



**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: \_\_\_\_\_ Email: \_\_\_\_\_

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. Have You acquired, created, sold, merged into, or consolidated with another entity within the last twelve (12) months, or are You currently contemplating any such sale, merger or acquisition?  YES  NO  
If You answered "YES" to question 2 above, please provide details on a separate page.
3. Have You acquired or created any Subsidiaries<sup>1</sup> within the last twelve (12) months?  YES  NO  
If You answered "YES" to question 3 above, please provide details of each Subsidiary on a separate page, including the nature of operations and Your percentage of ownership.
4. Is coverage requested for any entity or organization other than the Applicant and its Subsidiaries?  YES  NO  
If You answered "YES" to question 4 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.
5. 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

<sup>1</sup> 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. HISTORY**

Please complete question 6 and 7 only if requesting Medefense Plus limits higher than \$50,000.

6. Have any claims, lawsuits, proceedings, actions, complaints, demand letters, or investigations/inquiries regarding billing errors, billing practices, EMTALA violations, Stark or self-referral law violations, or HIPAA violations been made against You or any other person or entity proposed for this insurance within the last twelve (12) months?  YES  NO

7. If You answered "YES" to question 6 above, have all such claims, lawsuits, proceedings, actions, complaints, demand letters, or investigations/inquiries been reported to the insurer?  YES  NO  N/A

If "NO", please provide complete claim details on a separate page.

Please complete questions 8 and 9 if requesting Cyber Solutions or combined Cyber Solutions and Medefense Plus increased limits.

8. Have any claims, lawsuits, proceedings, actions, complaints, demand letters, or investigations/inquiries regarding security or privacy-related incidents (including denial of service attacks, computer virus infections, theft or loss of confidential information, damage to third-party networks, or the ability of third parties to rely on Your network) been made against You or any other person or entity proposed for this insurance within the last twelve (12) months?  YES  NO

9. If You answered "YES" to question 8 above, have all such claims, lawsuits, proceedings, actions, complaints, demand letters, or investigations/inquiries been reported to the insurer?  YES  NO  N/A

If "NO", please provide complete claim details on a separate page.

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: \_\_\_\_\_