# INSURANCE APPLICATION FORM
## MEDICAL BILLINGS

AUSTRALIA
CANADA
UNITED KINGDOM
**UNITED STATES**
REST OF WORLD

**The purpose of this application form is for us to find out more about you. You must provide us with all information which may be material to the cover you wish to purchase and which may influence our decision whether to insure you, what cover we offer you or the premium we charge you.**

### HOW TO COMPLETE THIS FORM

The individual who completes this application form should be a senior member of staff at the company and should ensure that they have checked with other senior managers and colleagues responsible for arranging the insurance that the questions are answered accurately and as completely as possible. Once completed, please return this form to your insurance broker.

### *SECTION 1:* COMPANY DETAILS

*1.1* Please state the name and address of the principal company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form.

Company name:

Primary address (address, state, ZIP, country):

Website:

*1.2* Date the business was established: MM / DD / YYYY

*1.3* Number of employees:

*1.4* Number of physicians:

*1.5* Please state your gross revenue and annual billings in respect of the following years:

| | Last complete FY | Estimate for current FY | Estimate for next FY |
|---|---|---|---|
| Total gross revenue: | $ | $ | $ |
| Annual billings in respect of Medicare patients: | $ | $ | $ |
| Medicaid patients: | $ | $ | $ |
| Private pay patients: | $ | $ | $ |
| Total annual billings: | $ | $ | $ |

*1.6* Please provide details for the primary contact for this insurance policy:

Contact name: Position:

Email address: Telephone number:

## *SECTION 2:* ACTIVITIES

*2.1* Please describe below the nature of your business activities:

*2.2* Please provide an approximate breakdown of how your revenue is generated broken down by activity:

| | |
|---|---|
| | % |
| | % |
| | % |
| | % |
| | % |
| | % |
| | % |
| | % |
| | % |

*2.3* Please provide a percentage breakdown of your billings by state:
The total of all activities should equal 100%:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AL: | % | AK: | % | AZ: | % | AR: | % |
| CA: | % | CO: | % | CT: | % | DE: | % |
| FL: | % | GA: | % | HI: | % | ID: | % |
| IL: | % | IN: | % | IA: | % | KS: | % |
| KY: | % | LA: | % | ME: | % | MD: | % |
| MA: | % | MI: | % | MN: | % | MS: | % |
| MO: | % | MT: | % | NE: | % | NV: | % |
| NH: | % | NJ: | % | NM: | % | NY: | % |
| NC: | % | ND: | % | OH: | % | OK: | % |
| OR: | % | PA: | % | PI: | % | SC: | % |
| SD: | % | TN: | % | TX: | % | UT: | % |
| VA: | % | WA: | % | WV: | % | WI: | % |
| WY: | % | Other overseas US territories: | % | Other: | % | **Total:** | % |

## *SECTION 3:* COMPLIANCE

*3.1* Please state who is directly responsible for medical billing compliance within your business including their name, job title and qualifications:

*3.2* Please provide your Medicare provider numbers:

*3.3* Have you ever been subject to a medical billings audit by a government body or private health insurance entity? ☐ Yes ☐ No

*3.4* Do you have a medical billings compliance program? ☐ Yes ☐ No

If 'yes', please state when the program was established. If 'no', please explain:

*3.5* Do you use the current edition of the CPT (Current Procedural Terminology) manual? ☐ Yes ☐ No

*3.6* Please confirm if software is used to ensure medical billing compliance: ☐ Yes ☐ No

If "yes", please state what software is utilized:

*3.7* Please confirm the originating site used for reimbursements under CMS for any telemedicine services:

| | | |
|---|---|---|
| ☐ Community Mental Health Center (CMHC) | ☐ Critical Access Hospital (CAH) | ☐ Federally Qualified Health Center |
| ☐ Hospital | ☐ Hospital-based or CAH-based Renal Dialysis Center (including satellites) | ☐ Physicians or practitioner office |
| ☐ Rural Health Clinic | ☐ Skilled Nursing Facility (SNF) | ☐ Other |

If "other", are you a distant site practitioner? ☐ Yes ☐ No

*3.8* Please state the address of originating site location:

## *SECTION 4:* CYBER SECURITY RISK MANAGEMENT

*4.1* Please describe the type of sensitive information you hold (including PII/PHI) and provide an approximate number of unique records that you store or process:

*4.2* Please describe the most valuable data assets you store:

*4.3* Please state whether you are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ☐ Yes ☐ No

*4.4* Please tick all the boxes below that relate to companies or services where you store sensitive data or who you reply upon to provide critical business services:

| | | | |
|---|---|---|---|
| ☐ Adobe | ☐ Amazon Web Services | ☐ Dropbox | ☐ Google Cloud |
| ☐ IBM | ☐ Microsoft 365 | ☐ Microsoft Azure | ☐ Oracle Cloud |
| ☐ Salesforce | ☐ SAP | ☐ Workday | |

*4.5* Please tick all the boxes below that relate to controls that you curently have implemented within your IT infrastructure (including where provided by a third party). If you're unsure of what any of these tools are, please refer to the explanation on the final page of this document.

| | | | |
|---|---|---|---|
| ☐ Advances endpoint protection | ☐ Application whitelisting | ☐ Asset inventory | ☐ Custom threat intelligence |
| ☐ Database encryption | ☐ Data loss prevention | ☐ DDoS mitigation | ☐ DMARC |
| ☐ DNS filtering | ☐ Employee awareness training | ☐ Incident response plan | ☐ Intrusion detection system |
| ☐ Mobile device encryption | ☐ Penetration tests | ☐ Perimeter firewalls | ☐ Security info & event management |
| ☐ Two-factor authentication | ☐ Vulnerability scans | ☐ Web application firewall | ☐ Web content filtering |

## *SECTION 5:* CLAIMS EXPERIENCE

*5.1* Please state whether you are aware of any incident:

a) which may result in a claim under any of the insurance for which you are applying to purchase in this application form: ☐ Yes ☐ No

b) which resulted in legal action being made against any of the companies to be insured within the last 5 years: ☐ Yes ☐ No

If you have answered "yes" to a) or b) above then please describe the incident, including the monetary amount of the potential claim or the monetary amount of any claim paid or reserved for payment by you or by an insurer. Please include all relevant dates, including a description of the status of any current claim which has been made but has not been settled or otherwise resolved.

## *SECTION 6:* ADDITIONAL INFORMATION

Please provide the following information when you send the application form to us.

- Directors or principals resumes if the company has been trading for less than 3 years;
- The organisation chart or group structure if any subsidiaries are to be insured including names, dates of acquisition, countries of domicile, percentages of ownership; and
- The standard form of contract, end user license agreement or terms of use issued by the company.

| Name: | Date of Acquisition: | Country of Domicile: | Percentage of ownership: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please provide this space below to provide us with any other releveant information:

## IMPORTANT NOTICE

*By signing this form you agree that the information provided is both accurate and complete and that you have made all reasonable attempts to ensure this is the case by asking the appropriate people within your business. CFC Underwriting will use this information solely for the purposes of providing insurance services and may share your data with third parties in order to do this. We may also use anonymised elements of your data for the analysis of industry trends and to provide benchmarking data. For full details on our privacy policy please visit* ***www.cfcunderwriting.com/privacy***

Contact name: Position:

Signature: Date: MM / DD / YYYY