U.S. Risk, LLC | 8401 N. Central Expressway, Dallas, Texas 75225

NOTE: If this policy is issued, it will be on a claims made basis. The policy provides that the limit of liability available to pay judgments or settlements shall be reduced by amounts incurred for legal defense. Amounts incurred for legal defense shall be applied against the deductible amount.

1. Applicant name: ______________________
   Mailing Address: ______________________
   City: ______________ State: __________ ZIP: __________ County: __________
   Telephone Number: ______________ Email: ______________________
   Website URL: ______________________
2. Corporate structure: ☐ Individual ☐ Partnership ☐ LLC ☐ Corporation: Federal ID# ______________
3. Year established: ______________
4. Is the applicant firm controlled by, owned by, or associated with, or does the applicant firm own or control any other firm corporation, or company? ☐ Yes ☐ No
   If yes, provide details:
5. Are any services of the applicant provided to such organizations described in question 4 above? ☐ Yes ☐ No
   If yes, provide details:
6. Number of employed:
   Accountants: __________ Data processing personnel: __________
   Actuaries: __________ Insurance agents/brokers: __________
   Claims administration personnel: __________ Other: __________
7. Limit of liability desired: ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000
8. Deductible desired: ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

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9. Approximate percentage of total business and corresponding revenues for each of the following operations:

Operation	Percentage	Revenues
Providing Actuarial Services	________ %	$ ________
Administration of Health and Welfare Plans		
Single Employer Plans	________	$ ________
Multi-Employer Benefit Plans		
Taft-Hartley Trusts	________ %	$ ________
Multiple Employer Welfare Arrangements (MEWAS)	________ %	$ ________
Mulitple Employer Trusts (METS)	________ %	$ ________
Administration of Pension Plans	________ %	$ ________
Computer Services		
Electronic Data Processing	________ %	$ ________
Electronic Data Consulting	________ %	$ ________
Software Design, Development or Customization (coverage is not provided for software design, development or customization)	________ %	$ ________
Employee Assistance Plans (EAP)		
Administrator	________ %	$ ________
Provider	________ %	$ ________
Providing Utilization Review Services	________ %	$ ________
Insurance Related Services		
Acting as an Insurance Agent or Broker	________ %	$ ________
Acting as an Advisor/Consultant	________ %	$ ________
Premium Collection and Billing	________ %	$ ________
Hold Underwriting Authority/Policy Issuance	________ %	$ ________
Providing Cost Containment Services	________ %	$ ________
Providing Case Management Services	________ %	$ ________
Providing Employee Wellness or Other Health Related Program Literature or Correspondence	________ %	$ ________
Acting as an Administrator for Credentialing Services	________ %	$ ________
Other Services		
Providing premium collection and billing services	________ %	$ ________
Benefit Enrollment Services	________ %	$ ________
Cost Containment Services	________ %	$ ________
Other (describe):	________ %	$ ________
TOTAL (MUST EQUAL 100%)	**100 %**	**$** ________

10. Is the applicant engaged in any business or profession other than as that described in question 9? ☐ Yes ☐ No
    If yes,explain:

11. List the total gross receipts for the past three years derived from the activities in question 9.

Year	Amount
a. Next Year Projected	$ ______
b. Current	$ ______
c. ______	$ ______
d. ______	$ ______

12. Number of plan sponsors: ______
    Number of participants for plans administered by the applicant: ______
    Total annual contributions to the plans administered by the applicant: $ ______
    Total annual benefit payments issued in the administration of all such plans: $ ______
    Number of plan sponsors added in the past year: ______
    Number of plan sponsors deleted in the past year: ______
    Percentage of plans self funded with stop loss: ______ %
    Percentage of plans self funded with no stop loss: ______ %
    Percentage of plans fully insured: ______ %
    List carriers that stop loss coverage is placed with:

13. Does the Applicant, or its Partners, Directors, Officers or Employees, act as Trustee for any clients or non-clients? ☐ Yes ☐ No
    If yes, explain in detail:

14. Name and address of law firm(s) acting as counsel to the Applicant and nature of services provided:

15. Name and address of accounting firm(s) providing services to the Applicant and nature of services provided:

16. Does the Applicant administer any self-funded Multiple-Employer Trusts (METS) or Multiple-Employer Welfare Arrangements (MEWAS)?
    ☐ Yes ☐ No
    If yes, provide details:

17. Does the Applicant firm belong to professional association(s)? ☐ Yes ☐ No
    If yes, list:

18. List all Partners, Principals and Key Employees:

Full Name	Professional Qualifications	Date Qualified	Years in Practice	How Long in Role

19. Does the applicant have Professional Liability Errors and Omissions Insurance in force? ☐ Yes ☐ No

If yes, complete the following:

Insurer: ______________________ Premium: ______________________

Limit of Liability: ______________________ Deductible: ______________________

Expiration Date: ______________________ Retroactive Date: ______________________

20. Does the applicant have a fidelity bond? ☐ Yes ☐ No

If yes, complete the following:

Insurer: ______________________ Premium: ______________________

Limit of Liability: ______________________ Deductible: ______________________

Expiration Date: ______________________ Retroactive Date: ______________________

21. Does the applicant have ERISA Fiduciary Liability Coverage? ☐ Yes ☐ No

If yes, complete the following:

Insurer: ______________________ Premium: ______________________

Limit of Liability: ______________________ Deductible: ______________________

Expiration Date: ______________________ Retroactive Date: ______________________

22. Describe how your firm screens and qualifies plan sponsors:

23. How does the firm comply with individual plan administration guidelines?

24. a. What percentage of inquiries are referred to a physician? ______________ %

    b. What percentage of claims are denied? ______________ %

    c. What percentage of denials are appealed? ______________ %

25. How do you determine denial of benefits?

26. How are claimants informed of denial of benefits?

27. What is the appeal process for the denial of claims?

28. What is the average error rate for your claims handlers? ______ %
29. Does the applicant firm use a written contract with clients? ☐ Always ☐ Sometimes ☐ Never
30. List the Applicant's five largest clients during the past three (3) years, including: a) the client's Name; b) nature of service(s) provided (type of plan administered; c) number of lives; and d) revenues from those services:

31. What percentage of the applicant firm's business involves subcontracting of work to others? ______ %
    What type of work? ______
32. a. Which of the following are functions of your firm's Electronic Data Processing system?
    - ☐ Calculation of co-payments
    - ☐ Calculation of Deductibles
    - ☐ Claim Eligibility
    - ☐ Confidentiality Safeguards
    - ☐ Enrollment Information
    - ☐ Monitoring of Duplicate Claims
    - ☐ Managing Reports
    - ☐ Appeal Tracking
    - ☐ Adjustors accuracy
    - ☐ Check Registers (weekly and monthly)
    - ☐ Details on Large Claims
    - ☐ Detailed Payment Registers/Analysis
    - ☐ Independent Stop Loss Information Off
    - ☐ Monthly Aggregate reports by case (claim or aggregate specific)
    - ☐ Summaries by Policy Year
    - ☐ Telephone Tracking Systems
    - ☐ Number of Callbacks Due to System Failure
    - ☐ Total Number of Calls Received
    - ☐ Turn Around Time
    - ☐ Time Service
    - ☐ Types of Losses
    - ☐ Cost Containment and Expense control
    - ☐ Audit Results
    - ☐ Productivity Reports

    b. Does your system contain check and balances to guard against the following:
    - ☐ Overpayment
    - ☐ Underpayment
    - ☐ Late Payments
    - ☐ Payments to wrong party
    - ☐ Payments to wrong fund
    - ☐ Payments of noncovered expenses
    - ☐ Improper refusal of benefits
    - ☐ Unfair/unjust enrichments
    - ☐ Failure to follow payment gudelines and procedures
33. How often does your organization do an internal audit? ______
34. What situations are the audit guidelines designed to reveal? ______
35. Has the applicant firm or any of the individuals listed in question 18 ever been the subject of disciplinary action by authorities as a result of any professional ativities? ☐ Yes ☐ No
    If yes, explain:

36. Does the proposed insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim? ☐ Yes ☐ No
    If yes, attach a fully completed supplemental claims form.
    IT IS AGREED THAT IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM OR ACTION ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED COVERAGE.
37. For any and all claims made against any proposed insured during the past 5 years, **complete and attach the supplemental claims form.**
    If no claims, check here: ☐

38. Please attach the following information to the application:
    - Resumes of key personnel
    - Marketing brochures
    - Most recent audited financial statements

    WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY NCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION DOES NOT BIND THE APPLICANT TO BUY, OR THE COMPANY TO ISSUE THE INSURANCE, BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY. THE UNDERSIGNED APPLICANT DECLARES THAT THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED. THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

NOTICE: IN SOME STATES, 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. IN NEW YORK, A PERSON WHO COMMITS SUCH CRIME SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED $5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Authorized signature _______________ Date _______________

Typed or printed name: _______________ Title: _______________

Producer: _______________

Address: _______________

IF A POLICY IS ISSUED, THIS APPLICATION IS ATTACHED TO AND MADE A PART OF THE POLICY, SO IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED IN DETAIL.