Epack 3

Supplemental Application
Healthcare Organizations

Instructions for Completing this Supplemental Application

This is a fillable PDF Document.

Please answer all questions fully. If necessary, please provide additional responses in a supplemental document on your letterhead attached to this Supplemental Application.

Upon completion the Supplemental Application must be signed and dated by an authorized representative of the Applicant.

Please also attach to this Supplemental Application financial statements for the prior 2 years (audited if prepared) and a copy of the partnership agreement if the Applicant is a partnership.

NOTICES

This is a Supplemental Application which must be completed if the Applicant is applying for coverage for any healthcare entity. This Supplemental Application is part of and will be deemed incorporated into the New Business, Small Business, or Renewal Application, or the application of another insurance carrier (all referred to as "Application"), whichever is applicable, and is subject to all notices, representations, and warranties set forth in the Application.

I. APPLICANT INFORMATION

The Applicant to be named in Item 1. of Declarations (the "named insured"): _____

II. GENERAL INFORMATION

1. Please indicate the Applicant's nature of operations below:

Aging Services (Long term care facilities/nursing homes)	_____	Hospital	_____
Ambulatory Care/Surgery Center	_____	Managed Care	_____
Behavioral Health/Psychiatric Facility	_____	Physician Groups and Clinics	_____
Home Healthcare/Hospice	_____	Other	_____

If you marked "Other" above, please provide complete details:

_____

2. Does the Applicant purchase the following:
   a. Healthcare/Medical Professional Insurance? ◯ Yes ◯ No
   b. Cyber/Privacy Insurance? ◯ Yes ◯ No

   If you answered "Yes" to any of the above, please provide description of insurance program including carrier(s) and limits purchased: _____

3. Does the Applicant or any Subsidiary perform Medical Review and Provider Selection? ◯ Yes ◯ No

   If you answered "Yes" above, please continue below:
   a. Does the Applicant or any Subsidiary have written policies and procedures in place regarding Medical Review and Provider Selection? ◯ Yes ◯ No
   b. Does the Applicant or any Subsidiary consult with outside counsel before any recommendation or decision is finalized that could adversely affect privileges, credentials, or healthcare staff membership? ◯ Yes ◯ No

4. Does the Applicant or any Subsidiary control more than 20% of the market share in any geographical area of any of the following?

   If you answer "Yes" to any of the following, please provide market share percentage:
   a. Providers in any field of practice? ◯ Yes ◯ No Market share percentage _____ %
   b. Hospital beds? ◯ Yes ◯ No Market share percentage _____ %
   c. Healthcare services? ◯ Yes ◯ No Market share percentage _____ %

5. Does the Applicant or any Subsidiary have any provider agreements which contain non-compete, "most favoured" pricing clauses, or other preferential terms? ◯ Yes ◯ No

   If you answered "Yes" above, please provide complete details: _____

6. Does the Applicant or any Subsidiary have exclusive contracts with any providers or hospitals? ◯ Yes ◯ No

   If you answered "Yes" above, does the Applicant or any Subsidiary consult with outside counsel before entering into exclusive contracts: ◯ Yes ◯ No

7. Does the Applicant consult with outside counsel for an antitrust opinion on all mergers, acquisitions, or affiliations? ◯ Yes ◯ No

8. Does the Applicant have a Compliance Officer? ◯ Yes ◯ No

   If you answered "Yes" above, does Compliance Officer have direct access to the Board of Directors: ◯ Yes ◯ No

9. Does the Applicant currently have a compliance program in place? ◯ Yes ◯ No

   If you answered "Yes" above, please provide:
   a. The date it was implemented: _____
   b. The date it was last updated: _____

10. Does the Applicant provide annual internal training and education programs regarding the following:
    a. Compliance? ◯ Yes ◯ No
    b. Privacy and data security (including HIPAA, if applicable) ◯ Yes ◯ No
    c. Billing and Coding? ◯ Yes ◯ No

11. Is the Applicant in compliance with provincial/ state and federal privacy and data security regulations? ◯ Yes ◯ No

12. Does the Applicant maintain a hotline to receive complaints concerning billing procedures or any other compliance concerns? ☐ Yes ☐ No

13. Does the Applicant have policies that address the protection of whistleblowers? ☐ Yes ☐ No

14. Does the Applicant use audits or other techniques to monitor billing/coding compliance? ☐ Yes ☐ No

15. Within the last 3 years, has the Applicant, any Subsidiary, or any person associated with such entities for whom this insurance is being sought ("Proposed Insureds"), been the subject of or involved in any regulatory compliance oversight, inquiry, investigation, indictment or proceeding for any actual, alleged, or potential violations of the following, regardless of whether or not such inquiry was a result of voluntary self-disclosure:

    a. False Claims Act, or any similar federal, provincial, territorial, state or local statutory or common law? ☐ Yes ☐ No

    b. Anti-kickback or anti-referral statute, or any similar federal, provincial, territorial, state or local statutory or common law? ☐ Yes ☐ No

    If you answered "Yes" to any of the above, please provide complete details: _____

16. Has the accreditation, license, or certification of any of the Proposed Insureds ever been suspended, denied, revoked, investigated, or granted subject to any contingencies or recommendations? ☐ Yes ☐ No

    If you answered "Yes" above, please provide complete details: _____

FRAUD NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties.

The Applicant, through the undersigned authorized representative, hereby acknowledges that the aforementioned statements and answers are accurate and complete. Applicant further understands that any inaccurate or incomplete statements may result in an exclusion or denial of insurance coverage. Applicant further authorizes CNA Insurance Companies to release the information on this Application and associated underwriting information.

Applicant:

By: _____ _____

*Signature and Title** *Printed Name of Authorized Representative*

Date: _____

*** This Supplemental Application must be signed by the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, General Counsel or Risk Manager of the Applicant acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.**

Note: For purposes of the Insurance Companies Act (Canada), this document was made in the course of Continental Casualty Company's insurance business in Canada.