. **ENROLLMENT:**

   Total number of enrollees: __________________________  __________________________
   (Note: Wherever used, “enrollees” means covered lives not just covered employees and not member months.)
   If enrollees are in more than one state, provide breakdown by state on a separate attachment.

   a) Number of enrollees in managed care plan(s): __________________________  __________________________

   b) Number of enrollees in non-managed care plan(s): __________________________  __________________________

   c) Number of enrollees for whom the **Applicant** is providing ASO/TPA services only: __________________________  __________________________

8. **HEALTH CARE PROVIDER:**

   a) Total number of physicians under contract: __________________________  __________________________

      (1) Number of employed physicians: __________________________  __________________________

      (2) Number of independent contractor physicians: __________________________  __________________________

   b) Total number of non-physician health care professionals under contract: __________________________  __________________________

   c) Total number of hospitals under contract: __________________________  __________________________

   d) Total number of other facilities under contract (e.g., clinics, nursing homes, laboratories, pharmacies): __________________________  __________________________
e) Does Applicant require and verify that all contracted health care providers (physicians, hospitals, and others) maintain medical malpractice insurance with minimum limits of $1,000,000/$3,000,000? □ Yes □ No
   If “No,” what minimum limits are required? ____________________________

f) Provide details of the Applicant’s compensation or participation arrangements with contracted health care providers or attach copies of sample contracts. ____________________________________________________________


g) Does Applicant have any provider agreements in which the Applicant assumes responsibility for overseeing the quality of the services provided by the health care providers? □ Yes □ No

9. Please provide details of insurance/self-insurance/reinsurance currently in force (if none, so state):

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Insurance Carrier(s)</th>
<th>Limits</th>
<th>Deductible/Retention</th>
<th>Premium</th>
<th>Policy Period</th>
<th>If Claims Made, Retroactive Date</th>
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<tbody>
<tr>
<td>Medical Malpractice*</td>
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<td>D&amp;O*</td>
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<td>Fiduciary*</td>
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<td>Stop Loss*</td>
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<td>Insolvency*</td>
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<tr>
<td>Fidelity*</td>
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<tr>
<td>General Liability</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

* Would the Applicant be interested in proposals for these coverages? □ Yes □ No

10. a) Stock ownership of the Applicant:
   Total number of authorized common shares: _________
   Total number of outstanding common shares: _________
   Total number of common shareholders: _________
   Total number of common shares owned by the Applicant’s directors and officers: _________

b) As an attachment to this Application, please provide the names and number of shares for all persons or entities that presently own or control, or have stated the intention to acquire, of record or beneficially, more than 5% of the Applicant’s outstanding stock.

c) Have there been any changes in the Applicant’s board of directors or senior management within the past 3 years for reasons other than death or retirement? □ Yes □ No
   If “Yes,” please explain: ______________________________________________________
   ______________________________________________________


d) Number of Applicant’s: Full-time employees: ________________
   Part-time employees: ________________

e) Has the Applicant been involved in within the past 36 months, or does the Applicant contemplate being involved in within the next 12 months, any of the following, whether or not such transactions were or will be completed?
   (1) Merger, acquisition, or consolidation with another entity? □ Yes □ No
(2) Sale, distribution, or divestiture of any assets or stock, other than in the ordinary course of business? □ Yes □ No

(3) Any registration for a public offering or private placement of securities? □ Yes □ No

(4) Any joint ventures? □ Yes □ No

(5) Any new business activities or services? □ Yes □ No

(6) Any new Medicare or Medicaid contracts? □ Yes □ No

If “Yes” to any of the above, please explain and describe the essential terms of each such transaction either here or as an attachment to this Application:

_____________________________________________________________________________________

_____________________________________________________________________________________

11. List the primary professional groups or associations to which the Applicant belongs:

_____________________________________________________________________________________

_____________________________________________________________________________________

12. ANTITRUST MARKET POSITION:

a) Does the Applicant contract with more than 25% of the physicians in any given field of practice (including without limitation primary care, family practice, or any specialty) within its geographical service area? □ Yes □ No
   If “Yes,” please explain: ____________________________________________________________________________

b) Do the Applicant’s members control more than 25% of the hospital beds or specialty services within its geographic service area? □ Yes □ No
   If “Yes,” please explain: ____________________________________________________________________________

c) Does Applicant have exclusive contracts with any physicians, hospitals or other providers? □ Yes □ No

d) Has the Applicant obtained advice from antitrust legal counsel (particularly related to mergers, acquisitions and network development)? □ Yes □ No
   If “Yes,” please specify firm name: ________________________________________________________________________

e) Has the Applicant received an opinion from the Federal Trade Commission (FTC) confirming that their activities (such as developing joint ventures or new plans) will not violate antitrust laws? □ Yes □ No

f) Does the Applicant have any provider agreements that contain “Most Favored” pricing clauses? □ Yes □ No

g) Does the Applicant have any provider agreements that contain non-compete clauses? □ Yes □ No

13. ACTIVITIES OR SERVICES:

Please indicate those managed care activities or services which the Applicant performs or subcontracts now or intends to begin performing or subcontracting within the next 12 months (Note: not all checked services may be covered):

<table>
<thead>
<tr>
<th>Activity or Service</th>
<th>Yes For Others</th>
<th>For Fee</th>
</tr>
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<tbody>
<tr>
<td>a) Credentialing or peer review of</td>
<td>□ (Complete Part II) □ (Complete Part II)</td>
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<tr>
<td>health care providers</td>
<td></td>
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<tr>
<td>b) Utilization review</td>
<td>□ (Complete Part III) □ (Complete Part III)</td>
<td></td>
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</tbody>
</table>

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c) Drafting practice guidelines/critical pathways □ □ □ □

d) Case management □ □ □ □

e) Disease management □ □ □ □

f) Handling and adjusting of enrollees' health care benefit claims □ (Complete Part IV) □ □ (Complete Part IV)

g) Application or enrollment processing for enrollees of health care plans □ □ □ □

h) Billing/other processing of enrollees' claims under health care plans □ □ □ □

i) Advertising, marketing, or selling health care plans/products □ (Complete Part V) □ □ (Complete Part V)

j) Establishing health care provider networks to provide managed care □ □ □ □

k) Actuarial services for health care plans □ □ □ □

l) Assisting customers in securing reinsurance □ □ □ □

m) Services for automobile liability or disability plans (please describe):

n) Third party administration (TPA) services for health care plans (please describe):

o) Employee Assistance Program (EAP) services (please describe):

p) Nurse call line (please describe):

q) Any other services (please describe):

14. RISK MANAGEMENT:

a) Does the Applicant have a formal risk management program (i.e., a formal overall approach to avoiding situations that might give rise to a claim)? □ Yes □ No

   If “Yes,” please explain:

b) Does the Applicant have someone designated as a “legislative or executive” inquiry ombudsman (i.e., someone who investigates all problems or complaints once they rise to a certain level)? □ Yes □ No

c) Does the Applicant have contracts with any employers or other member groups in which the Applicant assumes any of the employer’s liability, fiduciary obligations or decision-making? □ Yes □ No
If "Yes", please explain and attach a copy of the contract: ________________________________

d) Does the Applicant subcontract for services such as Utilization Review or handling or processing of claims to any organization where the subcontracted services are performed outside of the United States? □ Yes □ No

e) HIPAA:

(1) Does the Applicant have a Privacy Officer? □ Yes □ No
(2) Does the Applicant have a Security Officer? □ Yes □ No
(3) Has the Applicant established a HIPAA team? □ Yes □ No
(4) Has the Applicant conducted a HIPAA risk analysis? □ Yes □ No
(5) Has the Applicant modified its policies and procedures such that they are consistent with the elements of HIPAA? □ Yes □ No
(6) Has the Applicant conducted HIPAA privacy training? □ Yes □ No
(7) Is employee and vendor adherence to confidentiality requirements audited? □ Yes □ No
(8) Does the Applicant have a plan for ongoing HIPAA privacy training? □ Yes □ No
(9) Does the Applicant have a policy and procedure to address the responsibilities of its "Business Partners" under HIPAA? □ Yes □ No

f) Compliance:

(1) Does the Applicant have a written Corporate Compliance program? □ Yes □ No
If "Yes," how long has it been in place? __________________________

(2) Does the Applicant have an employee hotline as a part of the Compliance program? □ Yes □ No
If "Yes," how many calls per month are made to the hotline? ______________

APPLICANT: PLEASE COMPLETE THE FOLLOWING SECTIONS WHICH CORRESPOND TO “YES” ANSWERS IN QUESTION 13 ABOVE. IF NO CORRESPONDING SECTIONS ARE INDICATED, PLEASE PROCEED TO PART VI.

PART II. CREDENTIALING OR PROVIDER SELECTION OF HEALTH CARE PROVIDERS

15. Total revenue for credentialing/peer review services performed for others for a fee:          Last 12 months  Next 12 months
                                           $_____________  $_____________

16. a) Who does the credentialing of contracted health care providers?                    Applicant: □ Yes □ No
     Subcontractor: □ Yes □ No
     Other: __________ □ Yes □ No

b) If credentialing is subcontracted:

(1) Does the Applicant review or audit the process? □ Yes □ No

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(2) Is subcontractor required to maintain errors and omissions insurance? □ Yes □ No

(3) What minimum limits are required? ________________________________

(4) Does the Applicant indemnify the subcontractor? □ Yes □ No

(5) Does the subcontractor indemnify the Applicant? □ Yes □ No

17. Does the Applicant have written policies and procedures in place for provider selection, credentialing, re-credentialing, and making decisions which adversely affect a provider's credentials? □ Yes □ No

a) Do the written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws? □ Yes □ No

b) Are the procedures given to health care providers? □ Yes □ No

c) Is legal counsel consulted before any recommendation or decision which adversely affects a provider's privileges or credentials becomes final? □ Yes □ No

d) Are all providers offered a hearing or appeal prior to termination? □ Yes □ No

If “No,” please explain:

__________________________________________
__________________________________________

18. Does the Applicant query the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank or the Federal or State Medical Boards as part of the credentialing process? □ Yes □ No

19. How often does the Applicant re-credential contracted health care providers? __________________________________________

20. Does the Applicant perform on-site visits of contracted health care providers? □ Yes □ No

If “Yes,” how often? ____________________________

21. Does the Applicant restrict the practice of any health care provider who has a mental or physical disorder which may impair his/her ability to practice? □ Yes □ No

If “Yes,” please explain:

_____________________________________________________________________________________

22. Have any providers been removed or disqualified from the Applicant's panel in the last 12 months? □ Yes □ No

If “Yes,”

a) How many for credentialing or professional conduct reasons? _________

b) How many for reasons other than professional competence? _________

c) Is complete documentation maintained on all terminations? □ Yes □ No

PART III. UTILIZATION REVIEW

23. a) Please specify number or percentage (%) of enrollees by type of payor. If utilization review services are performed for others for a fee, indicate amount or percentage (%) of revenue generated by type of payor.
<table>
<thead>
<tr>
<th>Type of Payor</th>
<th>No./% Enrollees Last 12 Months</th>
<th>No./% Enrollees Next 12 Months</th>
<th>Amt./% Revenue Last 12 Months</th>
<th>Amt./% Revenue Next 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private (non-government) employer plans or trusts</td>
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<tr>
<td>Government employer plans</td>
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<tr>
<td>Union plans</td>
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<tr>
<td>Medicare or Medicaid plans</td>
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<tr>
<td>Other</td>
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</table>

b) Total revenue for utilization review services performed for others for a fee:

<table>
<thead>
<tr>
<th>Last 12 months</th>
<th>Next 12 months</th>
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<tbody>
<tr>
<td>$ ____________</td>
<td>$ ____________</td>
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</table>

24. a) Who does utilization review?

| Applicant: | □ Yes □ No |
| Subcontractor: | □ Yes □ No |
| Other: | □ Yes □ No |

b) Percentage of benefits denied/avoided in the utilization review process (e.g. denial rate):

(1) Last 12 months (actual): ____________ %
(2) Next 12 months (projected): ____________ %

c) Number of full-time equivalent (FTE) reviewers: ____________

Number of part-time equivalent (PTE) reviewers: ____________

d) If utilization review is subcontracted:

(1) Does the Applicant review or audit the process? □ Yes □ No
(2) Is the subcontractor required to maintain errors and omissions insurance? □ Yes □ No
(3) What minimum limits are required? ________________________________
(4) Does the Applicant indemnify the subcontractor? □ Yes □ No
(5) Does the subcontractor indemnify the Applicant? □ Yes □ No

e) Does the Applicant have written policies and procedures for utilization review, including for denials and appeals? □ Yes □ No

If “Yes,” do such policies and procedures follow NCQA or URAC standards and comply with all applicable laws? □ Yes □ No

f) Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the person who makes decisions regarding appeals? □ Yes □ No

g) Does a physician review all proposed denials of benefits prior to issuance of the denial? □ Yes □ No

h) Are external reviewers involved in the final level of review before appeal? □ Yes □ No

i) Is legal counsel consulted when considering appeals? □ Yes □ No

i) Does the Applicant have a “fast track” appeal system regarding denial of benefits or postponement of benefit procedures for organ transplants or any other procedure which may severely impair the quality of life for an enrollee if not performed? □ Yes □ No
k) How long does the **Applicant** maintain documentation regarding a denial? ________________

l) Does the **Applicant** use practice guidelines as part of its utilization review procedures? □ Yes □ No
   If “Yes,” do guidelines state in writing that physician’s judgment may override a guideline? □ Yes □ No

m) Does the **Applicant** utilize profit sharing, risk sharing or other financial incentives in its compensation arrangements with utilization reviewers? □ Yes □ No

n) Does the **Applicant** utilize the same specialty reviews for benefit/coverage denials? □ Yes □ No

o) Does the **Applicant** adhere to government mandated external review requirements in the states where it operates? □ Yes □ No

p) Does the **Applicant** have an external review process in those states where external review is not mandated? □ Yes □ No

q) What percentage of decisions which go through the external review process are ultimately decided in favor of the enrollee?
   (1) Last 12 months (actual): ____________ %  (2) Next 12 months (projected): ____________ %

25. Attach a sample copy of a utilization review denial letter (with the identity of the enrollee removed).

**PART IV. HANDLING AND ADJUSTING OF ENROLLEES’ HEALTH CARE BENEFIT CLAIMS**

26. Total revenue for claims handling and adjusting services performed for others for a fee: ___________________ ___________________

27. a) Number of claims processed: ___________________ ___________________

   b) Number of FTE claim adjusters: ___________________ ___________________

   c) Number or percentage of PTE claim adjusters: ___________________ ___________________

   d) Percentage of claims denied: ____________% __________________%

   e) Who does the handling and adjusting of claims for health care benefits?

      **Applicant:** □ Yes □ No

      **Subcontractor:** □ Yes □ No

      **Other:** □ Yes □ No

   f) If claim handling and adjusting are subcontracted:

      (1) Does the **Applicant** review or audit the process? □ Yes □ No

      (2) Is the subcontractor required to maintain errors and omissions insurance? □ Yes □ No

      (3) What minimum limits are required? ________________________________

      (4) Does the **Applicant** indemnify the subcontractor? □ Yes □ No

      (5) Does the subcontractor indemnify the **Applicant**? □ Yes □ No

   g) Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claim handlers or adjusters? □ Yes □ No
PART V. ADVERTISING/MARKETING/SALES

28. a) Do all contracts, sales literature, and brochures expressly identify covered and non-covered procedures? □ Yes □ No

b) Do any contracts, sales literature, or brochures use the term(s) “investigative” or “experimental” procedures? □ Yes □ No

If “Yes”:
(1) Do all such materials define what is considered “investigative” or “experimental”? □ Yes □ No

(2) Do all such materials clearly state that the Applicant has discretionary authority in the interpretation and administration of the plan’s provisions? □ Yes □ No

c) Do contracts, sales literature, and brochures expressly refer to all contracted health care providers as independent contractors? □ Yes □ No

d) Do any contracts, sales literature, or brochures make statements or warranties as to the quality of health care, breadth of plan, providing all the needed care or being the “best” plan, etc.? □ Yes □ No

e) Does the Applicant’s legal counsel review and approve all contracts, sales literature, brochures, advertisements, and other marketing materials prior to their use? □ Yes □ No

f) Are enrollee satisfaction surveys conducted? □ Yes □ No

If “Yes,” how often? ____________________________

g) Please attach or describe the results from the most recent enrollee survey: ____________________________

PART VI. CLAIMS INFORMATION

29. During the past five (5) years, no claims such as would fall within the scope of the proposed insurance have been made against the Applicant or any individual or entity proposed for coverage, except as follows (include loss payments and defense costs). If answer is none, so state: ________________________________________________________________

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 29 IS EXCLUDED FROM THE PROPOSED INSURANCE.

30. 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, except as follows. If answer is none, so state: ________________________________________________________________

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 30 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 30 IS EXCLUDED FROM THE PROPOSED INSURANCE.

31. 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 answer is none, so state: ________________________________________________________________
NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, 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 31 IS EXCLUDED FROM THE PROPOSED INSURANCE.

PART VII. ATTACHMENTS

32. Please attach copies of the following documents to this Application. These documents shall be a part of this Application:

a) Applicant's last 2 audited or accountant-prepared financial statements with notes;

b) Most recent actuarial report, if applicable;

c) If the Applicant is newly formed, Pro Forma financial statements;

d) If the Applicant is newly formed, Business Plan;

e) Applicant's by-laws;

f) The names, occupations, and business affiliations of all of the Applicant's directors and officers;

g) Applicant's organization chart;

h) Written utilization review procedures, including procedures for denials of benefits and appeals;

i) Written credentialing and peer review procedures;

j) Sample contract(s) with health care providers (physicians, hospitals, and others);

k) Sample contract(s) with enrollee(s) or membership handbook;

l) Sample contracts with vendors;

m) Sample TPA or ASO contract(s);

n) Sample sales literature, brochures, advertisements, and other marketing materials (including enrollee packet);

o) Privacy policies and procedures; and

p) Sample consent forms.

PART VIII. SIGNATURES

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract.

The information contained in and submitted with this Application is on file with the Underwriter, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.
The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant will immediately notify the Underwriter, and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand:

a) the policy, if issued, shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Underwriter in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period, if applicable and reported to the Underwriter in writing during the Extended Reporting Period or within the time period set forth in the policy; and

b) the limit of liability available under the policy, if issued, to pay damages, settlements, or judgments shall be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

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

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 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 or an application containing any false or misleading information is guilty of a felony of the third degree.

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

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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 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.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO 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.

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<th>APPLICANT</th>
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<td>BY (Chairman and/or President)</td>
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NOTE: This Application must be signed by the Chairman and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

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<th>PRODUCED BY (Insurance Agent)</th>
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| ADDRESS (No., Street, City, State, and ZIP Code) | |

| EMAIL ADDRESS | |

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