NAS insurance
16501 VENTURA BLVD. SUITE 200 ENCINO, CA 91436
Lic. #0677191 · NASinsurance.com

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must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.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: _____

   Date Established: _____

2. Description of Operations (Medical Specialty): _____

   If a physician/medical group, indicate the number of physicians: _____

3. Name of current medical professional liability carrier: _____

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. Does the Applicant anticipate any significant changes in nature or size (e.g. more than 20% increase in revenue) of the Applicant's business in the next (12) months?..... ☐ Yes ☐ No

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 with the Applicant ended. **(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, do you outsource your billings to a third-party billing company?..... ☐ Yes ☐ No

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 within your organization is responsible for billing compliance? Please include the person's name, title, qualifications and date of hire in this position and how often such person performs billing reviews:

_____

_____

SECTION III. NETWORK SECURITY AND PRIVACY CONTROLS

14. Are you HIPAA compliant?..... ☐ Yes ☐ No

15. 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

16. 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 16, how frequently is this done?
☐ Weekly ☐ Within 30 days ☐ More than 30 days

17. 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

18. Do your privacy and security policies include mandatory training for all employees?..... ☐ Yes ☐ No

19. Is all sensitive and confidential information stored on your organization's databases, servers and data file encrypted?..... ☐ Yes ☐ No

20. 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

21. Does your organization store personal information on portable devices, including laptops, PDA's back-up tapes, USB thumb drives and external hard drives?..... ☐ Yes ☐ No

If you answered "**Yes**" to question 21, is such data encrypted to industry standards?..... ☐ Yes ☐ No

22. Please estimate the total number of customer/patient and employee records stored by you or by third parties on your behalf, either electronically or in paper files: …… _____

23. 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.

24. Does your organization process, store, transmit or handle credit or debit card data?..... ☐ Yes ☐ No

If you answered "**Yes**" to question 24, are you PCI-DSS compliant?..... ☐ Yes ☐ No

SECTION IV. LOSS HISTORY

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

25. Had to refund amounts to Public and/or Private Payers within the last 3 years?..... ☐ Yes ☐ No

a) If you answered **"Yes"** to question 25, 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 25, were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure?..... ☐ Yes ☐ No

26. a) Been placed on prepayment review by any local, state or federal government agency or by any private (commercial) payer? …… ☐ Yes ☐ No

b) Been audited, investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding Medicare/Medicaid billing practices, utilization of Medicate/Medicaid services or the delivery of health care services or reimbursement thereof?..... ☐ Yes ☐ No

c) Been sued or deselected by a private (commercial) payer?..... ☐ Yes ☐ No

d) Been reviewed, investigated or sanctioned by a state medical licensing board?..... ☐ Yes ☐ No

e) Been investigated for HIPAA, EMTALA or stark/anti-kickback violations?..... ☐ Yes ☐ No

27. Been non-renewed, placed on extension, or declined for similar coverage?..... ☐ Yes ☐ No

28. Experienced any incidents, received any complaints or claims, or been the subject of litigation involving matters of privacy injury, identity theft, denial of service attacks, security breaches, privacy breaches, unscheduled network outages or interruptions, computer virus infections, theft of information, damage to third party networks, or your customer's ability to rely on your network?..... ☐ Yes ☐ No

29. Had knowledge of any facts, circumstances, situations, events or incidents that could result in a regulatory action, regulatory investigation or demand for restitution?..... ☐ Yes ☐ No

If you answered "Yes" to any of questions 25-29 above, please provide full details on a separate sheet of paper.

SECTION V. WARRANTIES AND REPRESENTATIONS

1. The undersigned warrants and represents that the statements and information contained herein or attached to this Application are true and complete, 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. **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. The Insurer may withdraw or modify any outstanding quotations and/or agreement to bind the insurance.**

4. **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 imputed to any other insured person except for material facts or information known to the person or persons who signed the Application. If 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 imputed.

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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