Cyber Solutions® and Medefense® Plus Application — Physician Claims-Made and Reported Basis

NOTICE: THIS APPLICATION IS FOR CLAIMS-MADE AND REPORTED INSURANCE. THE COVERAGE PROVIDES THAT THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS, SETTLEMENTS OR ANY OTHER LOSS WILL BE REDUCED AND MAY BE COMPLETELY EXHAUSTED BY DEFENSE COSTS.

The Applicant is required to make internal inquiry before completing this Application. This Application must be completed in type or ink by the Applicant. All questions must be answered for a quotation to be given. If more space is needed, please continue your answers on a separate sheet and attach it to this form.

The completion and signing of this Application does not bind the Applicant or the insurer to a policy or certificate of insurance.

I. APPLICANT INFORMATION *("You" or "Your" identified in this application shall mean the Applicant)*

Name of Applicant (Legal Entity Name): _____
(*as it should appear on the policy*)

Principal Address: _____

City: _____ State: _____ Zip Code: _____

Contact: _____ Telephone: _____ Facsimile: _____

E-mail Address: _____ Website: _____

1. Total number of Full Time Equivalent (FTE) physicians in your organization: _____
   (1 full time physician counts as 1 FTE. 2 part time physicians count as 1 FTE)

2. Date operations commenced under current ownership: _____

3. Description of operations: _____

4. Annual Total Annual Revenue: Current Year Annual Projection: _____ Prior Year: _____
   Total Annual Revenue is defined as patient and resident service revenue, net of contractual adjustments.

5. Do You own any subsidiaries[1]?..... ☐YES ☐NO

   If You answered "YES" to question 5 above, please provide a list of Your subsidiaries on separate page, with a description of each subsidiary's a) nature of operations, b) relationship to You, and c) percentage of ownership by You and Your stockholders/partners.

6. Is coverage requested for any entity or organization other than the Applicant and its Subsidiaries? ☐YES ☐NO

   If You answered "YES" to question 6 above, please provide details of each entity or organization on a separate page, including the a) nature of operations, b) relationship to You, and c) percentage of ownership by You and Your stockholders/partners.

[1] As used in this application, "Subsidiary" means any legal entity in which You own, directly or indirectly, more than 50% of the issued or outstanding voting securities.

II. **COVERAGE SELECTION** Please select the type of coverage and limit of liability you would like to purchase. Medefense Plus cannot be increased without increasing Cyber Solutions limits equal to or higher than Medefense Plus limits.

☐ Cyber Solutions Limit of Liability Requested $_____ (Up to $10,000,000 in limits available)

☐ Medefense Plus Limit of Liability Requested $_____ (Limits of $500,000 and $1,000,000 available)

Requested Effective Date (*mm/dd/yyyy*): _____
(*coverage may not be backdated*)

III. MEDEFENSE PLUS QUESTIONS

Section III only needs to be completed when requesting Medefense Plus limits higher than $50,000.

For question 7, if the answer is "NO", please provide an explanation on a separate sheet of paper and submit with this Application.

7. Are You utilizing a current edition of the CPT manual to ensure billing compliance?..... ☐YES ☐NO

For questions 8-15, if the answer is "YES", please provide an explanation on a separate sheet of paper and submit with this Application.

8. Do Your billings from federal and state health care programs, such as Medicare and Medicaid, exceed an average of $2,000,000 per physician in Your group?..... ☐YES ☐NO

   If "YES", please provide details on a separate page regarding your billings (including the nature of products or services being billed).

9. Have You or any physician in Your group ever been audited or investigated, or received a request for records or other documentation by or on behalf of a commercial payer or government entity?..... ☐YES ☐NO

10. Have You or any physician in Your group ever been placed on pre-payment review for Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?..... ☐YES ☐NO

11. Have You or any physician in Your group ever had to refund amounts to Public and/or Private payers of more than $10,000?..... ☐YES ☐NO

    a. If You answered "YES" to question 11, were these refunds due to an audit, allegation of improper billing, or voluntary self-disclosure?..... ☐YES ☐NO

    b. If You answered "YES" to question 11.a., please provide details on a separate page regarding the total amount of each refund, the name of the payer, and the reason for each refund.

12. Have You or any physician in Your group ever been accused of billing errors by any government agency or commercial payer?..... ☐YES ☐NO

13. Have You or any physician in Your Group ever:
    a. Been investigated or sanctioned by a state medical licensing board?..... ☐YES ☐NO
    b. Been involved in a Stark/anti-kickback investigation?..... ☐YES ☐NO
    c. Been sued or deselected by a private commercial payer?..... ☐YES ☐NO
    d. Been investigated for EMTALA violations?..... ☐YES ☐NO
    e. Been investigated for HIPAA violations?..... ☐YES ☐NO
    f. Voluntarily disclosed any billing errors or irregular billing practices?..... ☐YES ☐NO

14. Have You ever been non-renewed, placed on extension, or declined for similar regulatory/billing errors insurance?..... ☐YES ☐NO

15. Are You or any individual proposed for this insurance aware of any acts, errors, omissions, facts, circumstances, allegations, situations, events or incidents that could give rise to a regulatory investigation, regulatory action, or demand for restitution?..... ☐YES ☐NO

IV. CYBER SOLUTIONS QUESTIONS

Please complete Section IV if requesting Cyber Solutions or Cyber Solutions and Medefense Plus increased limits.

For questions 16–20, if the answer is "NO", please provide an explanation on a separate sheet of paper and submit with this Application.

16. Do You have a HIPAA compliance program in place?..... ☐YES ☐NO

17. Do You use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers?..... ☐YES ☐NO

18. Do You enforce privacy and security policies, including mandatory employee training, that must be followed by all employees, contractors, or other individuals or organizations with access to patient information?..... ☐YES ☐NO

19. Does Your organization store personal and/or confidential data on portable devices, including laptops, PDAs, back-up tapes, USB thumb drivers and external hard drives?..... ☐YES ☐NO

    a. If "YES", is such data encrypted to industry standards?..... ☐YES ☐NO
    b. If "NO", to question 19.a., please describe on a separate page the type of devices used, the nature of data/information stored, and the security measures You have in place to protect such data/information.

20. Does Your organization process, store, transmit or handle credit or debit card data?..... ☐YES ☐NO

    If "YES", are Your data security controls compliant with the Payment Card Industry Data Security Standard (PCI DSS)?..... ☐YES ☐NO

For questions 21-24, if the answer is "YES", please provide an explanation on a separate sheet of paper and submit with this Application.

21. Does the number of records You store, either electronic or paper, exceed 20,000 records per physician?..... ☐YES ☐NO

    If "YES", please provide the total number of records stored by the Applicant(s): _____

22. Have You or any physician in Your group received any complaints or claims or been the subject in litigation involving matters of privacy injury, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third-party networks or Your customer's ability to rely on Your network?..... ☐YES ☐NO

23. Are You or any physician in Your group aware of any security breaches, privacy-related events or incidents, or allegations of breach of privacy?..... ☐YES ☐NO

24. Have You ever been non-renewed, placed on extension, or declined for similar privacy/security liability coverage?..... ☐YES ☐NO

The Undersigned attests that the statements, representations, and information contained in or attached to this application are true and complete, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this application.

The Undersigned acknowledges and recognizes that the statements, representations, and information contained in or attached to this application are material to the risk assumed by the insurer; that any policy will have been issued in reliance upon the truth thereof; and that this application will be deemed incorporated into and made a part of the policy, should a policy be issued.

The Undersigned acknowledges and agrees that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the Applicant will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or agreement to bind the insurance.

Signed: _____ Date: _____

Authorized signature of the President, CEO or COO of the Applicant

Must be signed and dated no more than 60 days prior to the effective date of coverage.

Print Name: _____ Title: _____

