ASCENT™
UNDERWRITING

CyberPro & Regulatory Medical Billings

Renewal Application Form

As used throughout this application, "you" means the person signing the application, as well as the entity seeking insurance and the applicant's principals, partners, directors, risk managers, or employees that are in a supervisory role. The questions contained in this application pertain to all persons or entities seeking insurance, and not just the signatory.

Please answer all the questions on this form. Before any question is answered, please carefully read the declaration at the end of the application form, which you are required to sign. Underwriters will rely on the statements that you make on this form. In this context, ANY INSURANCE COVERAGE THAT MAY BE ISSUED UPON THIS FORM WILL BE VOID IF THE FORM CONTAINS FALSEHOODS, MISREPRESENTATIONS OR OMISSIONS. PLEASE TAKE CARE IN FILLING OUT THIS FORM.

1 General Information

Name	
Address	
	Zip code

Website home page (including subsidiaries)

Total number of employees

Number of Physicians full time (more than 20 hrs per week)

Number of Physicians part time (less than 20 hrs per week)

Gross Billings: Last Fully Completed

Gross Revenue: Last Fully Completed

Gross Revenue: Projected

Please advise approximate number of Personally Identifiable Information (PII*) records stored on your network, database or system. *PII is defined as a personally identifiable record that can be used to identify, contact or locate a single individual

2 Operational Changes

Since completion of your previous application form or over the forthcoming 12 months, have there been, or do you anticipate:

- any significant change to the nature, service or operation of your business, including any merger or acquisition? Yes ☐ No ☐
- any change to your responses regarding network security and risk control? Yes ☐ No ☐
- any changes to billings practices? Yes ☐ No ☐

3 Claims and Expiring Information

Since completion of your last application form have you or anyone else within the practice:

a) Been reviewed or investigated by the State board of Medical Examiners?	Yes ☐	No ☐
b) Been audited or investigated with regard to Medicaid/Medicare billing practices?	Yes ☐	No ☐
c) Lost any medical privileges, other than voluntary termination, with any provider?	Yes ☐	No ☐
d) Been investigated or sanctioned by any local, state or federal government or agency regarding the delivery of the healthcare service or the reimbursement thereof?	Yes ☐	No ☐
e) Been involved in an anti-kickback investigation?	Yes ☐	No ☐
f) Been sued or deselected from a commercial payer?	Yes ☐	No ☐
g) Sustained any unscheduled or unintentional network outage, intrusion, corruption or loss of data?	Yes ☐	No ☐
h) Received notice or become aware of any privacy violations or that any data or personally identifiable information has become compromised?	Yes ☐	No ☐
i) Become aware of any circumstance or incident that could be reasonably anticipated to give rise to a claim against the type of insurance(s) being requested in this application?	Yes ☐	No ☐

If 'yes' to any questions within this section, please provide full details:

Data Protection

By accepting this insurance you consent to Ascent Underwriting using the information we may hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities.

Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with relevant Data Protection legislation. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

IMPORTANT – Cyber Pro Policy Statement of Fact

By accepting this insurance you confirm that the facts contained in the proposal form are true. These statements, and all information you or anyone on your behalf provided before we agree to insure you, are incorporated into and form the basis of your policy. If anything in these statements is not correct, we will be entitled to treat this insurance as if it had never existed. You should keep this Statement of Fact and a copy of the completed proposal form for your records.

This application must be signed by the applicant. Signing this form does not bind the company to complete the insurance. With reference to risks being applied for in the United States, please note that in certain states, any person who knowingly and with intent to defraud any insurance company or other person submits an application for insurance containing any false information, or conceals the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

The undersigned is an authorized principal, partner, director, risk manager, or employee of the applicant and certifies that reasonable inquiry has been made to obtain the answers herein which are true, correct and complete to the best of his/her knowledge and belief. Such reasonable inquiry includes all necessary inquiries to fellow principals, partners, directors, risk manager, or employees to enable you to answer the questions accurately.

Name	Position
Signed	Date

Additional Notes