Lexington Insurance Company

Administrative Offices: 100 Summer Street, Boston, MA 02110

Application
Managed Care Risk Solutions℠

NOTICE: THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. COVERAGE IS ONLY PROVIDED FOR CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO US DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.

NOTICE: CLAIMS EXPENSES (WHICH INCLUDE ALL ATTORNEY FEES) ARE INCLUDED WITHIN AND REDUCE THE APPLICABLE LIMIT OF LIABILITY. CLAIMS EXPENSES ARE INCLUDED WITHIN AND REDUCE THE DEDUCTIBLE OR SELF INSURED RETENTION, WHICHEVER IS APPLICABLE.

The words "**you**" and "**your**" refer to the Applicant named in Section 1.a. below. If your answer to any question in this Application requires additional space, please complete your answer on an attachment. This Application and its respective attachments and any other related information, documentation or correspondence you provide or indicate is available on a website will be considered part of this Application.

Required Attachments:

a. Loss History for the last five years. The loss run should be updated within the last 30 days and include claim descriptions, breakdown of total incurred losses (paid and reserves for indemnity and expense), respective deductibles or retentions and full details on all losses paid or outstanding in excess of $25,000. Any non-Lexington loss runs must include open claim reserve amounts. If reserves are not disclosed, the applicant must provide full details on the claim. Details should include an evaluation from outside counsel with potential claim estimates and estimated defense costs.
b. **Your** most recent Audited Financials or Interim Financials with Treasurer's Warranty.
c. If start-up operation or in business less than 2 years, your business plan including your pro forma budget and resume of principal officers
d. Any other information **you** feel will help us understand **your** business.

1. General Information

Coverage for any subsidiaries, affiliates, partnerships or joint ventures must be specifically endorsed onto the Policy. Coverage may not be automatically available for all entities or services.

a. Full Name of Applicant:_____
   Address:_____
b. Policy effective date:_____Policy expiration date:
   Policy Retroactive date:
c. State of Incorporation:_____ Date Established:_____
d. Risk Manager/Contact:_____
   Email Address:_____
e. Applicant Home Page Website Address:_____
f. Ownership: □ Privately Held □ Publicly Traded
   □ For Profit □ Not For Profit
   □ Partnership □ Joint Venture
   □ Limited Liability Company
g. Organization Type:
   □HMO __IPA Model __Staff Model __Mixed Model __Provider Owned
   □PPO □IPA
   □PHO □MSO
   □ Peer Review Organization □TPA
   □Utilization Review Organization □Consumer Driven Provider
   □Are any of above a Dental or Vision only organization: □ Yes □ No
   □OTHER (Describe):_____

h. States of Operation (List States):

2. Exposure Information

Please complete the following tables or attach an internal enrollment breakdown.

Please insert the time frame you are tracking the exposure information (i.e. 9/30/07-9/30/08)

Healthcare Membership:	As of the Current Date	Projected in 12 Months	As of 12 Months Ago
(Include all Healthcare Services (HMO, PPO, etc.))	__/__/__	__/__/__	__/__/__
Commercial			
Medicare/Medicaid			
Individual			
Administrative Services Only (ASO)			

Providers:

Number of Contracted Physician Providers			
Number of Contracted Hospitals			

Service Revenue:	Most Current 12 Months	Projected 12 Months	Previous 12 Months
(Revenue paid by unaffiliated 3rd parties)	__/__/__ to __/__/__	__/__/__ to __/__/__	__/__/__ to __/__/__
Utilization Review / Case Management			
Claims Administration (other than solely bill review, repricing or network access)			
Bill review, repricing, network access			
MSO Services			
Peer Review/QIO			
Other (Describe):			

3. Limits of Insurance and Deductible/Retention Options

If you choose a Deductible the Limits of Insurance will be eroded by such Deductible. If you choose a Retention the Limits of Insurance will be in addition to the Limits of Insurance.

Limits of Insurance	□Deductible	□Retention
□1,000,000 each claim/1,000,000 policy aggregate	□$7,500	
□2,000,000 each claim/2,000,000 policy aggregate	□$10,000 each claim	
□3,000,000 each claim/3,000,000 policy aggregate	□$15,000 each claim	
□4,000,000 each claim/4,000,000 policy aggregate	□$25,000 each claim	
□5,000,000 each claim/5,000,000 policy aggregate	□$50,000 each claim	
□Other: _____	□Other:_____	

4. Additional Named Insured Information

Do you desire coverage for subsidiaries, joint venture or partnerships scheduled as Additional Named Insureds?
□Yes □No

If yes, please provide the following details listed below and be sure to include the exposure information in question #2 for all entities to be insured. Please provide attachment if necessary

Name	Address	Relationship to	Description of	Tax	%	Date

		the Applicant	Operations	Status	Owned	Acquired/ Formed
						__/__/__
						__/__/__
						__/__/__
						__/__/__

.

5. Existing Insurance Information

Carrier: _____

	E&O	D&O	EPLI
Limits			
SIR/Deductible			
Effective Date			
Retro Date			
Add'l Coverage			
Premium			

6. Claims Information

a. Do you have any claims or suits brought against you in the past 5 years? □Yes □No
If yes, please attach carrier or Self insured loss run.

b. Have you ever had any antitrust claims? □Yes □No
If yes, please attach full description.

c. Have you ever had any class action lawsuits? □Yes □No
If yes, please attach full description.

7. Operational Information

a. Do you own or operate or supervise any medical facility? □Yes □No

b. Do you employ any healthcare providers except to perform administrative duties? □Yes □No

c. Are all services provided under a written contract? □Yes □No

d. Do you have plans for a merger, acquisition, consolidation? □Yes □No
If yes, please provide a narrative describing details, including whether it has been approved by board, shareholders &/or regulatory entity.

e. Have you been under any supervision order, receivership bankruptcy, or similar protection in the last 5 years? □Yes □No
If yes, please provide written description on a separate page.

f. Have you been subject to administrative proceedings, fines penalties, sanctions or like punishments in the last 5 years? □Yes □No
If yes, please provide written description on a separate page.

g. Do legal representatives review & approve all of your contracts, contract amendments & sales literature prior to their use, including amendments or revisions? □Yes □No
If yes, please provide a written explanation on a separate page.

h. Are your marketing materials subject to state regulations? □Yes □No

i. Do you follow NCQA guidelines for credentialing ? □Yes □No
If no, please provide a written explanation on a separate page.

j. Who does your credentialing? _____

k. If you subcontract credentialing, what minimum professional liability insurance do you require? _____

l. Do you audit the credentialing vendor? □Yes □No

m. What minimum medical malpractice insurance limits do you require for contracted providers:
□$1,000,000 or greater and/or limits meet a patient compensation fund requirement
□ less than $1,000,000

n. Do your utilization review, denial and appeal procedures comply with NCQA & URAC standards? □Yes □No
If no, please provide a written explanation on a separate page.

o. Do you use independent external review? □Yes □No

p. Do you abide by independent external review decisions? □Yes □No

q. Do you use financial incentives or profit sharing to compensate utilization reviewers? □Yes □No
If yes, please provide written description on a separate page

r. Do you have cancellation or rescission goals or bonuses for Departments or individuals assigned to review coverage applications? □Yes □No
If yes, please provide written description on a separate page

s. Do you subcontract any services overseas? □Yes □No
If yes, please provide written description on a separate page including the type of services and where they are performed.

t. Do you develop and/or license software to others for a fee? □Yes □No
If yes, please provide written description on a separate page

8. Historical Information

a. **New Lexington Business Only**:

1. In the past 5 (five) years, has any claim been made against you including any director, officer or employee of the Applicant, arising out of any of your operations described in this Application that is not set forth on your Loss History submitted with this Application?
□Yes □No If yes, please explain._____

2. Do you or any principal, owner, partner, or employee know of any incident, act, error or omission that is reasonably likely to result in a claim or suit against you or any of your predecessor firms, if any? □Yes □No
If yes, please explain._____
If you answer "Yes" to question a. 1 or 2, please attach full details.

3. Have all matters in Questions a. 1 and 2 been reported to the Applicant's former or current insurer(s)?
□Yes □No

b. **Lexington Renewal Accounts**:

1. Number of continuous years insured by Lexington Insurance Company:
□5 or more □ 3-4 years □ Less than 3

2. If seeking Limits of Liability higher that expiring Limits of Liability or coverage for new services or a new entity, you must answer the following:

Are you aware of any incident, act, error or omission that is reasonably likely to result in a claim or suit against you or any of your predecessor firms, if any? □Yes □No
If yes, please explain._____

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY

PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

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

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

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

NOTICE TO MAINE 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 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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

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 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THIS APPLICATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE.
This application must be signed by an officer or principal of the Applicant

_____	_____
Signature (Authorized Officer or Director of the Applicant)	Title
_____	_____
Print Name	Date
_____	_____
Producer Signature	License Number
_____	_____
Producer / Print Name	Date