Cyber & Professional Lines Group
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main (818) 382-2030

MEDEFENSE® Plus Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for 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			
City, State, Zip		Phone	
Website		Fax	

2. FORM OF BUSINESS			
a. Applicant is a(an): ☐ Individual ☐ Corporation ☐ Partnership ☐ Other: _____			
b. Date established:			
c. Description of operations (medical specialty):			
d. Current medical professional liability carrier:		Policy number:	
e. Total full-time equivalent physicians:			
f. Please attach a list of all subsidiaries, affiliated companies or entities owned by the Applicant. Please describe (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.			

3. REVENUES			
	Current Fiscal Year ending / (current projected)	Last Fiscal Year ending /	Two Fiscal Years ago ending /
Total gross revenues:	$	$	$

4. COVERAGE DESIRED	
a. Proposed Effective Date:	
b. Retroactive Date:	
c. Limit(s):	
d. Deductible(s):	

5. BILLING AND COMPLIANCE		
a. Your 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. What have your Medicare / Medicaid billings been for each of the past three years: Current Year: _____ One Year Ago: _____ Two Years Ago: _____		
e. Do you have a billing compliance program in place? **If "Yes", when was it implemented?** _____ **If "No", do you outsource your billings to a third-party billing company?**		☐ Yes ☐ No ☐ Yes ☐ No
f. Do you use credentialed staff to perform billing procedures? **If Yes", how many credentialed staff members do you employ for this purpose?** _____		☐ Yes ☐ No
g. 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
h. Is your practice using a current edition of the CPT manual?		☐ Yes ☐ No

i. Is software used to ensure billing compliance? **If "Yes", when was the software installed? _____**	☐ Yes ☐ No
j. Who within your organization is responsible for billing compliance? Please include the person's name, title, qualifications, date of hire in this position and how often such person performs billing compliance reviews **(use additional sheets if necessary)**. _____	
k. Are you HIPAA compliant?	☐ Yes ☐ No

6. LOSS HISTORY

If the answer to question in 6.a. or 6.b. below is "Yes", please complete a Claim Supplemental Form for each claim, allegation or incident.

a. After internal inquiry, have you, any member of your staff, any other person or entity proposed for this insurance, any consultant, or any person or entity for whom you perform billing services:	
(1) had to refund amounts to government (public) and/or commercial (private) payers within the past three years? **If "Yes", please provide estimated amounts:** **Current Year (Fiscal): Public: $_____ Private: $_____** **Last Year (Fiscal): Public: $_____ Private: $_____** **Two Years Ago (Fiscal): Public: $_____ Private: $_____**	☐ Yes ☐ No
If "Yes", were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure?	☐ Yes ☐ No
(2) been placed on prepayment review by any local, state or federal government agency or by any commercial payer?	☐ Yes ☐ No
(3) been audited, investigated or sanctioned by a local, state or federal government agency or commercial payer regarding Medicare/Medicaid billing practices, utilization of Medicare/Medicaid services or the delivery of health care services or reimbursement thereof?	☐ Yes ☐ No
(4) been sued or deselected by a commercial payer?	☐ Yes ☐ No
(5) been reviewed, investigated or sanctioned by a state medical licensing board?	☐ Yes ☐ No
(6) been investigated for HIPAA, EMTALA or Stark/anti-kickback violations?	☐ Yes ☐ No
b. Do you or any other person or organization proposed for this insurance have knowledge of any facts, circumstances, situations, events or incidents that could result in a medical regulatory action, regulatory investigation or demand for restitution?	☐ Yes ☐ No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy nor will coverage apply to any claim or circumstance identified or that should have been identified in questions 6.a. through 6.b. of this application.

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 a MEDEFENSE® Plus Insurance risk have been revealed.

By signing below, the Applicant consents to the Insurer conducting non-intrusive scans of the Applicant's internet-facing systems / applications for common vulnerabilities.

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

California Fraud Warning

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.