



e-MD®/MEDEFENSE® Plus Program 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. Current or prospective Physicians Insurance insured? YES NO

3. Physicians Insurance policy number (if available): _____

4. Date operations commenced under current ownership: _____

5. Description of operations: _____

6. Annual Gross Revenues: Current Year Annual Projection: _____ Prior Year: _____

7. Do You own any subsidiaries¹?..... YES NO

If You answered "YES" to question 7 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.

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

If You answered "YES" to question 8 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.

II. COVERAGE SELECTION

Type of Coverage: Standalone e-MD Standalone MEDEFENSE Plus Combined e-MD/MEDEFENSE Plus

Limit Desired: \$ _____ Requested Effective Date (mm/dd/yyyy): _____ (coverage may not be backdated)

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.

III. MEDEFENSE® PLUS QUESTIONS

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

For question 9, if the answer is “NO”, please provide an explanation on a separate sheet of paper and submit with this Application.

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

For questions 10-17, if the answer is “YES”, please provide an explanation on a separate sheet of paper and submit with this Application.

10. 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).

11. 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

12. 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

13. 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 13, were these refunds due to an audit, allegation of improper billing, or voluntary self-disclosure?..... YES NO

b. If You answered “YES” to question 13.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.

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

15. 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

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

17. 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. e-MD® QUESTIONS

Please complete Section IV only if standalone e-MD or Combined e-MD/MEDEFENSE Plus coverage is desired.

For questions 18–22, 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. 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
- 21. 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 21.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.
- 22. 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 23-26, if the answer is “YES”, please provide an explanation on a separate sheet of paper and submit with this Application.

- 23. 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): _____
- 24. 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
- 25. 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
- 26. Have You ever been non-renewed, placed on extension, or declined for similar privacy/security liability coverage?..... YES NO

V. NOTICE TO APPLICANT

The Undersigned acknowledges and understands that, with respect to questions 17 and 25 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.

VI. 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: _____