NAS insurance
16501 Ventura Blvd. Suite 200 Encino, CA 91436
LIC #0677191 · NASinsurance.com

e-MD®/MEDEFENSE® Plus Application

NOTICE: THIS APPLICATION IS FOR CLAIMS-MADE AND REPORTED COVERAGE WITH DEFENSE COSTS PAID WITHIN THE LIMITS OF LIABILITY. READ THE ENTIRE APPLICATION CAREFULLY. APPLICANT IS REQUIRED TO MAKE INTERNAL INQUIRY BEFORE COMPLETING THIS APPLICATION.

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: _____

Telephone: _____ Facsimile: _____ E-mail Address: _____

Website: _____

1. Total number of Full Time Equivalent (FTE) physicians in your group: _____
   (1 full time physician counts as 1 FTE. 2 part time physicians count as 1 FTE)
2. Name of the Medical Malpractice carrier that insures the physicians. If none, please indicate "N/A" _____
3. Date operations commenced under current ownership: _____
4. Description of operations: _____
5. Annual Revenues: Current Year: _____ One Year Ago: _____ Two Years Ago: _____
6. Do You own any subsidiaries?..... ☐YES ☐NO

   If You answered "YES" to question 6 above, please provide a list of Your subsidiaries with an explanation of each subsidiary's a) nature of operations, b) relationship to You, and c) percentage of ownership by You. Please use a separate sheet of paper, if necessary: _____

   _____
7. Do Your operations include chiropractic care, oncology, alternative medicine, wellness treatment, acupuncture, anti-aging services, hormone modification, naturopathic services, pain management, or physical or occupational therapy?..... ☐YES ☐NO

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)

III. MEDEFENSE® PLUS QUESTIONS

Please complete Section III 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

10. 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

11. Have You or any physician in Your group ever been placed on pre-payment review for 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 the total amount of refunds (list refunds to public and private payers separately):

    _____

    _____

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 by 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 from similar coverage? ☐YES ☐NO

16. Do You or any individual proposed for this insurance have knowledge of any facts, circumstances, allegations, situations, events, incidents or billing errors 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.

17. Do You use a cloud provider to store data? ☐ YES ☐ NO

    If "Yes", please name the cloud provider: _____

    If You use more than one cloud provider to store data, please name the cloud provider storing the largest quantity of customer and/or employee records, including medical records, personal health information, social security numbers, bank account details, and credit card numbers.

For questions 18–23, 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 that must be followed by all employees, contractors, or other individuals or organizations with access to patient information? ☐YES ☐NO

21. If Your organization stores personal information on portable devices, including laptops, cell phones, PDAs, back-up tapes, USB thumb drivers 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 ☐

22. Do Your security and privacy policies include mandatory training for all employees? ☐YES ☐NO

23. Do You accept, transmit, process or store any payment cardholder data? ☐YES ☐NO

    If "YES", are You compliant with the Payment Card Industry Data Security Standard? ☐YES ☐NO

For questions 24-26, if the answer is "YES", please provide an explanation on a separate sheet of paper and submit with this Application.

24. Does the number of records you store, either electronic or paper, exceed 20,000 per physician? ☐YES ☐NO

    If "Yes", please provide the total number of records stored by the Applicant(s): _____

25. 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

26. Are You or any physician in Your group aware of any security breaches, privacy-related incidents, or allegations of breach of privacy? ☐YES ☐NO

V. NOTICE TO APPLICANT

A. The Applicant represents that the statements and information contained in this application are true and complete.

B. The Applicant acknowledges that the statements and information contained in this application shall be deemed 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 will be deemed incorporated into and made a part of the policy, should a policy be issued.

C. The Applicant acknowledges and agrees that if the information supplied on this application 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 modify or deny coverage.

Signed: _____ Date: _____

Authorized signature of the President, CEO or COO of the Applicant
Must be signed and dated no more than 45 days prior to binding coverage.

Print Name: _____ Title: _____

NOTICE:

1. **THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357 OR INTERNET WEB SITE WWW.INSURANCE.CA.GOV. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC'S INTERNET WEB SITE AT WWW.NAIC.ORG.**
5. **FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**
6. **FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT (IID) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSURERS. ASK YOUR AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.**
7. **CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: WWW.INSURANCE.CA.GOV.**
8. **IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: _____

Insured: _____