TOKIO MARINE HCC

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 unless noted otherwise below.

1. GENERAL INFORMATION

Name of Primary Applicant:

Business Address: Phone:

Description of operations:

2. ADDITIONAL ENTITIES

Names of all additional entities seeking coverage under the policy. Include each entity's description of operations and relationship to you, including any percentage of ownership.

3. WEBSITES / DOMAINS

List all websites/domains owned/operated by all entities seeking coverage:

4. CONFIRMATION OF ENTITIES

This Application is reflective of the total exposure for all entities seeking coverage, including revenues, records, controls, vendors and loss history. ☐ Yes ☐ No

5. TOTAL GROSS REVENUES

a. Current Full Fiscal Year:	$
b. Last Completed Full Fiscal Year:	$

6. BILLING AND COMPLIANCE

a. Your annual projected billings: $

b. Do you have a billing compliance program in place? ☐ Yes ☐ No

If "Yes", when was it implemented? _____

If "No", do you outsource your billings to a third-party billing company? ☐ Yes ☐ No

c. Do you use credentialed staff to perform billing procedures? ☐ Yes ☐ No

d. 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

e. Is your practice using a current edition of the CPT manual? ☐ Yes ☐ No

f. Is software used to ensure billing compliance? ☐ Yes ☐ No

g. 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).

7. REGULATORY LOSS HISTORY

If the answer to any question in 7.a. through 7.b. below is "Yes", please provide details 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? ☐ Yes ☐ No

i. If "Yes", were refunds greater than or equal to 2% of gross annual billings? ☐ Yes ☐ No

ii. If "Yes", were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure? ☐ Yes ☐ No

iii. If "No" to **a.(1)ii.** above, were these refund amounts routine in nature? ☐ 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, sanctioned, sued, or deselected by a government agency of any level, commercial payer, or state medical board regarding Medicare/Medicaid billing or utilization of such services, healthcare services, or reimbursement? ☐ Yes ☐ No

(4) 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 7.a. through 7.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, CONSENT 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.