NAS insurance
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LIC #0677191 · NASinsurance.com

e-MD™/Medefense™ Plus Application

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. DEFENSE COSTS WILL BE APPLIED TO THE RETENTION AMOUNT. READ THE ENTIRE APPLICATION CAREFULLY.

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 Gross Revenues: Current Year Annual Projection:____________ Prior Year: ______________

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.

7. Do Your operations include alternative medicine, wellness treatment, acupuncture, anti-aging services, hormone modification, naturopathic services, pain management, or home health care or durable medical equipment distributing services?... ☐**YES** ☐**NO**

[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. MEDEFENSE™ PLUS QUESTIONS

Please complete Section II only if standalone Medefense™ Plus or Combined e-MD™/Medefense™ Plus coverage is desired.

For question 8, if the answer is "NO", please provide an explanation on a separate sheet of paper and submit with this Application.

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

For questions 9-16, if the answer is "YES", please provide an explanation on a separate sheet of paper and submit with this Application.

9. 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).

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

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

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

    a. If You answered "**YES**" to question 12, were these refunds due to an audit, allegation of improper billing, or voluntary self-disclosure?.. ☐**YES** ☐**NO**

    b. If You answered "**YES**" to question 12.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.

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

14. 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 from 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**

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

16. 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**

III. e-MD™ QUESTIONS

Please complete Section III only if standalone e-MD™ or Combined e-MD™/Medefense™ Plus coverage is desired.

17. Please estimate the total number of patient and employee records you store either electronically or in physical files:

    ____

For questions 18–21, if the answer is “NO”, please provide an explanation on a separate sheet of paper and submit with this Application.

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

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

20. Does Your organization store personal and/or confidential data on portable devices, including laptops, cell phones, 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 20.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.

21. 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 22-25, if the answer is “YES”, please provide an explanation on a separate sheet of paper and submit with this Application.

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 or any physician in Your group experienced a financial loss resulting from wire transfer fraud, telecommunications fraud or a phishing attack in the past three years?.................................. ☐**YES** ☐**NO**

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

IV. NOTICE TO APPLICANT

The Undersigned acknowledges and understands that, with respect to questions 16 and 23 above, if knowledge of any such act, error, omission, fact, circumstance, allegation, situation, event or incident exists, whether or not disclosed, any claim or action against you, or any other entity or person proposed for this insurance, arising therefrom is expressly excluded from coverage under the proposed insurance.

V. WARRANTY AND REPRESENTATIONS

A. The Undersigned warrants and represents 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.

B. 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 and all written statements and materials furnished to the Insurer in conjunction with this application shall be deemed incorporated into and made a part of the policy, should a policy be issued.

C. The Undersigned acknowledges and agrees that if the information supplied on this application or in any attachments 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 binding coverage.

Print Name: ____ Title:______________________________