

New Life Agency, Inc. Lloyd's Coverholder

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Underwritten by Certain Underwriters at Lloyd's

APPLICATION FOR MEDGUARD BILLING ERRORS AND OMISSIONS & FDA & HIPAA & EMTALA INSURANCE THIS APPLICATION IS FOR A CLAIMS MADE INSURANCE POLICY

APPLICANT'S INSTRUCTIONS:

1. ALL QUESTIONS MUST BE ANSWERED COMPLETELY; PLEASE TYPE OR PRINT CLEARLY; IF ANY QUESTIONS ARE CONSIDERED "NOT APPLICABLE", PLEASE EXPLAIN WHY.
2. CALCULATE THE PREMIUM FROM THE PREMIUM CHART BELOW.
3. SIGN AND DATE (MUST BE WITHIN 45 DAYS PRIOR TO BINDING) AND RETURN THE COMPLETED APPLICATION TO YOUR BROKER WITH YOUR CHECK OR CC PAYMENT ONLINE FOR THE PREMIUM, PLUS STATE TAXES, POLICY ISSUANCE FEE AND ANY APPLICABLE BROKER FEE.

THIS IS AN APPLICATION FOR CLAIMS MADE AND REPORTED

MEDGUARD – FDA, BILLING ERRORS AND OMISSIONS, HIPAA, EMTALA & STARK INSURANCE COVERAGE

This insurance does not apply to billing errors for medical services or items which are not provided or prescribed by you or your business. 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must notify the Insurer, and at the sole discretion of the Insurer, any outstanding quotations may be modified or withdrawn.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 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 policy, unless otherwise stated.

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.

1. Applicant Name: _____
Address: _____
Business Phone: (____) _____ Business FAX: (____) _____
2. The Applicant is (select one):
 - Physician - Specialty: _____
 - Physician Group - Total Number of Physicians: _____
 - Other - List Operations: _____
List Gross Annual Revenues: _____
3. Does the Applicant use an outside billing service or compliance audit software? Yes No

For questions 4-10, if the answer is "Yes", coverage cannot be bound as per the terms and conditions of this program.

If you desire an indication outside the program, please provide the details for the "Yes" answers.

4. Do gross annual revenues exceed \$3,000,000? Yes No
5. Does the percentage of the Applicant's Gross Annual Revenue from Federal and State health care programs, such as Medicare and Medicaid, exceed 75%? Yes No
6. Has the Applicant ever been investigated or sanctioned by the FDA, any local, state or federal government or agency regarding the delivery of health care services or reimbursement thereof? Yes No

7. Has the Applicant ever had to refund amounts to Public and/or Private payers in excess of \$10,000? Yes No
8. Has the Applicant ever been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? Yes No
9. Has the Applicant ever been accused of errors by any government agency or commercial payer? Yes No
10. Does the Applicant have knowledge of any specific Claims or facts, circumstances, situations, events or transactions (for the past 5 years) that may result in a claim which may be covered by the proposed policy? Yes No

The undersigned warrants and represents that, to the best of his or her knowledge, the statements herein are true and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the Insurer and shall be deemed attached, as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The Undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the Insurer, any insurance issued shall be void in its entirety. The undersigned agrees that if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the undersigned shall notify the insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.

The Insurer is hereby authorized to make an investigation and inquiry in connection with this Application as it may deem necessary.

APPLICANT		
BY <i>(President and/or CEO Signature)</i>	TITLE	DATE

Instructions for Coverage Selection

1. Solo Physicians:

- a) **Select limit and deductible options from below table. Premium is the price reflected under "Physician 1"**

2. Physician Groups:

- a) **Determine the number of physicians in your group.**
 b) **Select limit and deductible options from below table. Premium is the price reflected in the respective band where your total number of physicians falls into:**

<u>Option:</u>	A	B	C	D
<u>Per Insured Event Limit:</u>	\$500,000	\$500,000	\$1,000,000	\$1,000,000
<u>Deductible (per claim):</u>	\$25,000 legal expense and fines & penalties	\$1,000 legal expense and fines & penalties	\$25,000 legal expense and fines & penalties	\$1,000 legal expense and fines & penalties
<u>Price per physician:</u>				
Physician 1	\$1,300	\$1,500	\$1,600	\$1,850
Physicians 2-5	\$1,105	\$1,275	\$1,360	\$1,573
Physicians 6-15	\$ 975	\$1,125	\$1,200	\$1,387
Physicians 16-30	\$ 845	\$ 975	\$1,040	\$1,202
Physicians/ 31-50	\$ 780	\$ 900	\$ 960	\$1,110
TOTAL PREMIUM:	\$ _____	\$ _____	\$ _____	\$ _____

For greater than 50 physicians, submit to New Life Agency for quotation.

- *Endorsements to be issued with policy:
1. *Nuclear Incident Exclusion Clause;*
 2. *Disciplinary Proceedings Endorsement (legal expense reimbursement sublimit of \$50,000 per Disciplinary Proceeding and in all)*

How Group Aggregate Limits Work:

The Maximum Aggregate Limit per group is the total limit available for all claims during a policy period. For example, if the policy has a limit of \$1,000,000 per Insured Event/\$5,000,000 in the aggregate, payment for one claim cannot exceed \$1,000,000 and payment for all claims during the policy period cannot exceed \$5,000,000.

The aggregate limit is the insured event limit multiplied by the number of physicians in the group, or \$5,000,000, whichever is less. For example, if a 3-physician group purchases a \$500,000 insured event limit, the maximum aggregate limit offered will be \$1,500,000.

3. **Non-Physician Groups:**

- a) **Determine the total gross revenue amount.**
- b) **Select limit and deductible options from below table. Premium is the price reflected in the respective band where your total revenue amount falls into:**

Option:	A	B	C	D
Per Insured Event Limit:	\$500,000	\$500,000	\$1,000,000	\$1,000,000
Deductible (per claim):	\$25,000 legal expense and fines & penalties	\$1,000 legal expense and fines & penalties	\$25,000 legal expense and fines & penalties	\$1,000 legal expense and fines & penalties
Price based on Total Revenue:				
\$1 - \$749,999	\$1,315	\$1,518	\$1,620	\$1,875
\$750,000 - \$1,249,999	\$1,750	\$2,000	\$2,162	\$2,500
\$1,250,000 - \$1,999,999	\$2,850	\$3,280	\$3,500	\$4,000
\$2,000,000 - \$2,499,999	\$3,950	\$4,560	\$4,865	\$5,625
\$2,500,000 - \$3,000,000	\$4,800	\$5,575	\$5,950	\$6,875
TOTAL PREMIUM:	\$ _____	\$ _____	\$ _____	\$ _____

For businesses with greater than \$3,000,000 in revenue, submit to New Life Agency for quotation.

- *Endorsements to be issued with policy:
1. *Nuclear Incident Exclusion Clause;*
 2. *Disciplinary Proceedings Endorsement* (legal expense reimbursement sublimit of \$50,000 per Disciplinary Proceeding and in all)

How Group Aggregate Limits Work:

The Maximum Aggregate Limit per group is the total limit available for all claims during a policy period. For example, if the policy has a limit of \$1,000,000 per Insured Event/\$5,000,000 in the aggregate, payment for one claim cannot exceed \$1,000,000 and payment for all claims during the policy period cannot exceed \$5,000,000.

The aggregate limit is the same as the insured event limit. For example, if the purchases a \$500,000 insured event limit, the maximum aggregate limit offered will also be \$500,000.

Payment Instructions:

RETURN THE COMPLETED APPLICATION TO YOUR BROKER WITH YOUR CHECK OR CC PAYMENT ONLINE FOR THE PREMIUM, PLUS STATE TAXES, POLICY ISSUANCE FEE AND ANY APPLICABLE BROKER FEE.

Premium:	\$ _____	
CA Taxes & Fees:	\$ _____	(3.125% in addition)
	\$ _____	(.225% in addition)
Broker fee:	\$ _____	(in addition)
TOTAL PAYMENT	\$ _____	

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.”**

Name of Applicant: _____

Title: _____

Date: _____

Signature of Applicant _____