Custom Assurance
PLACEMENTS, LTD.
A SPECIALTY LINES INSURANCE BROKER

Application

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 INFORMATION:

1. 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 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.
2. Most Recent **Audited** Financials.
3. Specimen copy of plan documents and summary plan descriptions.
4. Specimen provider and vendor contracts.
5. Specimen Credentialing and Utilization Review Procedures.
6. Sample denial letter.
7. Any other information **you** feel will help us understand **your** business.

SECTION 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.

1. Full Name of Applicant:_____
2. Address:_____
3. Policy effective date:_____Policy expiration date: _____
   Policy Retroactive date: _____
4. State of Incorporation:_____ Date Established:_____
5. Risk Manager/Contact:_____
6. Email Address:_____
7. Applicant Home Page Website Address:_____
8. Tax Status: □For Profit □Joint Venture
   □Not For Profit (taxable) □MEWA or MET
   □Not For Profit (non-taxable) □Other (Describe)
   _____

9. States of Operation (List States): _____
10. Do you desire coverage for subsidiaries, joint venture or partnerships? ☐Yes ☐No
    If yes, please provide the following details listed below. Please provide attachment if necessary.
    Please be sure to include the respective exposure information in question below.

Name and Address	Relationship to Applicant	Description of Operations	Tax Status	% Owned	Date Acquired/Formed

SECTION 2. LIMITS OF INSURANCE AND DEDUCTIBLE/SELF INSURED RETENTION

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:_____	

SECTION 3. DESCRIPTION OF OPERATIONS

1. Structure of your Health and Welfare Benefit Program:
   Self Insured ☐ Insured ☐
   If Self Insured:
   a. Per Claim retention amount $_____
   b. Annual Aggregate retention amount $_____
   c. Claims are handled
      ☐ by internal staff ☐ Number of internal claims staff: _____
      ☐ by an outside TPA ☐ Name of TPA: _____
2. Applicant purchases healthcare services for: ☐ Exclusively for its own employees
   ☐ On behalf of multiple employers
3. Do you contract directly with providers (e.g. physicians, surgeons, hospitals, etc.)? ☐Yes ☐No
   IF YES, PLEASE COMPLETE SECTION 5 – CREDENTIALING.
4. Please list all health plan, network, vendor or Insurer available through the Applicant:

Name of Plan, Network, Insurer or Vendor	Type of Benefit Provided (Vision, Medical, Dental)	Type of Plan (HMO, PPO, TPA, POS, Indemnity, Consumer Driven Plans etc.)	Number of Enrollees(Covered Lives and Dependents)		
			Current	Previous 12 Months	Next 12 Months

5. Does your employee healthcare benefit plan include a Global Healthcare Outsourcing (Medical Tourism) option?
☐Yes ☐No **IF YES, COMPLETE BELOW AND SECTION 7 – GLOBAL HEALTHCARE OUTSOURCING**

Name of Plan, Network, Insurer, Vendor or Intermediary	Type of Benefit Provided (Types of Surgeries)	Number of Enrollees using benefit Current	Number of Enrollees using benefit Previous 12 Months	Number of Enrollees using benefit Next 12 Months

6. Do you own, operate, or supervise a hospital, inpatient or outpatient clinic, pharmacy, dispensary, or any other medical facility? ☐Yes ☐No
If yes, please provide details:_____
Do you employ any health care professionals except to perform administrative duties, peer review or utilization functions? ☐Yes ☐No
If yes, please provide details:_____
7. Do you require all subcontractors carry Professional Liability Insurance? ☐Yes ☐No
Minimum Limits Required: _____
8. Is the applicant currently or ever been under any supervision order, receivership, bankruptcy or similar protection? Or, is the applicant currently under or ever been subject to administrative proceedings, fine, penalties, sanctions or like punishments. If yes, please explain in detail. ☐Yes ☐ No

_____

SECTION 4. ADVERTISING

1. Who prepares plan documents/communications to enrollees? ☐Applicant ☐Vendor
2. Do your legal representatives review and approve all plan documents, contracts and sales literature/brochures prior to their use, including any amendments or revisions? ☐Yes ☐No
3. Are your marketing materials subject to state regulations? ☐Yes ☐No

SECTION 5. CREDENTIALING

PLEASE COMPLETE THIS SECTION ONLY IF YOU CONTRACT DIRECTLY WITH PROVIDERS

1. Please provide the following exposure information:

	# For Last 12 Months	# For Next 12 Months
Providers under Direct Contract		
Hospitals under Direct Contract		
Providers Available through Network Vendor		

2. Do you follow NCQA guidelines for credentialing? **If no, please provide details:** ☐Yes ☐No
3. How often does applicant recredential contracted health care providers? _____
4. How often does applicant perform on-site visits of contracted health care providers? _____
5. Are all contracted health care providers required to maintain medical malpractice insurance?
What minimum limits are required? _____ ☐Yes ☐No
5. Do you provide details on the appeal process to providers who are not approved /accepted into your network as part of the credentialing process? ☐Yes ☐No
Please provide a sample non-acceptance letter.
6. If the credentialing is sub-contracted, do you review or audit the process? ☐Yes ☐No

SECTION 6. UTILIZATION REVIEW AND COST CONTAINMENT

1. Who performs the Utilization Review/Cost Containment function?_____

IF THE APPLICANT PERFORMS THE UTILIZATION REVIEW/COST CONTAINMENT FUNCTION, PLEASE COMPLETE QUESTIONS #3-5.

2. 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.
3. Do you use independent external review? ☐Yes ☐No
4. Do you abide by independent external review decisions? ☐Yes ☐No

SECTION 7. GLOBAL HEALTHCARE OUTSOURCING

1. Please list the medical facilities within your overseas provider network

Name of Provider	Address	Country	JCI Accredited	Approved Procedures	Date Provider Added to Network
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

2. Are any of the providers listed in 1. above owned, supervised, or operated by or affiliated with any medical facility based in the United States? ☐Yes ☐No
   If Yes, please name the parties and describe the relationship between them: _____
3. Do you require that the providers listed in 1. above carry medical malpractice insurance coverage? ☐Yes ☐No
   If Yes, what limits of liability must the provider(s) carry? _____
4. Do you use a vendor or intermediary to access care to foreign medical services? ☐Yes ☐No
   If Yes, What is the name of the vendor?_____
5. What minimum professional liability insurance limits do you require of the vendor or intermediary?_____
6. Please attach a copy of the contract(s) between you and any vendor or intermediary you utilize.
7. Do you or the vendor provide the following:
8. Credential providers within your overseas provider network? ☐Yes ☐No
   a. Select providers within your overseas provider network? ☐Yes ☐No
   b. Is there an on site inspections of the overseas facilities? ☐Yes ☐No
   c. Assess the appropriateness of overseas healthcare for each employee seeking such overseas healthcare? ☐Yes ☐No
      If Yes, please describe the procedures used to assess this._____
   d. Arrange for medical consultation(s) with overseas medical provider(s) for employees electing to receive overseas healthcare? ☐Yes ☐No
      If No, please describe how/if such consultations are arranged. _____
   e. Recommend a specific medical provider within your network to an employee seeking an overseas medical procedure? ☐Yes ☐No
   f. Arrange for and/or coordinate the transport and return of the employee's medical records? ☐Yes ☐No
   g. Arrange for and/or coordinate travel for employees seeking overseas healthcare? ☐Yes ☐No

h. Arrange for and/or coordinate continuity of medical care for employee(s) upon return to the United States? ☐Yes ☐No
Explain:_____
i. Provide the enrollee with an informed consent form? ☐Yes ☐No
j. Explain surgical complications? ☐Yes ☐No
k. Explain specific legal recourse for each country against treating providers? ☐Yes ☐No

9. Are the medical facilities staffed with English speaking providers or foreign patient services center? ☐Yes ☐No
10. Are the medical records written in English? ☐Yes ☐No
11. How do you or the vendor ensure the privacy of the employee's medical records?

_____

12. Do you provide any financial incentives to employees who elect an overseas medical procedure? ☐Yes ☐No

If Yes, please check all that apply:

☐ Reduce healthcare deductibles ☐ Cover travel for a spouse/companion
☐ Provide extended time-off ☐ Split some/all of the savings
☐ Cover travel expenses Other, Please describe

13. Can an employee choose to receive a medical procedure from a provider in the US if there is a less expensive and equally qualified overseas provider? ☐Yes ☐No
14. Can the employee choose any overseas medical provider within your network or is the overseas provider chosen on behalf of the employee? ☐Yes ☐No
15. How long have you offered a Global Healthcare benefit option to your employees?_____
16. Please complete the following for each year since you have offered a Global Healthcare benefit option to your employees:

Year	Employee Breakdown - Number electing overseas medical procedures	Provider Breakdown Number and Type of Procedures by Overseas Provider

17. To your knowledge, has any employee who has elected to receive care from your overseas medical provider network:
    a. Required longer than anticipated time-off from work? ☐Yes ☐No
    b. Required care or incurred reimbursable medical expenses beyond what you anticipated? ☐Yes ☐No
    c. Become permanently disabled or disfigured? ☐Yes ☐No

18. Please attach a copy of Global Healthcare benefit materials you provide to your employees.

SECTION 8. HISTORICAL INFORMATION

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

2. Does 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 the Applicant or any of its predecessor firms, if any? ☐**Yes** ☐**No**
   If yes, please explain._____

If you answer "Yes" to question 1 or 2, please attach full details.

It is agreed that with respect to questions 1 and 2 above, of such knowledge, information or involvement exists, any claim or action arising therefrom is excluded from the proposed coverage.

3. Are you currently insured for healthcare purchasing professional liability? ☐**Yes** ☐**No**
   If yes, please provide: Company/limits/retro date/deductible or SIR/annual premium _____
   _____

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
_____	_____
Custom Assurance Placements, Ltd. PO Box 5736, Columbia, SC 29250-5736 Phone: (803) 799-1770 Fax: (803) 799-1817	Date