CYBER Pro + Healthcare

Application Form

ASCENT™ UNDERWRITING

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 BASED UPON THIS FORM WILL BE VOID IF THE FORM CONTAINS FALSEHOODS, MISREPRESENTATIONS, OR OMISSIONS. PLEASE TAKE CARE IN FILLING OUT THIS FORM.**

You may provide any further additional information by means of a separate attachment if necessary.

1 GENERAL INFORMATION

a. Name (s) of Applicant/Practice

b. Address

c. Website

d. Date business established (dd/mm/yyyy)

e. Detail the main specialities of the practice.

f. Legal Structure (Please tick one)

Individual	☐	Joint Venture	☐
Corporation	☐	Professional Association	☐
Partnership	☐	Other	☐

g. Tax Status

For Profit	☐	Not For Profit	☐
Government	☐	Other	☐

h. Please list any/all accreditation from governmental agencies/clients and association memberships held by your faculty?

Ownership:

Private	☐	Are any services hospital-based?	☐
Physician	☐	Have there been any change in ownership since the date the entity was established?	☐
Hospital	☐		

If **YES,** to any of the above please provide details:

2 OPERATIONAL INFORMATION

a. Date business established (dd/mm/yyyy)

b. Annual gross billings	Last year		Current year		Next year (est.)	
c. Annual gross collections	Last year		Current year		Next year (est.)	
d. Annual gross revenue	Last year		Current year		Next year (est.)	
e. Number of patient visits	Last year		Current year		Next year (est.)	
f. Number of test performed	Last year		Current year		Next year (est.)	

g. How many PII's are retained within your computer network, databases and records?(PII is defined as a personally identifiable record on an individual that can be used to identify, contact or locate a single individual)

h. Please provide number of all practitioners whether employed or contracted, as below.

Number of Physicians full time (more than 20hrs per week)	
Number of Physicians part time (less than 20hrs per week)	
Number of other practitioners including, physician assistants, nurses, midwives etc	
Total number of employee	

3 PROFESSIONAL SERVICES

a. Please provide a breakdown of patient visits or percentage of total patient visits:

	Visits	%		Visits	%
Acupuncturist/Naturopathic Medicine			Medical Spa Services		
Alcohol/Drug Rehabilitation			Nursing Home/LTC Facility		
Ambulance Services/Patient Transport			Optical Services		
Ambulatory Surgical Center			Out-Patent Clinic		
Blood Bank/Sperm			Pathology Services		
Community Health Clinic			Pharmacy Services		
Diagnostic Imaging			Rehabilitation		
Dialysis Center			Social Services		
Fertility Services			Speech Therapy		
Health/Fitness Center			Telemedicine		
Healthcare Staffing			Urgent Care		
Home Healthcare Services			Weight Loss		
Laboratory Services			Other (Please specify)		

Other:

3 PROFESSIONAL SERVICES (Cont.)

b. Does the applicant have beds for overnight stays **Yes** ☐ **No** ☐

If **YES** – No of Beds/Average occupancy

c. Does the applicant perform hospital emergency room care:

i. For its own patients? **Yes** ☐ **No** ☐

ii. For patients but not their own? **Yes** ☐ **No** ☐

If answer to '**i**' is **YES** then please specify - % of time devoted to this work? Number of hours per month devoted to this work?

d. Is anesthesia (other than topical or by means of local infiltration) administered by the either applicant or others? **Yes** ☐ **No** ☐

If **YES**, please explain:

e. Does the applicant use drugs for weight reduction of patients **Yes** ☐ **No** ☐

If **YES**, please list drugs used and advise on the frequency and duration of prescriptions for weight reduction drugs and quantity dispensed by applicant.

f. Please state the number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both?

g. Please state whom the treatment is given and number of procedures?

If **YES**, please explain:

h. Do you compound in bulk, manufacture or wholesale medicine? **Yes** ☐ **No** ☐

If **YES**, please explain:

i. If the applicant provides **Ambulance and/or Patient Transport Services**, please answer the following:

- Total Number of Ground Ambulance patient movements?
- Total Number of Air Ambulance patient movements?
- Total Number of Emergency Calls?
- Total Number of non-emergency calls?

j. If the applicant provides **Surgical Services**, please answer the following:

- Total Number of Surgical procedures?
- % of procedures using anesthesia?

3 PROFESSIONAL SERVICES (Cont.)

k. Do you perform OB/GYN services? **Yes** ☐ **No** ☐

If **YES**, please explain:

l. Do you perform Bariatric services? **Yes** ☐ **No** ☐

If **YES**, please explain:

m. If the applicant provides **Dialysis Treatment**, please answer the following:

- Number of hemodialysis treatments?
- Number of peritoneal treatments?
- Number of In-home treatments?
- Number of stations?

n. If the applicant provides **Alcohol/Drug/Psychiatric Rehabilitation Services**, please answer the following:

- Total Number of Licensed Beds?
- Do you provide offsite counselling? **Yes** ☐ **No** ☐
- Are all counsellors licensed? **Yes** ☐ **No** ☐
- Are all interns and students supervised at all times? **Yes** ☐ **No** ☐

o. Does the applicant anticipate making any significant changes in the services provided within the next 12 months? **Yes** ☐ **No** ☐

If **YES**, please explain:

p. Does the applicant any services outside of the United States **Yes** ☐ **No** ☐

4 STAFFING INFORMATION

Profession	FT	PT	Contracted	Profession	FT	PT	Contracted
Acupuncturists				Optician			
Chiropractors				Optometrist			
Counsellor				Paramedic			
Dentist				Perfusionist			
EMT				Pharmacist			
Home Health Aide				Pharmacist Technician			
Inhalation therapist				Physician Assistant			
Laboratory Technician				Physician – No Surgery			
Licenced Practical Nurse				Physician – Minor Surgery			
Massage Therapist				Physiotherapist			
Medical Director				Psychologist			
Nurse Anesthetist				Registered Nurse			
Nurse Practitioner				Speech Therapist			
Midwife				Other:			

4 STAFFING INFORMATION (Cont.)

a. Are all the listed individuals (page 4) licenced in accordance with applicable state and federal regulations? **Yes** ☐ **No** ☐

If **NO**, please explain:

b. Are all employed/contracted physicians board certified in their speciality? **Yes** ☐ **No** ☐

c. Do all physicians, surgeons and dentists who provide professional services on behalf of the applicant maintain their own Medical Malpractice coverage with limits of indemnity of at least 1million/$3million? **Yes** ☐ **No** ☐

d. Is Physician credentialing and privileging formalized and documented? **Yes** ☐ **No** ☐

e. Do you require contracted staff to carry their own professional liability insurance? **Yes** ☐ **No** ☐

f. Do you maintain certificates of insurance to confirm such coverage? **Yes** ☐ **No** ☐

g. Has the applicant or have any of the above employees/volunteers/independent contractors:

- Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association **Yes** ☐ **No** ☐
- Even been convicted for an act committed in violation of any law or ordinance other than traffic offences **Yes** ☐ **No** ☐
- Ever been treated for alcoholism or drug addiction? **Yes** ☐ **No** ☐
- Ever had any state professional licence to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? **Yes** ☐ **No** ☐

If **YES** to any of the above please explain below

h. Please provide the name of the applicants medical director and attach a copy of his/her curriculum vitae

5 RISK MANAGEMENT

a. Does the applicant have a full time risk manager on staff **Yes** ☐ **No** ☐

If **YES**, please provide:

Name

Title

Qualifications and Experience

b. Does the applicant have a formal, written risk management/loss prevention program? **Yes** ☐ **No** ☐

Please provide/attach any details if necessary

c. Does the applicant have a formal, written quality assurance program? **Yes** ☐ **No** ☐

d. Does the applicant have a formal, written procedure for reporting all incidents? **Yes** ☐ **No** ☐

e. Does the applicant require all new employees to participate in a training program that instructs them on all applicable company policies and procedures? **Yes** ☐ **No** ☐

6 BILLING PROCEDURES

a. Please detail the "payer" mix of your practice as below.

Payer Source	Gross billings last 12 months	Collections last 12 months
Medicare		
Medicaid		
Other		
Total		

Total for all payer's should equal the total gross billings for the practice

b. How many individuals are responsible for the billing?

c. How many credential billers* do you have?

*** A credential biller is one who has completed a certification course relative to billing and coding procedures.**

d. Does your practice have:

- A billing compliance program? **Yes** **No**

If you answer **NO,** please provide full details of practice billing guidelines.

- A written policy regarding the collection of receivable balances? **Yes** **No**

If **YES** does the policy include write-off's of the outstanding balances, co-payments and deductibles? **Yes** **No**

What edition of the Current Procedural Terminology (CPT) manual are you currently using throughout the practice?

- Do you keep copies of Explanation Of Benefits (EOB) files after they are recorded in the billing system? **Yes** **No**
- Does the practice keep separate files of outstanding/denied/queried EOBs? **Yes** **No**
- Are all contracts and referral relationships reviewed by outside counsel to ensure they conform with anti-kickback statutes? **Yes** **No**
- Do you monitor all billing and procedural codes to alert practice management of possible up coding, over-utilization or other billing anomalies? **Yes** **No**
- Does the practice management monitor free and/or discounted samples of medications and supplies to guard against co-mingling with purchased inventory or inappropriate billing for items dispatched? **Yes** **No**
- If any physician is required to serve "on call" for patients requiring emergency medical treatment, are all physicians familiar with their responsibilities under EMTALA as they apply to the individual practitioner? **Yes** **No**

If billing is currently performed by a billing company please detail the name and address of such.

- Is there any common ownership between your practice and the third party billing company? **Yes** **No**

7 NETWORK SECURITY AND BUSINESS CONTINUITY

a. Do you have antivirus software on all computer devices, servers and networks? **Yes** ☐ **No** ☐

b. Do you have access control procedures and hard drive encryption to prevent unauthorized exposure of data on all laptops, PDAs, smartphones and portable devices? **Yes** ☐ **No** ☐

c. Do you encrypt all sensitive information that is transmitted within and from your organization? **Yes** ☐ **No** ☐

d. Is all sensitive and confidential information stored on your databases, servers and data files encrypted? **Yes** ☐ **No** ☐

e. Do you have procedures in force for deleting all sensitive data from systems and devices prior to their disposal from the company? **Yes** ☐ **No** ☐

f. Is all information held in physical form (paper, disks, CD's etc) disposed of or recycled by confidential and secure methods, which are recognized throughout the organisation? **Yes** ☐ **No** ☐

If you answered **NO** to questions above, please provide details of procedures in force to protect unauthorized exposure of.

g. Briefly describe your recovery/continuity plans to mitigate or avoid business interruption due to network failure, which may include outsourcing, additional employment, system redundancy etc.

h. Please confirm up-to-date compliance with relevant regulatory and industry frameworks (eg Gramm-Leach Bliley Act, Health Insurance Portability & Accountability Act, Payment Card Industry (PCI) Data Security Standard).

8 CLAIMS AND CIRCUMSTANCES

During the last five years have you or anyone else within the practice:

a. 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:

b. Been reviewed or investigated by the State board of Medical Examiners? **Yes** ☐ **No** ☐

c. Been audited or investigated with regard to Medicaid/Medicare billing practices? **Yes** ☐ **No** ☐

d. Lost any medical privileges, other than voluntary termination, with any provider? **Yes** ☐ **No** ☐

e. 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** ☐

f. Been involved in an anti-kickback investigation? **Yes** ☐ **No** ☐

g. Been sued or deselected from a commercial payer? **Yes** ☐ **No** ☐

h. Sustained any unscheduled or unintentional network outage, intrusion, corruption or loss of data? **Yes** ☐ **No** ☐

i. Received notice or become aware of any privacy violations or that any data or personally identifiable information has become compromised? **Yes** ☐ **No** ☐

9 PREVIOUSLY PURCHASED COVERAGE

a. Do you have insurance in place for the type of coverage being requested in this application? Please provide details.

Insurer	Limits	Deductible	Expiry dd	Expiry mm	Expiry yyyy	Premium	Retroactive Date dd	Retroactive Date mm	Retroactive Date yyyy

b. Have you ever been refused insurance or had any special terms or conditions imposed by any insurer? **Yes** ☐ **No** ☐

c. Has any insurance for the type of coverage requested in this application been declined or cancelled? **Yes** ☐ **No** ☐

If **YES** to (b), or (c) above, please provide full details

Disclosure

You are not required to disclose convictions regarded as 'spent' by virtue of any rehabilitation of offenders legislation. Any other facts known to you, which are likely to affect acceptance or assessment of the risks proposed for insurance must be disclosed. Should you have any doubt about what you should disclose, do not hesitate to tell us. We recommend you keep a record (including copies of letters) for your future reference, of any additional information given. Making sure we are informed is for your own protection, as failure to disclose may mean that your policy will not provide you with the cover you require, or could invalidate the policy. We reserve the right to decline any proposal.

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 managers, or employees to enable you to answer the questions accurately.

Name | **Position**

Signature | **Date** (dd/mm/yyyy)

10 ADDITIONAL NOTES