HIGHMARK. CASUALTY INSURANCE COMPANY

P.O. Box 535057
Pittsburgh, PA 15253-5057
Tel: 800-328-5433 | Fax: 412-544-1246
hmig.com

Provider Excess Loss Insurance Application

Please Type or Print – Must be completed in full.

APPLICANT INFORMATION

Full Legal Name of Group (*to appear on Policy*)			Tax ID Number	
Key Contact Person	Email Address		Business Phone Number	Fax Number
Address	City	State	ZIP Code + 4	County
Delivery Address (*if different than above*)	City	State	ZIP Code + 4	County

SIC Code	Nature of Business:	☐ Hospital	☐ IPA	☐ CCO	☐ Medical Group	☐ Other *(describe)*
		☐ PHO	☐ ACO	☐ IDO	☐ ASO	_____

IF APPLICABLE: Affiliates to be insured? ☐ Yes* ☐ No *If yes, complete the table below and attach additional sheets if necessary.

AFFILIATE #1	Full Legal Name		Nature of Business	
Address	City	State	ZIP Code	County
AFFILIATE #2	Full Legal Name		Nature of Business	
Address	City	State	ZIP Code	County
AFFILIATE #3	Full Legal Name		Nature of Business	
Address	City	State	ZIP Code	County

COVERAGE TYPE *(Check all that apply)*

All Services	☐ Covered	☐ Not Covered
Ambulance Services	☐ Covered	☐ Not Covered
Dialysis Services	☐ Covered	☐ Not Covered
Durable Medical Equipment	☐ Covered	☐ Not Covered
Home Health Care	☐ Covered	☐ Not Covered
Hospice Services	☐ Covered	☐ Not Covered
Inpatient Hospital Services	☐ Covered	☐ Not Covered
Long-term Acute Care	☐ Covered	☐ Not Covered
Outpatient Services	☐ Covered	☐ Not Covered
Pharmaceutical Services	☐ Covered	☐ Not Covered
Physician Services	☐ Covered	☐ Not Covered
Subacute Care	☐ Covered	☐ Not Covered
Transplant Services	☐ Covered	☐ Not Covered

Other _____

COVERED POPULATIONS *(Check all that apply)*

☐ Commercial *(please indicate specific class descriptor e.g. Large Group/Small Group/Individual, POS/PPO/HDHD/HAS, On Exchange/Off Exchange, etc.)*

_____

☐ Medicaid

☐ Medicare Advantage

☐ Medicaid SSI

☐ Medicaid TANF/AFDC

☐ Medicare SNP *(please specify Dual, Eligible, Institutional or Chronic Condition)*

_____

☐ Other Population Description/Legal Entity Name

_____

Applicant's Initials: _____

COVERAGE REQUESTED

Effective Date: ____ / ____ / _____ Policy Period: ____ / ____ / _____ through ____ / ____ / _____

Claims Reporting Period

Claims Incurred From: ____ / ____ / _____ To: ____ / ____ / _____ Claims Paid From: ____ / ____ / _____ To: ____ / ____ / _____

Claims Reporting Deadline: ____ / ____ / _____ Claims Submitting Deadline: ____ / ____ / _____

Insured Percentage Retained by You in Addition to the Deductibles:

	Commercial	Medicaid	Medicare	Other
All Services	%	%	%	%
Ambulance Services	%	%	%	%
Dialysis Services	%	%	%	%
Durable Medical Equipment	%	%	%	%
Home Health Care	%	%	%	%
Hospice Services	%	%	%	%
Inpatient Hospital Services	%	%	%	%
Long-term Acute Care	%	%	%	%
Outpatient Services	%	%	%	%
Pharmaceutical Services	%	%	%	%
Physician Services	%	%	%	%
Subacute Care	%	%	%	%
Transplant Services	%	%	%	%
Other	%	%	%	%

Maximum Amount Reimbursable Per Member Per Policy Pay Period: $_____

Deductible Amounts Per Member Per Policy Period:

	Inpatient Hospital Services	Physician Services	All Services
Commercial	$	$	$
Medicaid	$	$	$
Medicare	$	$	$
Other	$	$	$

REQUIRED DATA *(The following items must be submitted prior to or with this Application)*

1. CAPITATION AGREEMENT(S): Include executed copies of Capitation Agreement(s) along with the financial responsibility matrices for each such Capitation Agreement(s) to be covered.

2. INTERMEDIARY AGREEMENT(S): All Intermediary Agreements and all other agreements that may define the Policyholders risk sharing arrangements and obligations under the Covered Plan and Capitation Agreements.

3. HISTORICAL UNDERWRITING INFORMATION:
For the two most recent completed years:
a.) Claims detail for all members who exceeded [50] % of the lowest Specific Deductible amount being requested; b.) Historical member months by population; and c.) Covered Plan(s) terms and conditions.

For the current year-to-date period: (Not applicable to physician-only accounts)
a.) A listing of members who have been approved or who are under evaluation for an organ or tissue transplant; b.) Hospital confined for [30] or more consecutive days as of the date coverage is bound; and c.) Undergoing treatment which may, in the opinion of the Applicant's chief medical office or other authorized clinician, result in incurred charges exceeding [50] % of the lowest Specific Deductible amount requested.

4. UTILIZATION INFORMATION (Not applicable to physician-only accounts)
For the most recent completed year and the current year-to-date period: a.) Days per 1,000; and b.) Average cost per day

5. OTHER: Any other data requested needed to properly process underwrite and rate the Application for provider excess loss insurance coverage.

Applicant's Initials: _____

PRODUCER (*Agent/Broker*)				
Name		License Number(s) – *attach a copy, if not on file.*		Tax ID Number
Business Phone Number	Fax Number	Email Address		
Address		City	State	Zip Code + 4

Requested Effective Date: _____ / _____ / _____

Premium Deposit of $_____ included. Estimated 1st month's premium must be attached to this application. The Premium Deposit will be applied to the first premium when due. Make check payable to Highmark Casualty Insurance Company. Do not make the check payable to the agent or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

FRAUD NOTICE (*Please read carefully*)

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

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.

In Kentucky, 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.

In Maryland, any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In Oregon, any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties if intentional and material to the risk.

In 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.

We certify that the above information is correct and that the claims have been paid in accordance with the plan.

APPLICANT UNDERSTANDS AND AGREES THAT

The provider excess loss insurance requested and requested effective date must be approved by Highmark Casualty Insurance Company as under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of the Required Data outlined on page 2 of this application and the first month's premium, and any other information requested in connection with this Application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Highmark Casualty Insurance Company, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of receipt of the Required Data provided on page 2 of this Application. Should subsequent information become known which, if known as of the date specified by Highmark Casualty Insurance Company, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A true and accurate copy of the Capitation Agreement(s) in force on the effective date of this Policy, and all other Required Data outlined on page 2 of the Application must be provided to Us for the Application and Policy to be fully executed and losses reimbursable. Changes to those documents must be reported as required by the Policy. Changes to the Capitation Agreement(s) may require changes to the rating basis indicated in the Schedule of Insurance.

If the description of the terms of the capitation agreement differ from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The provider excess loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the Required Data outlined on page 2, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for Highmark Casualty Insurance Company's approval of the requested provider excess loss insurance. You and We agree that this Application replaces any prior application made for the same Policy.

Applicant's Initials: _____

PLEASE SAVE, PRINT, SIGN AND RETURN THE APPLICATION VIA MAIL, EMAIL OR FAX	
This Application must be signed by an Authorized Representative of the Company who is authorized to execute this Application and legally bind the Company. I hereby agree to the terms as stated above and warrant that I am duly authorized to execute this Application: _____ Printed Name of Applicant's Authorized Representative _____ Title _____ _____ Signature of Applicant's Authorized Representative Date _____ Printed Name of Witness _____ _____ Signature of Witness (Licensed Producer) Date	On behalf of Highmark Casualty Insurance Company: _____ Printed Name of Authorized Representative _____ Title _____ _____ Signature of Authorized Representative Date _____ Printed Name of Witness _____ _____ Signature of Witness Date

Applicant's Initials: _____