Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436
main (818) 382-2030

e-MD® / MEDEFENSE® Plus Insurance Renewal 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	
Applicant is a(an): ☐ Individual ☐ Corporation ☐ Partnership ☐ Other: _____			

2. REQUIRED ADDITIONAL INFORMATION			
a. Applicant's medical professional liability carrier:		Policy number:	
b. Total full-time equivalent physicians:			

c. Has the nature of the professional services performed by the Applicant changed in any way in the last twelve (12) months? **If "Yes", please provide details on a separate page.**	☐ Yes ☐ No
d. Has the name of the Applicant changed, or has any merger or consolidation taken place, in the past 12 months? **If "Yes", please provide details on a separate page.**	☐ Yes ☐ No
e. Have there been any material changes in the Applicant's security controls in the past 12 months? **If "Yes", please provide details on a separate page.**	☐ Yes ☐ No
f. Has the Applicant acquired any subsidiaries, affiliated companies or entities in the past 12 months? **If "Yes", please attach a list with a description of (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.**	☐ Yes ☐ No

3. REVENUES		
	Current Fiscal Year ending / (current projected)	**Last** Fiscal Year ending /
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? **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 ☐ Yes ☐ No
5.	**BILLING AND COMPLIANCE (Please complete Section 5 only if MEDEFENSE Plus (Regulatory) coverage is desired.**	
a.	Your total 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.	Has the Applicant's billing compliance or HIPAA compliance program changed since last year?	☐ Yes ☐ No
e.	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
6.	**INFORMATION AND NETWORK SECURITY CONTROLS (Please complete Section 6 only if e-MD (Cyber Liability) coverage is desired.**	
a.	Do you use anti-virus software and a firewall to protect your network?	☐ Yes ☐ No
b.	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., medical records, personal health information, social security numbers, bank account details and credit card numbers) for you.**	☐ Yes ☐ No
c.	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? **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 ☐ Yes ☐ No

8.	**PHISHING CONTROLS (Please complete Section 8 only if e-MD (Cyber Liability) coverage is desired.)**	
a.	Do all employees with financial or accounting responsibilities at your company complete social engineering training?	☐ Yes ☐ No
	If "Yes", does such 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 below is "Yes", please complete a Claim Supplemental Form for each claim, allegation or incident.	
a.	In the past 12 months, has the Applicant, any staff member, any other person or organization proposed for this insurance, any consultant, or any person or entity for whom the Applicant performs billing services had to refund amounts to any government (public) or commercial (private) payer?	☐ Yes ☐ No
	(1) If "Yes", please provide refund amounts: **Public: $_____ Private: $_____**	
	(2) If "Yes", were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure?	☐ Yes ☐ No
b.	In the past 12 months, has the Applicant or any other person or organization proposed for this insurance received any billing errors proceeding, demand for restitution or notice of any regulatory investigation, inquiry or action involving actual or potential billing errors or HIPAA, EMTALA or Stark violations?	☐ Yes ☐ No
c.	Has the Applicant notified Tokio Marine HCC of all claims, suits, demands, investigations or inquiries received in the past 12 months?	☐ Yes ☐ No
	If "No", please forward complete details to Tokio Marine HCC immediately.	☐ None to Report
10.	**CYBER/PRIVACY LOSS HISTORY (Please complete Section 10 only if e-MD (Cyber Liability) coverage is desired.)**	
a.	In the past 12 months, 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.	In the past 12 months, has any IT service provider that the Applicant relies on sustained an unscheduled network outage or interruption lasting longer than 4 hours?	☐ Yes ☐ No
	If "Yes", did the Applicant experience an interruption in business due to such outage or interruption?	☐ Yes ☐ No
c.	Has the Applicant notified Tokio Marine HCC of all incidents or losses occurring, or claims, suits or demands received, in the past 12 months?	☐ Yes ☐ No
	If "No", please forward complete details to Tokio Marine HCC immediately.	☐ None to Report

NOTICE TO APPLICANT

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 an 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