APPLIED MEDICO-LEGAL SOLUTIONS

NAS insurance

e-MD™/Medefense™ Plus
Program 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: _____
(*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. 1 part time physician counts as 1/2 FTE)
2. Current or prospective AMS insured? ☐**YES** ☐**NO**
3. AMS policy number (if available): _____
4. Date operations commenced under current ownership: _____
5. Description of operations: _____
6. Annual Revenues: Current Year: _____ One Year Ago: _____ Two Years Ago: _____
7. Do You own any subsidiaries?..... ☐**YES** ☐**NO**

   If You answered "**YES**" to question 7 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: _____

   _____

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", coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside of the program, please provide the details for the "NO" answer 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", coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside of the program, please provide the details for the "YES" answer 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 $1,000,000 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 with regard to 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 "**YES**", 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 from 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. Are You or any individual proposed for this insurance aware of any facts, circumstances, allegations, situations, events or incidents 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.

For questions 17–21, if the answer is "NO", coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside of the program, please provide the details for the "NO" answer on a separate sheet of paper and submit with this Application.

17. Do You have a HIPAA compliance program in place?..... ☐**YES** ☐**NO**

18. Do You use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers?..... ☐**YES** ☐**NO**

19. 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**

20. 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 ☐

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

For questions 22-24, if the answer is "YES", coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside of the program, please provide the details for the "YES" answer on a separate sheet of paper and submit with this Application.

22. Does the number of records you store, either electronic or paper, exceed 5,000 per physician?..... ☐**YES** ☐**NO**

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

23. 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**

24. 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: _____