Cyber & Professional Lines Group
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e-MD® / MEDEFENSE® Plus Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for e-MD® / MEDEFENSE® Plus Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

1. GENERAL INFORMATION			
Name of Applicant			
Street Address		Phone	
City, State, Zip		Fax	
Website		Contact e-mail	

2. FORM OF BUSINESS			
a. Applicant is a(an): ☐ Individual ☐ Corporation ☐ Partnership ☐ Other: _____			
b. Date established:			
c. Description of operations (medical specialty):			
d. Current medical professional liability carrier:		Policy number:	
e. Total full-time equivalent physicians:			
f. Please attach a list of all subsidiaries, affiliated companies or entities owned by the Applicant. Please describe (1) the nature of operations of each such subsidiary, affiliated company or entity, (2) its relationship to the Applicant and (3) the percentage of ownership by the Applicant.			

3. REVENUES		
	Last 12 months	Projected for the next 12 months
Total gross revenues:	$	$

4. RECORDS (Please complete Section 4 only if e-MD (Cyber Liability) coverage is desired.)	
a. Do you collect, store, host, process, control, use or share any private or sensitive information* in either paper or electronic form? **If "Yes", please provide the approximate number of unique records**: **Paper records:** _____ **Electronic records:** _____ ***Private or sensitive information includes any information or data that can be used to uniquely identify a person, including, but not limited to, social security numbers or other government identification numbers, payment card information, drivers' license numbers, financial account numbers, personal identification numbers (PINs), usernames, passwords, healthcare records and email addresses.**	☐ Yes ☐ No
b. Do you collect, store, host, process, control, use or share any biometric information or data, such as fingerprints, voiceprints, facial, hand, iris or retinal scans, DNA, or any other biological, physical or behavioral characteristics that can be used to uniquely identify a person?	☐ Yes ☐ No
If "Yes", have you reviewed your policies relating to the collection, storage and destruction of such information or data with a qualified attorney and confirmed compliance with applicable federal, state, local and foreign laws?	☐ Yes ☐ No

5.	**BILLING AND COMPLIANCE (Please complete Section 5 only if MEDEFENSE Plus (Regulatory) coverage is desired.)**	
a.	Your annual projected billings:	$
b.	Percentage of your annual projected billings attributable to Medicare patients:	%
c.	Percentage of your annual projected billings attributable to Medicaid patients:	%
d.	What have your Medicare / Medicaid billings been for each of the past three years: Current Year: _____ One Year Ago: _____ Two Years Ago: _____	
e.	Do you have a billing compliance program in place? **If "Yes", when was it implemented? _____** **If "No", do you outsource your billings to a third-party billing company?**	☐ Yes ☐ No ☐ Yes ☐ No
f.	Do you use credentialed staff to perform billing procedures? **If Yes", how many credentialed staff members do you employ for this purpose? _____**	☐ Yes ☐ No
g.	Do you bill all services under the National Provider Identifier (NPI) of the individual who performed the service? **If "No', in instances where a mid-level provider's services are billed under a physician's NPI, is that physician present when the services are being rendered?**	☐ Yes ☐ No ☐ Yes ☐ No
h.	Is your practice using a current edition of the CPT manual?	☐ Yes ☐ No
i.	Is software used to ensure billing compliance? **If "Yes", when was the software installed? _____**	☐ Yes ☐ No
j.	Who within your organization is responsible for billing compliance? Please include the person's name, title, qualifications, date of hire in this position and how often such person performs billing compliance reviews **(use additional sheets if necessary)**. _____ _____	
6.	**INFORMATION AND NETWORK SECURITY CONTROLS (Please complete Section 6 only if e-MD (Cyber Liability) coverage is desired.)**	
a.	Are you HIPAA compliant?	☐ Yes ☐ No
b.	Do you use anti-virus software and a firewall to protect your network?	☐ Yes ☐ No
c.	Do you use a cloud provider to store data? **If "Yes", please provide the name of the cloud provider: _____** **If you use more than one cloud provider to store data, please specify the cloud provider storing the largest quantity of sensitive customer and/or employee records (e.g., including medical records, personal health information, social security numbers, bank account details and credit card numbers) for you.**	☐ Yes ☐ No
d.	Do you encrypt all sensitive and confidential information stored on your organization's systems and networks? **If "No", are the following compensating controls in place?** **(1) Segregation of servers that store sensitive and confidential information?** **(2) Access control with role-based assignments?**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
7.	**RANSOMWARE CONTROLS (Please complete Section 7 only if e-MD (Cyber Liability) coverage is desired.)**	
a.	Do you use 2-factor authentication to secure remote access to your network?	☐ Yes ☐ No
b.	Do you use 2-factor authentication to secure remote access to your email accounts?	☐ Yes ☐ No
c.	Do you use Endpoint Detection and Response (EDR) or a Next-Generation Antivirus (NGAV) software (e.g., CrowdStrike, Cylance, Carbon Black) to secure all system endpoints? **If "Yes", please list your provider:_____**	☐ Yes ☐ No
d.	Do you use an email filtering solution designed to prevent phishing or ransomware attacks (in addition to any filtering solution(s) provided by your email provider)? **If "Yes", please provide the name of your filtering solution provider:_____**	☐ Yes ☐ No

e. Do you use a data backup solution for all critical data? ☐ Yes ☐ No

If "Yes":

(1) How frequently does it run? ☐ **Daily** ☐ **Weekly** ☐ **Monthly**

(2) Which of the following best describes your data backup solution?

- ☐ **Local backup**
- ☐ **Network drive**
- ☐ **Tape backup**
- ☐ **Off-site storage**
- ☐ **Cloud backup**
- ☐ **Other:** _____

(3) Please list your data backup provider: _____

(4) Is your data backup solution segregated or disconnected from your network in such a way to reduce or eliminate the risk of the backup being compromised in a malware or ransomware attack that spreads throughout your network? ☐ Yes ☐ No

8. PHISHING CONTROLS (Please complete Section 8 only if e-MD (Cyber Liability) coverage is desired.)

a. Do any of the following employees at your company complete social engineering training:

(1) Employees **with** financial or accounting responsibilities? ☐ Yes ☐ No

(2) Employees **without** financial or accounting responsibilities? ☐ Yes ☐ No

If "Yes" to question 8.a.(1) or 8.a.(2) above, does your social engineering training include phishing simulation? ☐ Yes ☐ No

b. Does your organization send and/or receive wire transfers? ☐ Yes ☐ No

If "Yes", does your wire transfer authorization process include the following:

(1) A wire request documentation form? ☐ Yes ☐ No

(2) A protocol for obtaining proper written authorization for wire transfers? ☐ Yes ☐ No

(3) A separation of authority protocol? ☐ Yes ☐ No

(4) A protocol for confirming all payment or funds transfer instructions/requests from a new vendor, client or customer via direct call to that vendor, client or customer using only the telephone number provided by the vendor, client or customer before the payment or funds transfer instruction/request was received? ☐ Yes ☐ No

(5) A protocol for confirming any vendor, client or customer account information change requests (including requests to change bank account numbers, contact information or mailing addresses) via direct call to that vendor, client or customer using only the telephone number provided by the vendor, client or customer before the change request was received? ☐ Yes ☐ No

9. REGULATORY LOSS HISTORY (Please complete Section 9 only if MEDEFENSE Plus (Regulatory) coverage is desired.)

If the answer to any question in 9.a. through 9.b. below is "Yes", please complete a Claim Supplemental Form for each claim, allegation or incident.

a. After internal inquiry, have you, any member of your staff, any other person or entity proposed for this insurance, any consultant, or any person or entity for whom you perform billing services:

(1) Had to refund amounts to government (public) and/or commercial (private) payers within the past three years? ☐ Yes ☐ No

If "Yes", please provide estimated amounts:

Current Year (Fiscal): **Public: $**_____ **Private: $**_____

Last Year (Fiscal): **Public: $**_____ **Private: $**_____

Two Years Ago (Fiscal): **Public: $**_____ **Private: $**_____

If "Yes", were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure? ☐ Yes ☐ No

(2) Been placed on prepayment review by any local, state or federal government agency or by any commercial payer? ☐ Yes ☐ No

(3) Been audited, investigated or sanctioned by a local, state or federal government agency or commercial payer regarding Medicare/Medicaid billing practices, utilization of Medicare/Medicaid services or the delivery of health care services or reimbursement thereof? ☐ Yes ☐ No

(4) Been sued or deselected by a commercial payer?	☐ Yes ☐ No
(5) Been reviewed, investigated or sanctioned by a state medical licensing board?	☐ Yes ☐ No
(6) Been investigated for HIPAA, EMTALA or Stark/anti-kickback violations?	☐ Yes ☐ No
b. Do you or any other person or organization proposed for this insurance have knowledge of any facts, circumstances, situations, events or incidents that could result in a medical regulatory action, regulatory investigation or demand for restitution?	☐ Yes ☐ No

10. CYBER/PRIVACY LOSS HISTORY (Please complete Section 10 only if e-MD (Cyber Liability) coverage is desired.)

If the answer to any question in 10.a. through 10.c. below is "Yes", please complete a Claim Supplemental Form for each claim, allegation or incident.

a. In the past 3 years, has the Applicant or any other person or organization proposed for this insurance:	
(1) Received any complaints or written demands or been a subject in litigation involving matters of privacy injury, breach of private information, network security, defamation, content infringement, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third party networks or the ability of third parties to rely on the Applicant's network?	☐ Yes ☐ No
(2) Been the subject of any government action, investigation or other proceedings regarding any alleged violation of privacy law or regulation?	☐ Yes ☐ No
(3) Notified customers, clients or any third party of any security breach or privacy breach?	☐ Yes ☐ No
(4) Received any cyber extortion demand or threat?	☐ Yes ☐ No
(5) Sustained any unscheduled network outage or interruption for any reason?	☐ Yes ☐ No
(6) Sustained any property damage or business interruption losses as a result of a cyber-attack?	☐ Yes ☐ No
(7) Sustained any losses due to wire transfer fraud, telecommunications fraud or phishing fraud?	☐ Yes ☐ No
b. Do you or any other person or organization proposed for this insurance have knowledge of any security breach, privacy breach, privacy-related event or incident or allegations of breach of privacy that may give rise to a claim?	☐ Yes ☐ No
c. In the past 3 years, has any service provider with access to the Applicant's network or computer system(s) sustained an unscheduled network outage or interruption lasting longer than 4 hours?	☐ Yes ☐ No
If "Yes", did the Applicant experience an interruption in business as a result of such outage or interruption?	☐ Yes ☐ No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy nor will coverage apply to any claim or circumstance identified or that should have been identified in questions 9.a. through 10.c. of this application.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a e-MD® / MEDEFENSE® Plus Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage, and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant