

**NON-PROFIT ORGANIZATION MANAGEMENT LIABILITY
RENEWAL APPLICATION**



NOTICE: THIS IS A CLAIMS MADE AND REPORTED POLICY THAT APPLIES ONLY TO THOSE CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE INSURER DURING THE POLICY PERIOD, OR THE EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSS SHALL BE REDUCED OR TOTALLY EXHAUSTED BY PAYMENT OF DEFENSE EXPENSES.

I. GENERAL INFORMATION SECTION

1. (a) Name of Organization:
Los Medanos Community Healthcare District

(b) Organization Address:
Mailing: PO Box 8698, Pittsburg, CA 94565
Please do not send mail to physical address: 2311 Loveridge Road, Pittsburg, CA 94565

2. Indicate Coverage and Limit Requested:

D&O Liability Insurance Coverage: Yes No Limit Requested: \$ 5,000,000

Employment Practices Liability Coverage: Yes No Limit Requested: \$ 5,000,000

Third Party Liability Coverage: Yes No

Fiduciary Liability Insurance Coverage: Yes No Limit Requested: \$ _____

3. Indicate the Type of Limit Requested:

Shared Limit of Liability for multiple Coverage Sections

Separate Limit of Liability for each Coverage Section

Combination of Shared and Separate Limits (provide details): _____

4. Please provide the following financial information for the Applicant and its Subsidiaries:

| | Current Year | Prior Year | |
|-------------------------------|--------------------------------------|--------------------------------------|---|
| Date of Financial Statement: | 07/01/2021-09/30/2021 Unaudited***** | 07/01/2020-06/30/2021 Unaudited***** | *****As noted in the notes on the financial statements, these statements combine the General Fund and leasing fund even though these are on two different bases of accounting under GAAP. |
| Total Assets: | \$ 3,548,132.63 | \$ 3,345,462.10 | |
| Total Liabilities: | \$ 215,708.09* | \$ 81,987.84* | |
| Fund Balance: | \$ 3,129,753.21** | \$ 3,466,144.79** | ***In interim financial statements, revenue is recognized only when it is received, and the District does not normally receive any property tax revenue, its most significant revenue source, until November. |
| Total Revenues: | \$ 25,749.41**** | \$ 1,553,491.49*** | |
| Net Income or Net Loss: ***** | \$ <142,652.05>**** | \$ 99,410.37 | |

*After the June 2021 financial statements were prepared, the books were adjusted to add an estimate of a liability due to the Statewide Office of Health Planning and Development (OSHDP) that is based on lease payments to due in the future. That estimate is based on an assumption about future lease income that may change.

5. As part of this Application, please submit the following with respect to the Applicant: income that may change.
Includes both General Fund Balance and Proprietary Fund net assets. *06/30/2021 unaudited financial statement did not include about \$91,663 of lease income paid directly to creditor.

- Directors & Officers Liability Coverage:*****Net Income or Net Loss includes changes in fund balance/net assets for both General and Proprietary
- (a) COMPLETE COPY OF LATEST ANNUAL REPORT. IF AUDITED FINANCIALS, PLEASE INCLUDE AUDITORS NOTES AND A COPY OF LATEST INTERIM FINANCIAL STATEMENT
 - (b) CURRENT LIST OF DIRECTORS AND OFFICERS
 - (c) COMPLETE COPY OF BY LAWS AND ARTICLES OF INCORPORATION

No changes to governing docs so these are not included. District does not have Articles of Incorporation as a government entity.

Employment Practices Liability Coverage:

(a) EEO-1 REPORT (IF REQUIRED BY FEDERAL LAW) N/A

(b) EMPLOYEE HANDBOOK

Fiduciary Liability Coverage:

(a) A COPY OF THE MOST RECENTLY FILED FORM 5500 OR MOST RECENT AUDITED PLAN FINANCIAL STATEMENTS N/A

II. DIRECTORS & OFFICERS LIABILITY SECTION (Please complete only if coverage requested)

1. (a) Have there been any changes in the Organization operations within the last twelve (12) months or is the Organization currently contemplating any merger or acquisition? Yes No

If "Yes", please provide details on a separate page. *The meetings are on Zoom and the team worked from home during Covid 19.*

(b) Has the Organization acquired or created any Subsidiaries within the last twelve (12) months? Yes No

If "Yes", please provide details on a separate page.

2. Does the organization have an incident response plan for data breaches that is tested at least annually? Yes No

If "No", please provide details on a separate page.

3. If applicable, is the organization Payment Card Industry Data Security Standard (PCI/DSS) compliant? Not applicable Yes No

If "No", please provide details on a separate page.

4. Does the organization purchase First Party and Third Party Network Security and Privacy Insurance Coverage? Yes No

5. If applicable, is the organization Health Insurance Portability & Accountability Act (HIPAA) / Health Information Technology for Economic & Clinical Health (HITECH) compliant? *N/A* Yes No

If "No", please provide details on a separate page.

6. Does the organization receive more than 10% of their revenues from any governmental source? Yes No

7. Does the organization offer, sell, advertise, market or solicit any product or service, or debt collection, employing any automatic/robo dialing, mobile phone texting, faxing, or any other type of communications based mechanism or strategy governed under the rules and regulations of the Telephone Consumer Protection Act of 1991 (TCPA), The Fair Debt Collection Practices Act or any laws governing unsolicited advertising or contacts for collections or promotion of goods or services? *County collects taxes and distributes the portion to the District required by law.* Yes No

8. Does the organization have a contract or agreement with any third party vendor to perform the above services on their behalf? Yes No

III. EMPLOYMENT PRACTICES LIABILITY SECTION (Please complete only if coverage requested)

| Number of Employees: | Full time: | Part time: | Independent Contractors: | Volunteers: | Total: |
|----------------------|------------|------------|--------------------------|-------------|--------|
| 1. | 1 | 6 | approx. 6* | | 13 |

*Independent contractors above include only sole proprietors. The district contract with additional contractors who do business in

2. List total number of Employees in the following states; other entity forms.
CA 7 FL 0 NJ 0 NY 0 TX 0

3. Does the Organization anticipate making any reductions in the work force within the next twelve (12) months? Yes No

If "Yes", please provide details on a separate page.

4. How many Employees or Officers have been terminated within the last twelve (12) months?
 Number of Employees: 1 Number of Officers: 0

IV. FIDUCIARY LIABILITY SECTION (Please complete only if coverage requested)

1. Please provide the following information for the largest four Plans of the Applicant:

| Plan Name | *Plan Type | **Plan Status | Total Plan Assets (\$) | Annual Contributions | Number of Participants |
|-----------|------------|---------------|------------------------|----------------------|------------------------|
| | | | \$ | | |
| | | | \$ | | |
| | | | \$ | | |
| | | | \$ | | |

*Plan Types: Defined Benefit (DB); Defined Contributions (DC); Self-Funded Welfare Benefit Plan (W); Other (O) – Attach explanation

**Plan Status: Active (A); Frozen (F); Sold (S); Termination (T) – If any plan has been termination, indicate date of transaction

2. Has any plan (a) been amended within the last 12 months in a way that will result in the reduction of benefits or are any such amendments anticipated within the next 12 months; or (b) been merged with another plan, terminated or sold within the past 2 years or is any such merger, Termination, sale or freezing anticipated in the next 12 months? Yes No
 If "Yes", please provide details of implementation, disclosure and any relevant blackout periods.
3. Does any plan invest in a mutual fund, collective trust or similar investment pool that receives investment management services from the Organization for a fee? Yes No
 If "Yes":
 How often are these fees reviewed by the trustees for fairness? _____
 Are these fees disclosed to participants? Yes No
4. Are any Plans non-compliant with plan agreements or ERISA? Yes No
 If "Yes", please provide details on a separate page.

The undersigned authorized Officer of the Organization, on behalf of the Organization and its Subsidiaries, and on behalf of the Directors and Officers of the Organization and its Subsidiaries declares that to the best of his/her knowledge and belief, the information, particulars, documents, representations and statements contained in, attached or referred to in this application for insurance and/or as a result of the underwriting process are true and accurate and recognizes that the Insurer, in issuing this policy, will rely on such information, particulars, documents, representations and statements.

Although the signing of this application does not bind the undersigned to effect insurance, the undersigned agrees, on behalf of the Organization and its Subsidiaries, and on behalf of the Directors and Officers of the Organization and its Subsidiaries, that the information, particulars, documents, representations and statements contained in, attached or referred to in this application for insurance and/or as a result of the underwriting process shall be the basis of the contract should a policy be issued and that this application will be attached to and will become part of such policy. The Insurer is hereby authorized to make any investigation and inquiry it deems necessary in connection with this application.

NOTE: This application must be signed by the Chairman of the Board, President or Executive Director and dated within thirty (30) days of the effective date of coverage.

The undersigned authorized Officer agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the Insurer of such changes, and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature _____ Title Executive Director
(Chairman of the Board, President or Executive Director)

Date _____ Organization Los Medanos Community Healthcare District

Submitted By  _____ Date 11/9/21
(Producer)

**SIGNATURE REQUIRED
NEW YORK FRAUD STATEMENT**

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.

Applicant's Signature Date

No Signature Required

ARKANSAS, LOUISIANA, RHODE ISLAND, TEXAS AND WEST VIRGINIA FRAUD STATEMENT

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

ALABAMA FRAUD STATEMENT

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

ALASKA FRAUD STATEMENT

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA FRAUD STATEMENT

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA FRAUD STATEMENT

For your protection, California law requires that you be made aware of the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO FRAUD STATEMENT

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.

DELAWARE FRAUD STATEMENT

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA FRAUD STATEMENT

WARNING: It is a crime to provide false, or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA FRAUD STATEMENT

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.

HAWAII FRAUD STATEMENT

For your protection, Hawaii law requires you to be informed that any person who presents a fraudulent claim for payment of a loss or benefit is guilty of a crime punishable by fines or imprisonment, or both.

IDAHO FRAUD STATEMENT

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

INDIANA FRAUD STATEMENT

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS FRAUD STATEMENT

An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

KENTUCKY FRAUD STATEMENT

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.

MAINE FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND FRAUD STATEMENT

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.

MINNESOTA FRAUD STATEMENT

Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE FRAUD STATEMENT

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY FRAUD STATEMENT

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO FRAUD STATEMENT

Any person who, with intent to defraud or knowing that he 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.

OKLAHOMA FRAUD STATEMENT

WARNING: 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.

OREGON FRAUD STATEMENT

Any person who knowingly files a claim containing a false or deceptive statement for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PENNSYLVANIA FRAUD STATEMENT

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.

PUERTO RICO FRAUD STATEMENT

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 by 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.

TENNESSEE, VIRGINIA, AND WASHINGTON FRAUD STATEMENT

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.



Current List of Board Directors

Patt Young

Position: Board President

Lee Mason

Position: Board Vice President & Secretary

Linda Strong

Position: Board Treasurer

Arthur Fountain

Position: Board Member

Dennisha Owens-Marsh

Position: Board Member

Lamar A. Thorpe

Position: Executive Director