Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436
main (818) 382-2030

MEDEFENSE® Plus Insurance Renewal 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. Applicant's medical professional liability carrier:		Policy number:	
c. Total full-time equivalent physicians:			

d. Has the nature of the professional services performed by the Applicant changed in any way in the last 12 months? **If "Yes", provide details on a separate page.**	☐ Yes ☐ No
e. Has the name of the Applicant changed, or has any merger or consolidation taken place, in the past 12 months? **If "Yes", provide details on a separate page.**	☐ Yes ☐ No
f. Have there been any material changes in the Applicant's security controls in the past 12 months? **If "Yes", provide details on a separate page.**	☐ Yes ☐ No
g. Has the Applicant acquired any subsidiaries, affiliated companies or entities in the past 12 months? **If "Yes", attach a list with a description of (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.**	☐ Yes ☐ No

3. REVENUES		
	Current Fiscal Year ending / (current projected)	Last Fiscal Year 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. Has the Applicant's billing compliance or HIPAA compliance program changed since last year?		☐ Yes ☐ No
e. Do you bill all services under the National Provider Identifier (NPI) of the individual who performed the service?		☐ Yes ☐ No
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
f. 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. In the past 12 months, has the Applicant, any staff member, any other person or organization proposed for this insurance, any consultant, or any person or entity for whom the Applicant performs billing services had to refund amounts to any government (public) or commercial (private) payer? **(1) If "Yes", provide refund amounts:** Public: $_____ Private: $_____ **(2) If "Yes", were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure?**	☐ Yes ☐ No ☐ Yes ☐ No
b. In the past 12 months, has the Applicant or any other person or organization proposed for this insurance received any billing errors proceeding, demand for restitution or notice of any regulatory investigation, inquiry or action involving actual or potential billing errors or HIPAA, EMTALA or Stark violations?	☐ Yes ☐ No
c. Has the Applicant notified Tokio Marine HCC of all claims, suits, demands, investigations or inquiries received in the past 12 months? **If "No", forward complete details to Tokio Marine HCC immediately.**	☐ Yes ☐ No ☐ None to Report

NOTICE TO APPLICANT

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.