

**International Placement Services, Inc.**

101 S. Hanley Rd., Ste 700

St. Louis, MO 63105

**APPLICATION FOR DIRECTORS, OFFICERS AND TRUSTEES LIABILITY INSURANCE  
INCLUDING HEALTHCARE ORGANIZATION REIMBURSEMENT**

**NOTICE: THIS IS A CLAIMS MADE INDEMNITY POLICY. DEFENSE EXPENSES ARE INCLUDED WITHIN AND REDUCE THE LIMIT OF LIABILITY. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

- 1. a. Name of Parent Organization: \_\_\_\_\_  
(Wherever used, the term "Applicant" means the above entity and its subsidiaries.)
- b. Principal address: \_\_\_\_\_
- c. Date of incorporation: \_\_\_\_\_
- 2. a. Name and title of the person who will receive all notices from the Insurer pursuant to Section IV. Condition (F) of the Policy.  
Name: \_\_\_\_\_ Title: \_\_\_\_\_
- b. Name of Risk Manager: \_\_\_\_\_

3. Please provide the following information regarding the Applicant's insurance coverages:

	D&O Liability	HPL/Med Mal	Fiduciary
Limit(s)			
Retention(s)			
Insurer			
Expiration Date			
Premium			

4. Is any of the Applicant's medical malpractice/HPL exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk sharing arrangement or pool?  Yes  No

If "Yes", please describe that insurance program by attachment to this Application and state how the program is administered. If a funded trust, captive or subsidiary is used:

- a. Does the funded trust, captive or subsidiary provide insurance other than to the Applicant?  Yes  No
- b. Is the program funded in accordance with annually determined actuarial requirements?  Yes  No

5. Does the Applicant now have tax-exempt status under applicable federal, state and local law, including the U.S. Internal Revenue Code?  Yes  No
- If "Yes", is any challenge to the Applicant's tax-exempt status pending or anticipated?  Yes  No
6. Do the Applicant's Charter and By-Laws limit or eliminate, by indemnification or otherwise, the personal liability of the Applicant's directors, officers, trustees, employees, volunteers and staff, faculty and committee members to the broadest extent permitted by law?  Yes  No
7. Within the last eighteen (18) months:
- a. Has the JCAHO or any other certifying or accrediting body found the Applicant to be in substantial compliance with its certifying or accrediting standards?  Yes  No
- b. Has any federal or state regulatory authority criticized or noted deficiencies in any of the Applicant's operations, procedures or finances?  Yes  No
8. During the last three (3) years, have the Applicant's outside auditors identified any material weaknesses in the Applicant's system of internal controls?  Yes  No
9. Does the Applicant contract with any third party to manage, operate or administer its facilities or operations?  Yes  No
- If "Yes", please identify: \_\_\_\_\_
10. Is the Applicant owned or operated by a state, city, town or county or by an agency, authority or other governmental or quasi-governmental entity established by state or local law?  Yes  No
- If "Yes":
- a. Are the Applicant's directors or trustees  elected or  appointed?
- b. By whom are they elected or appointed? \_\_\_\_\_
11. The Policy can, at the Insurer's discretion, be extended to provide coverage for the Applicant's directors, officers, trustees, employees, volunteers, staff, faculty and committee members in connection with their service with one or more joint ventures in which the Applicant has an ownership interest. Is the Applicant seeking such extended coverage?  Yes  No
- If "Yes", with respect to each such venture, please list by attachment to this Application the nature of its business or operations, when it commenced operations, the identities of each co-venturer or partner and the percentage(s) of ownership of each co-venturer or partner.
12. Does the Applicant have any subsidiaries?  Yes  No
- If "Yes", please provide an organizational chart which includes a description of operations, tax status and percentage of ownership for each.
13. **Reminder: the term "Applicant" means the Parent Organization and its subsidiaries.**
14. Does the Applicant have an ownership interest in any for-profit venture which provides services similar to or as a continuation of any services commonly provided by a hospital?  Yes  No
- If "No", proceed to Question 19.
15. Does any other entity within the Applicant's geographic service area provide services similar to or competitive with those provided by any venture described in Question 14?  Yes  No
- If "No", proceed to Question 19.

16. a. Are any of the services described in Question 15 offered in collaboration with any other hospital(s) within the Applicant's geographic service area?  Yes  No
- b. Does the Applicant control more than 25% of all of the primary care hospital beds within the Applicant's geographic service area?  Yes  No

If the answers to questions 16.a and 16.b are both "No", proceed to Question 19.

17. Has any for-profit venture described in Question 14 commenced business or operations within the last two (2) years?  Yes  No

If "No", proceed to Question 19. If "Yes", with respect to each such venture and, to the extent such information has not already been provided in response to Question 11, please list the nature of each venture's business or operations, when it commenced operations, the identities of each co-venturer and the percentage(s) of ownership of each co-venturer.

18. With respect to each for-profit venture listed in response to Question 17:
- a. Does the Applicant have written procedures requiring all patients who are prospective customers of the venture to be informed of the Applicant's ownership interest in such venture and of qualified competing providers? (If not known, please refer to the Applicant's discharge personnel and procedures.)  Yes  No
- b. Were all such procedures drafted or reviewed by outside counsel?  Yes  No
- c. Does the Applicant take affirmative steps to ensure or promote compliance with all such procedures on a continuing basis? (If not known, please refer to the Applicant's legal counsel or compliance officer.)  Yes  No

To answer Questions 19 through 22, you may want to consult with the Applicant's legal counsel, or with the individual(s) responsible for administering or overseeing the Applicant's peer review and credentialing process.

19. Within the last two (2) years, has the Applicant closed or restricted staff admissions to any patient service department for reasons other than professional competence?  Yes  No

Are there any formal plans for future closings or restrictions?  Yes  No

If the answer to either part of this Question 19 is "Yes", has the Applicant consulted with legal counsel regarding proper procedures and safeguards in each such instance?  Yes  No

If "Yes", please attach to this Application copies of such counsel's advice or recommendations regarding such procedures and safeguards.

20. Does the Applicant have written procedures for peer review and credentialing that follow the standards established in the JCAHO's Accreditation Manual for Hospitals?  Yes  No

21. Does the Applicant have written procedures to ensure that all peer review and credentialing decisions adversely affecting a physician's clinical privileges are reported to the National Practitioner Data Bank?  Yes  No

22. a. Is internal or outside legal counsel consulted before any recommendation or peer review or credentialing decision adversely affecting a physician's clinical privileges becomes final?  Yes  No

If "Yes", proceed to Question 23.

- b. Does any person other than a member of the Applicant's medical staff become involved in any peer review or credentialing proceeding before a recommendation or decision adversely affecting a physician's clinical privileges becomes final?  Yes  No

If "Yes", please describe by attachment to this Application the qualifications of such person(s), and proceed to Question 23.

- c. Does the Applicant have written procedures to ensure that its peer review and credentialing procedures have been followed in any instance in which there is a peer review or credentialing decision adversely affecting a physician's clinical privileges?  Yes  No

If "Yes", please attach to this Application a copy or description of such procedures.

23. 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, its directors, officers, trustees, employees, volunteers or staff, faculty or committee members, except as follows (include loss payment and defense costs). If answer is "None", so state:

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24. No person or entity proposed for this insurance is cognizant of any fact, circumstance or situation which they have reason to suppose might afford valid grounds for any claims such as would fall within the scope of the proposed insurance, except as follows. If answer is "None", so state:

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Without prejudice to any other rights and remedies of the Insurer, any claim arising from any claim, fact, circumstance or situation required to be disclosed in response to 23 and 24 is excluded from the proposed insurance.

25. Please attach the following to this Application:
- a. Complete copies of the Applicant's last 2 CPA-audited financial statements with notes. If not consolidated, provide financial statements on each unconsolidated entity.
  - b. The names and occupations of each member of the Parent Organization's Board of Directors and Trustees.
  - c. The Parent Organization's Charter and By-Laws.

**THE UNDERSIGNED, AS AUTHORIZED AGENT OF ALL PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE, DECLARES THAT, TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS IN THIS APPLICATION ARE TRUE AND COMPLETE.**

**THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION WILL BE ON FILE WITH THE INSURER AND, ALONG WITH THE APPLICATION, WILL BE CONSIDERED PHYSICALLY ATTACHED TO, AND PART OF, THE POLICY IF ISSUED. THE INSURER WILL HAVE RELIED UPON THIS APPLICATION AND ATTACHMENTS IN ISSUING ANY POLICY. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE INSURER'S ACCEPTANCE OF THIS APPLICATION AND THE MAKING OF ANY SUBSEQUENT INQUIRY WILL NOT, HOWEVER, BIND IT TO COMPLETE THE INSURANCE.**

**IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT WILL SO NOTIFY THE INSURER, AND THE INSURER MAY MODIFY OR WITHDRAW ANY QUOTATION.**

**THE UNDERSIGNED DECLARES THAT ALL PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE UNDERSTAND:**

- A. THE POLICY, IF ISSUED, WILL APPLY ONLY TO "CLAIMS" FIRST MADE OR DEEMED MADE AGAINST THE "INSUREDS" DURING THE "POLICY PERIOD";**
- B. THE LIMIT OF LIABILITY OF THE POLICY, IF ISSUED, WILL BE REDUCED BY THE PAYMENT OF AMOUNTS INCURRED AS "DEFENSE EXPENSES" AND SUCH EXPENSES SHALL BE SUBJECT TO THE RETENTION; AND**
- C. THE POLICY, IF ISSUED, WILL NOT PROVIDE FOR ANY DUTY BY THE INSURER TO DEFEND THE "INSUREDS".**

**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 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 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 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 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 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 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.**

APPLICANT		
BY ( <i>President and/or CEO Signature</i> )	TITLE	DATE

**NOTE:** This Application must be signed by the President and/or CEO of the Applicant acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

PRODUCED BY ( <i>Insurance Agent</i> )	INSURANCE AGENCY
INSURANCE AGENCY TAXPAYER I.D. OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS ( <i>No., Street, City, State, and ZIP Code</i> )	

SUBMITTED BY ( <i>Insurance Agency</i> )	INSURANCE AGENCY TAXPAYER I.D. OR SOCIAL SECURITY NO.	AGENT LICENSE NO.
ADDRESS ( <i>No., Street, City, State, and ZIP Code</i> )		