TRAVELERS

Managed Care Errors and Omissions Liability Plus+ Coverage Application

Travelers Casualty and Surety Company of America *(not applicable in Guam, Puerto Rico, or the Virgin Islands)*
Travelers Casualty and Surety Company *(only applicable in Guam, Puerto Rico, and the Virgin Islands)*

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Website Address: _____

   Year **Applicant's** business was established: _____

   Description of **Applicant's** operations: _____

2. Applicant is*:*

   ☐ For Profit Corporation ☐ Limited Liability Company ☐ Partnership
   ☐ Not for Profit Tax Exempt Corp. ☐ Not for Profit Taxable Corp. ☐ Joint Venture
   ☐ Other (please describe):_____

3. Risk Manager or authorized representative(s) designated to receive any and all notices concerning this issue:

   Name:_____ Email:_____

   Title:_____ Phone:_____

   Complete address if different than information provided under General Information:

   Address:_____ City, State, ZIP:_____

II. ORGANIZATION INFORMATION

1. Subsidiary and controlled partnership and non-profit organization information:

Name	% Owned	Year Started	Description of Operations	Tax Status*	Entity Type**
	%				
	%				
	%				

***Tax Status: FP=For-Profit or NP=Non-Profit**

****Entity Type: 501(c)(3); S Corporation, General Partnership (GP); Limited Partnership (LP); Limited Liability Partnership (LLP); Limited Liability Company (LLC)**

To enter more information, please attach a separate page to the Application.

2. Provide the locations of each **Applicant's** organization and the total number of employees* for each category:

State or Foreign Country	Number of Locations	Full Time Employees		Part Time Employees	
		As of Date of Application	12 Months Ago	As of Date of Application	12 Months Ago

*Include leased, seasonal, temporary and volunteer employees

3. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

   a. Any actual or proposed merger, acquisition, or divesture? Yes ☐ No ☐

   b. Any creation of a new business, subsidiary, joint venture or division? Yes ☐ No ☐

   c. Any issuance of debt, a tax exempt bond offering, a public offering or private placement of securities? Yes ☐ No ☐

   d. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

   e. Any branch location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes ☐ No ☐

   f. Any new government contracts (Medicare or Medicaid)? Yes ☐ No ☐

   If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, and the surrounding circumstances.

4. Have any **Applicant's** had any changes in the Board of Directors, Board of Managers, Board of Trustees or executive officers within the past 3 years for reasons other than term completion or retirement? Yes ☐ No ☐
   If Yes, please attach full details.

5. Have there been any changes in the **Applicant's** CPA or outside legal counsel in the last 36 months? Yes ☐ No ☐
   If Yes, please explain: _____

   _____

6. Is the **Applicant** a subsidiary of a foreign parent? Yes ☐ No ☐

7. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

8. Nature of business *(Check all that apply):*

☐ HMO – Type: _____	☐ Staff Model HMO	☐ IPA Network	☐ PPO
☐ Combined Network & Staff Model	☐ PHO	☐ IPA	☐ Medical Group or Clinic
☐ Dental HMO or PPO	☐ TPA	☐ ASO	☐ MSO
☐ Case Management	☐ Disease Mgmt.	☐ Utilization Review Org.	☐ Peer Review Org.
☐ Insurance Agency	☐ Other – Describe: _____		

9. Is any **Applicant** licensed by any federal, state, or local agency? Yes ☐ No ☐
   If Yes, identify the licensing agency:

   _____

10. Is any **Applicant** accredited or certified by any organization (such as the National Committee for Quality Assurance (NCQA) or URAC), state or federal agency? Yes ☐ No ☐
If Yes, identify the accrediting agency, date and rating of the last certification below:

_____

_____

_____

11. Has any **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 attach full details.

III. FINANCIAL AND AUDITOR INFORMATION

Please submit CPA audited financial statement as directed in the Required Attachments section. If Applicant does not have a CPA audited financial statement, please submit an internally prepared balance sheet and income statement for the most recent fiscal year end and most recent year to date.

1. Has any auditor issued a "going concern" opinion for the **Applicant's** financial statements during the past 3 years? N/A ☐ Yes ☐ No ☐
If Yes, please attach an explanation.

2. Have the outside auditors stated there are material weaknesses in the **Applicant's** systems of internal controls? N/A ☐ Yes ☐ No ☐
If Yes, please attach an explanation and provide the latest CPA letter to management and management's response.

3. Has the **Applicant** implemented all material recommendations of the auditor? N/A ☐ Yes ☐ No ☐
If No, please attach an explanation.

IV. ENROLLMENT INFORMATION

Note: Wherever used, "enrollees" means covered lives not just covered employees and not member months. If there are enrollees in more than one state, please provide a breakdown by state on a separate attachment.

1. Provide breakdown of enrollment by product line:

Product Line	Last 12 Months	Next 12 Months - Estimate
HMO		
PPO		
POS		
ASO/TPA		
Indemnity		
Other		
Total number of all **Applicant's** enrollees:		

If 'Other' is completed, please describe:

_____

_____

_____

_____

V. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

1.

Coverage	Carrier	Limit	Retention	Premium	Policy Period
Directors and Officers Liability (D&O)		$	$	$	
Employment Practices Liability (EPL)		$	$	$	
Excess D&O and/or EPL		$	$	$	
Healthcare/Medical Professional Liability		$	$	$	
Fiduciary Liability		$	$	$	
Crime		$	$	$	

2. Requested Managed Care Errors and Omissions Liability Insurance:

Effective Date: _____ Limit: $_____ Retention: $_____

VI. HEALTH CARE PROVIDER INFORMATION

	Last 12 Months	Estimate Next 12 Months
1. Total number of physicians under contract with any **Applicant**:		
a. Number of employed physicians:		
b. Number of independent contractor physicians:		
2. Total number of non-physician health care professionals under contract:		
3. Total number of hospitals under contract:		
4. Total number of other facilities under contract (e.g., clinics, nursing homes, laboratories, pharmacies):		

5. Are all contracted health care professionals required to maintain medical malpractice insurance? Yes ☐ No ☐
If Yes, what limits are required and how often are limits verified?

_____

6. Does any **Applicant** have any provider agreements in effect whereby the **Applicant** assumes responsibility for overseeing the quality of the services provided by the health care providers? Yes ☐ No ☐

7. Does the **Applicant** review, profile, tier quality or costs of, or provide quality assurance of any provider of medical services? Yes ☐ No ☐

8. 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 ☐

9. Does the **Applicant** employ any physicians, psychologists, dentists, or any other medical professionals in any medical capacity other than for peer or utilization review or administrative duties? Yes ☐ No ☐

10. Provide details of the **Applicant's** compensation or participation agreements with contracted health care professionals, or attach copies of sample contracts:

_____

_____

VII. MARKET POSITION

1. Does any **Applicant** have exclusive service contracts with any physicians, hospitals or other providers? Yes ☐ No ☐
2. Does any **Applicant** have any provider agreements that contain "Most Favored" pricing clauses? Yes ☐ No ☐
3. Does any **Applicant** have any provider agreements that contain non-compete clauses? Yes ☐ No ☐
4. Has the **Applicant** received an opinion from the Federal Trade Commission confirming that their activities (mergers, acquisitions and network development) will not violate antitrust laws? Yes ☐ No ☐
5. Has the **Applicant** obtained advice from antitrust legal counsel related to mergers, acquisitions or network development? Yes ☐ No ☐
   If Yes, please specify firm name and advice sought:

   _____

6. 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 attach full details.
7. 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 attach full details.

VIII. RISK MANAGEMENT OPERATIONS

1. Does the **Applicant** have a formal Risk Management program? Yes ☐ No ☐
2. Does the **Applicant** have a full time risk manager? Yes ☐ No ☐
3. Does risk management coordinate with legal on claims and litigation claims management? Yes ☐ No ☐

_____

IX. MANAGED CARE ACTIVITIES AND SERVICES

1. Indicate those managed care activities or services the **Applicant** currently performs or subcontracts, or plans to begin performing or subcontracting within the next 12 months (Note: Not all checked services may be covered.):

Activity/Service	For the Applicant	For Others for a Fee	Fee Revenue
Credentialing or peer review of health care providers	Yes ☐ No ☐	Yes ☐ No ☐	$
Utilization review	Yes ☐ No ☐	Yes ☐ No ☐	$
Drafting practice guidelines/critical pathways	Yes ☐ No ☐	Yes ☐ No ☐	$
Case management	Yes ☐ No ☐	Yes ☐ No ☐	$
Disease management	Yes ☐ No ☐	Yes ☐ No ☐	$
Handling and adjusting of enrollees' health care benefit claims	Yes ☐ No ☐	Yes ☐ No ☐	$
Application or enrollment processing for enrollees of health care plans	Yes ☐ No ☐	Yes ☐ No ☐	$
Billing/other processing of enrollees' claims under health care plans	Yes ☐ No ☐	Yes ☐ No ☐	$
Advertising, marketing, or selling health care plans/products	Yes ☐ No ☐	Yes ☐ No ☐	$
Establishing health care provider networks to provide managed care	Yes ☐ No ☐	Yes ☐ No ☐	$
Third Party Administrative Services for Healthcare plans	Yes ☐ No ☐	Yes ☐ No ☐	$
Assisting Self-Insured Plans in purchasing reinsurance	Yes ☐ No ☐	Yes ☐ No ☐	$

Activity/Service	For the Applicant	For Others for a Fee	Fee Revenue
Actuarial services for health care plans	Yes ☐ No ☐	Yes ☐ No ☐	$
Administering health savings accounts	Yes ☐ No ☐	Yes ☐ No ☐	$
Administering employee assistance programs	Yes ☐ No ☐	Yes ☐ No ☐	$
Wellness, health promotion activities or education services	Yes ☐ No ☐	Yes ☐ No ☐	$
Administering nurse call line or other telephonic triage programs	Yes ☐ No ☐	Yes ☐ No ☐	$

2. Does the **Applicant** provide or render advice on, or comparisons of, eligibility requirements processes or procedures for enrollment or changes in participation status, or coverage features for customers? Yes ☐ No ☐

3. Does the **Applicant** design or implement benefit plans or financial incentive plans, including any Pay for performance programs that compensate providers of medical services? Yes ☐ No ☐

4. Does the **Applicant** subcontract for services including Utilization Review or the handling or processing of claims to any organization where the subcontracted services are performed outside of the United States? Yes ☐ No ☐

5. Does the **Applicant** have any programs that provide members with the option of having Medical Services performed outside of the United States? Yes ☐ No ☐

6. Has the **Applicant** ever had its Medicare or Medicaid participation status revoked or restricted? Yes ☐ No ☐

If Other services provided, please describe below:

_____

X. HIPAA AND COMPLIANCE PROGRAMS

1. Does the **Applicant** have a privacy officer? Yes ☐ No ☐

2. Has the **Applicant** conducted a HIPAA risk analysis? Yes ☐ No ☐

3. Does the **Applicant** have a program for on-going HIPAA privacy training? Yes ☐ No ☐
If Yes, how often is the training performed? _____

4. Has the **Applicant** modified its policies and procedures to comply with all changes and updates to HIPAA? Yes ☐ No ☐

5. Does the **Applicant** have policies and procedures addressing the responsibilities of its "business partners" under HIPAA? Yes ☐ No ☐

6. Does the **Applicant** have a written corporate compliance program? Yes ☐ No ☐

7. Does the **Applicant** have an employee hotline as part of the compliance program? Yes ☐ No ☐
If Yes, how many calls are made to the hotline per month? _____

8. Is employee and vendor adherence to confidentiality/non-disclosure requirements audited? Yes ☐ No ☐

XI. CREDENTIALING OF PROVIDERS

*If the **Applicant** does not perform or sub-contract credentialing of contracted healthcare providers, check here ☐ and skip to the next section below. Otherwise, please answer the following questions.*

1. a. Who performs the credentialing of contracted health care providers? **Applicant**? Yes ☐ No ☐
Subcontractors? Yes ☐ No ☐

b. If credentialing is subcontracted:

(i) What percentage of credentialing is subcontracted? _____ %

(ii) Does **Applicant** review or audit the process? Yes ☐ No ☐

(iii) Is the subcontractor required to maintain E&O insurance? N/A ☐ Yes ☐ No ☐
If Yes, what limits are required? $_____

(iv) Does the subcontractor indemnify the **Applicant**? N/A ☐ Yes ☐ No ☐

(v) Does the **Applicant** indemnify the subcontractor? N/A ☐ Yes ☐ No ☐

2. Does the **Applicant** have written policies and procedures in place for the following:
   a. Peer review? Yes ☐ No ☐
   b. Credentialing? Yes ☐ No ☐
   c. Re-credentialing? Yes ☐ No ☐
3. Do the **Applicant's** written credentialing procedures follow JCAHO or NCQA standards and comply with all applicable laws? Yes ☐ No ☐
4. Are the **Applicant's** credentialing and peer review procedures given to the health care providers? Yes ☐ No ☐
5. Is the **Applicant's** legal counsel consulted before any recommendation or decision is made which might adversely affect a provider's privileges or credentials? Yes ☐ No ☐
6. What group has the final authority for credentialing or peer review decisions:
   a. Board of Directors? Yes ☐ No ☐
   b. Other Board Committee(s)? Yes ☐ No ☐
      If Yes, please specify: _____
   c. Other? Yes ☐ No ☐
      If Yes, please describe: _____
7. Does the **Applicant** query the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank of the Federal or State Medical Boards as part of the credentialing process? Yes ☐ No ☐
8. How often does the **Applicant** re-credential contracted health care providers? Yes ☐ No ☐
9. Does the **Applicant** perform on-site visits of contracted health care providers? Yes ☐ No ☐
   If Yes, how often are the visits? _____
10. 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 attach full details.
11. Have any providers been removed or disqualified from the **Applicant's** network panel in the last 12 months? Yes ☐ No ☐
    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 ☐
12. Have any removed or disqualified providers been reinstated in the last 12 months? Yes ☐ No ☐
13. Are the policies and procedures governing the reasons for termination of providers expressly enumerated by the **Applicant** in its contracts? Yes ☐ No ☐
14. Has the **Applicant** established or implemented any pay for performance, tiered networks, or any other financial performance incentives for its providers? Yes ☐ No ☐
    If yes, are the standards for these programs available to all providers? Yes ☐ No ☐
    If yes, is there an appeals process available to all providers address disputes? Yes ☐ No ☐

XII. UTILIZATION REVIEW

*If the **Applicant** does not perform or sub-contract utilization review, check here ☐ and skip to the next section below. Otherwise, please answer the following questions.*

1. a. Who performs utilization review? **Applicant**? Yes ☐ No ☐
   Subcontractors? Yes ☐ No ☐

b. If utilization review is subcontracted:

(i) What percentage of utilization review is subcontracted? _____ %

(ii) Does **Applicant** review or audit the process? Yes ☐ No ☐

(iii) Is the subcontractor required to maintain E&O insurance? N/A ☐ Yes ☐ No ☐
If Yes, what limits are required? $_____

(iv) Does the subcontractor indemnify the **Applicant**? N/A ☐ Yes ☐ No ☐

(v) Does the **Applicant** indemnify the subcontractor? N/A ☐ Yes ☐ No ☐

2. What is the **Applicant's** utilization review denial rate for the last 12 months? _____ %

3. How many of the **Applicant's** denials were appealed in the last 12 months? _____

4. How many of the appeals in the last 12 months were reversed? _____

5. Does the **Applicant** have written policies and procedures in place for utilization review? Yes ☐ No ☐
*If Yes, does the **Applicant** follow NCQA or URAC standards and comply with all applicable laws?* Yes ☐ No ☐

6. Are claim denial and appeal procedures explained in writing to enrollees, including the identity of the individual who makes decisions regarding appeals? Yes ☐ No ☐

7. Does a physician review all proposed denials of benefits prior to issuance of the denial? Yes ☐ No ☐

8. Are external reviewers involved in the final level of review before appeal? Yes ☐ No ☐

9. Does the **Applicant** have an external review process in those states where external review is not mandated by law? Yes ☐ No ☐
If Yes, does the Applicant abide by the external review decisions in every case? Yes ☐ No ☐
If No, please explain:

_____

10. Does the **Applicant** have a "fast track" appeal system regarding denial of benefits or postponement of benefit procedures for organ transplant or any other procedure which may severely impair the quality of life for an enrollee if not performed? Yes ☐ No ☐

11. Does the **Applicant** use practice guidelines as part of its utilization review process? Yes ☐ No ☐
If Yes, do guidelines state in writing that a physician's judgment may override a guideline? Yes ☐ No ☐

12. Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with utilization reviewers? Yes ☐ No ☐

XIII. CLAIM HANDLING OF ENROLLEES' HEALTH CARE BENEFITS

*If the **Applicant** does not perform or sub-contract claim handling for health care benefits, check here ☐ and skip to the next section below. Otherwise, please answer the following questions.*

1. a. Who performs the claim handling for health care benefits? **Applicant**? Yes ☐ No ☐
Subcontractors? Yes ☐ No ☐

b. If claim handling is subcontracted:

(i) What percentage of claim handling is subcontracted? _____ %

(ii) Does **Applicant** review or audit the process? Yes ☐ No ☐

(iii) Is the subcontractor required to maintain E&O insurance? N/A ☐ Yes ☐ No ☐
If Yes, what limits are required? $_____

(iv) Does the subcontractor indemnify the **Applicant**? N/A ☐ Yes ☐ No ☐

(v) Does the **Applicant** indemnify the subcontractor? N/A ☐ Yes ☐ No ☐

2. Does the **Applicant** utilize profit sharing, risk sharing, or other financial incentives in its compensation arrangements with claim handlers or adjusters? Yes ☐ No ☐

3. How many claims did the **Applicant** process in the last 12 months? _____

4. What was the percentage of the claims denied in the last 12 months? _____ %

XIV. ADVERTISING/MARKETING/SALES

*If the **Applicant** does not have contracts, sales literature or brochures, check here ☐ and skip to the next section below. Otherwise, please answer the following questions.*

1. Do all contracts, sales literature and brochures expressly identify covered and non-covered procedures? Yes ☐ No ☐

2. Do any contracts, sales literature, or brochures use the term(s) "investigative" or "experimental" procedures? Yes ☐ No ☐
   *If Yes, are those terms defined in the **Applicant's** marketing material?* Yes ☐ No ☐
   *If Yes, odes the **Applicant's** marketing material clearly state that the **Applicant** has discretionary authority in the interpretation and administration of the plan's provisions?* Yes ☐ No ☐

3. Do contracts, sales literature or brochures expressly refer to all contracted health care providers as independent contractors? Yes ☐ No ☐

4. 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 ☐

5. Does the **Applicant's** legal counsel review and approve all contracts, sales literature, brochures, advertisements and other marketing material prior to their use? Yes ☐ No ☐
   If No, please attach full details.

6. Does the **Applicant** conduct enrollee satisfaction surveys? Yes ☐ No ☐
   If Yes, how often are the surveys conducted? _____

   If Yes, how large is the survey sample size? _____

XV. LOSS INFORMATION

1. Has there been during the past 5 years, or are there now pending, any managed care errors and omissions claims, administrative proceedings, charges, hearings, demands or lawsuits against any **Applicant** or any entity or person proposed for this insurance, including claims involving independent contractors or full time, temporary, or leased employees, whether or not such claim or action would be covered under any managed care errors and omissions liability insurance? Yes ☐ No ☐
   If Yes, please attach full details of each, including the type of complaint, loss payments, defense costs, how resolved, whether any insurance responded to any aspect of the claim, and any corrective procedures implemented.

2. If managed care errors and omissions liability **<u>is currently purchased</u>**, please answer the following question:

   As of the date the **Applicant** first purchased managed care errors and omissions liability insurance, did the **Applicant** or any person proposed for insurance have any knowledge of any fact, circumstance, or situation related to the managed care errors and omissions liability insurance that could have reasonably given rise to a claim against them? Yes ☐ No ☐
   If Yes, please attach full details.

3. If managed care errors and omissions liability insurance **<u>is not currently purchased</u>**, please answer the following question:

   Does the **Applicant** of any person proposed for this insurance have any knowledge of any fact, circumstance, or situation related to the managed care errors and omissions liability insurance that could reasonably give rise to a claim against them? Yes ☐ No ☐
   If Yes, please attach full details.

4. If the requested limit of liability for which application is being made exceeds the expiring limit of liability, please answer the following questions:

   With respect to the increased portion of the limit of liability requested, does the **Applicant** or any person proposed for this insurance have any knowledge of any fact, circumstance, or situation

related to the managed care errors and omissions liability insurance that could reasonable give rise to a claim against them? Yes ☐ No ☐
If Yes, please attach full details.

Without prejudice to any other rights and remedies of the Company, any claim arising from any facts circumstances required to be disclosed in Question 2, 3, or 4 above is excluded from the proposed insurance.

XVI. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents and indicate below which are included in conjunction with this Application (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the* ***Applicant*** *or are obtained by the Company from any public source, including the Internet*):

- ☐ Most recent consolidated CPA audited financial statements including notes and schedules
- ☐ Most recent CPA audited financial statements including notes and schedules for each unconsolidated subsidiary
- ☐ Interim financial statements, if audited financial statements are 6 months or older
- ☐ If newly formed organization, most recent business plan to include pro-forma balance sheet and income statement projections.
- ☐ Current organizational chart of the first named insured organization, listing each subsidiary, controlled non-profit organization and joint venture, including the ownership percentage and tax status of each
- ☐ A description of operations for each subsidiary
- ☐ A listing of the Board of Directors, Board of Managers or the Board of Trustees, as applicable, with employers and occupations of each, as well as other boards on which such directors, managers or trustees serve
- ☐ Copy of the **Applicant's** bylaws
- ☐ Copy of the **Applicant's** code of conduct policy
- ☐ Copy of the written credentialing and peer review procedures
- ☐ Copy of the written utilization review procedures, including the procedures for denial of benefits and the appeal process
- ☐ Copy of the member ship handbook or samples of contracts with enrollees
- ☐ Samples of sales literature, brochures advertisements and other marketing materials
- ☐ A copy of the results of the most recent enrollee satisfaction survey

XVII. COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

XVIII. FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado
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 Agencies.

Attention: Insureds in Florida
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 of the third degree.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Maine, Tennessee, Virginia, and Washington
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.

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

XIX. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (CHAIRMAN, PRESIDENT, CEO, ADMINISTRATOR OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature of **Applicant's** Authorized Representative (Chairman, President, CEO or Administrator)	Name (Printed)
Title	Date

XX. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA AND NEW HAMPSHIRE):

Producer Signature	Producer Name (Printed)	
Agency Name	Agency Code	License Number