

APPLICATION for:

MEDEFENSE™ PLUS / e-MD™

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

The Insurer agrees to use all information provided in this Application solely in connection with the proposed insurance.

If a material change occurs to any of the answers given below prior to the inception of any insurance, the Applicant must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.

The particulars, representations and statements contained in this Application and any other information submitted are the basis for the proposed insurance and will be considered as incorporated into, and constituting part of, the proposed certificate and/or policy.

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.

“You” and “your” as used in this Application shall mean the Applicant.

The completion and signing of this Application does not bind the Applicant or the insurer to a policy or certificate of insurance.

SECTION I. GENERAL INFORMATION

1. Name of Applicant: _____
Principal Address: _____
City: _____ State: _____ Zip: _____
Telephone Number: _____ Email Address: _____
Website: _____

2. Description of Operations: _____

a) If a physician/medical group:
Number of physicians: _____
Specialty: _____

3. If the Applicant is an entity, date of formation of the entity: _____

4. Please provide a list of subsidiaries and entities owned by the Applicant. Please describe the nature of business of each such subsidiary or entity, its relationship to the Applicant, and the percentage of ownership by the Applicant. __

5. Applicant's Annual Revenues: Current Year: _____ One Year Ago: _____ Two Years Ago: _____

6. Have you acquired any practices in the last 5 years?..... Yes No

If you answered “**Yes**” to question 6, please provide specific details, including the size of each practice, date(s) of acquisition, the specialty/specialties of each practice, and total percentage of Medicare/Medicaid billings, if any, for each practice for each of the past five years. **(Use separate sheet):**

7. a) Applicant's total annual projected billings: \$ _____
 b) Percentage of annual projected billings attributable to Medicare Patients: _____ %
 c) Percentage of 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: _____

8. Have any officers or senior management voluntarily or involuntarily left your employ within the last 18 months? Yes No
 If you answered "Yes" to question 8, please provide specific details, including the exact date (mm/dd/yyyy) of the separation, the name and title of each individual, and the reason each individual's employment was discontinued. **(Please use a separate sheet if necessary):**

SECTION II. COMPLIANCE

9. Do you have a billing compliance program in place?..... Yes No
 If you answered "Yes" to question 9, when was it implemented? _____
 If you answered "No" to question 9, please describe your billing guidelines on a separate sheet of paper.
10. Do you utilize credentialed staff to perform billing procedures?..... Yes No
 If you answered "Yes" to question 10, how many? _____
11. Is your practice using a current edition of the CPT manual?..... Yes No
12. Is software used to ensure billing compliance?..... Yes No
 If you answered "Yes" to question 12, when was it installed? _____
13. Who is responsible for billing compliance? Please include their name, title, qualifications and date of hire in this position:

14. If you outsource your billing to a third party billing company, are certified billers used?..... Yes No
15. How often are billing reviews performed and by whom? _____
16. Are all contracts and referral relationships reviewed by outside counsel to ensure you are compliant with anti-kickback statutes/regulations?..... Yes No
 If you answered "Yes" to question 16, please provide the date of last review? _____

SECTION III. NETWORK SECURITY AND PRIVACY CONTROLS

17. Does your company use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers, and is it updated in accordance with the software provider's recommendations?..... Yes No
18. Do you enforce a software update process that includes monitoring of vendors or automatically receiving notices from them for availability of security patches, upgrades, testing and installing critical security patches?..... Yes No
 If you answered "Yes" to question 18, how frequently is this done?
 Weekly Within 30 days More than 30 days
19. Do you enforce privacy and security policies that must be followed by all employees, contractors, or other individuals or organizations with access to your patients' information?..... Yes No
20. Do your privacy and security policies include mandatory training for all employees? Yes No

21. Is all sensitive and confidential information stored on your organization's databases, servers and data file encrypted?..... Yes No
22. If encryption is not in place for databases, servers and data files, are the following compensating controls in place:
- a) Segregation of servers that store confidential information?..... Yes No
- b) Access control with role-based assignments?..... Yes No
23. If your organization stores personal information on portable devices, including laptops, cell phones, PDA's, back-up tapes, USB thumb drives and external hard drives, is such data encrypted to industry standards?..... Yes No
- If you do not store personal information on portable devices, check here**
24. Please estimate the number of customer/patient and employee records you store either electronically or in paper files:..... _____

SECTION IV. LOSS HISTORY

After internal inquiry, have you or any member of your staff, or any person or entity for whom you perform billing services ever:

25. Been investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding the delivery of health care services or reimbursement thereof?..... Yes No
26. Had to refund amounts to Public and/or Private Payers within the last 3 years?..... Yes No
- a) If you answered "Yes" to question 26, please provide estimated amounts:
- Current Year (Fiscal): Public: \$ _____ Private: \$ _____
- Last Year (Fiscal): Public: \$ _____ Private: \$ _____
- Two Years Ago (Fiscal): Public: \$ _____ Private: \$ _____
- b) If you answered "Yes" to question 26, were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure?..... Yes No
27. Been:
- a) Audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?..... Yes No
- b) Been placed on prepayment review by any local, state, or federal government agency?..... Yes No
- c) Been placed on prepayment review by any private (commercial payer)?..... Yes No
28. Been sued or deselected from a private (commercial) payer?..... Yes No
29. Been reviewed, investigated or sanctioned by a state medical licensing board?..... Yes No
30. Been involved in a stark/anti-kickback investigation? Yes No
31. Been accused of billing errors by any local, state or federal government agency or private (commercial) payer?..... Yes No
32. Been investigated for HIPAA or EMTALA violations? Yes No
33. Been non-renewed, placed on extension, or declined for similar coverage?..... Yes No
34. Experienced any incidents and/or received any complaints or claims or been the subject of 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
35. Been aware of any facts, circumstances, situations, events or incidents that could result in a regulatory action, regulatory investigation or demand for restitution?..... Yes No

36. In the last five (5) years, been aware of any security breaches, privacy breaches, privacy-related incidents or allegations of breach of privacy?..... Yes No

If the answer to any of questions 25 through 36 is "Yes", please explain on a separate sheet of paper.

SECTION V. OTHER INFORMATION

1. The undersigned declares that the statements herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. The signing of this Application does not bind the undersigned to complete the insurance.
2. It is warranted that the particulars and statements contained in this Application and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto) are the basis for the proposed Policy (should a Policy be issued) and will be considered as incorporated into and constituting a part of the proposed Policy (if issued). Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.
3. The undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the insurer, any insurance issued shall be void in its entirety.
4. It is agreed that, if after the date of this Application and prior to issuance of the insurance policy, any information supplied on this Application changes, the undersigned shall immediately notify the insurer of such change(s) and shall provide the insurer with any information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the insurer.
5. For purposes of creating a binding contract of insurance by this Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall have the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

Severability: No knowledge or information possessed by any insured person will be implied to any other insured person except for material facts or information known to the person or persons who signed the Application. In the event that any of the particulars or statements in the Application are untrue, this policy will be void with respect to any insured person who knew of such untruth or to who such knowledge is implied.

Authorized Signature (Must be signed by the Applicant's President, CEO or COO): _____

Title: _____

Print Name: _____

Applicant Organization: _____

Date (MM/DD/YYYY): _____



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