CHUBB®

Chubb Group of Insurance Companies
202B Hall's Mill Road
Whitehouse Station, NJ 08889

FOREFRONT PORTFOLIO 3.O℠
CYBERSECURITY COVERAGE PART
DENTISTS BENEFITS CORPORATION APPLICATION

BY COMPLETING THIS DENTISTS BENEFITS CORPORATION APPLICATION THE APPLICANT IS APPLYING FOR COVERAGE WITH PACIFIC INDEMNITY COMPANY (THE "COMPANY")

NOTICE: THIS IS A CLAIMS-MADE POLICY, WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD," OR ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY DAMAGES OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY "DEFENSE COSTS," AND "DEFENSE COSTS" WILL BE APPLIED AGAINST THE RETENTION. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR THE AMOUNT OF ANY JUDGEMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE POLICY CAREFULLY.

To be used only in the following states: Oregon, Washington, Tennessee, Arizona, Idaho and Montana

DENTISTS BENEFITS CORPORATION APPLICATION INSTRUCTIONS:

1. Whenever used in this Dentists Benefits Corporation Application, the term "**Applicant**" shall mean **"**the Dental Practice and all subsidiaries", unless otherwise stated.
2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.
3. Please sign and date this Dentists Benefits Corporation Application.

I. NAME, ADDRESS AND CONTACT INFORMATION:

1. Name of **Applicant**: _____
2. Address of **Applicant**: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____
3. Web address: _____
4. Name and Address of Primary Contact: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____ e-Mail: _____

II. INSURANCE INFORMATION:

1. Please indicate below, by placing an "X" in the box, which coverage's are being requested for Cyber Liability, including Privacy Notification and Crisis Management Expenses:

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Limit of Liability	$500,000	$1,000,000	$500,000	$1,000,000	$500,000	$1,000,000
Retention Amount	$2,500	$2,500	$5,000	$5,000	$10,000	$10,000
Check Requested Option	☐	☐	☐	☐	☐	☐

*Options 1 and 2 are only available for Dental Practices of $750,000 or less in gross annual revenues.

*Options 3 and 4 are only available for Dental Practices of $1,250,000 or less in gross annual revenues.

*Options 5 and 6 are available for all Dental Practices.

2. Policy Period Requested:

   From _____ to _____ both days at 12:01 a.m. at the principal address of the Dental Practice.

III. GENERAL RISK INFORMATION:

1. Please indicate the **Applicant's** gross annual revenue: _____

IV. INFORMATION SECURITY POLICIES:

1. An Information Security Policy which is applicable to all of the **Applicant's** business units is a minimum requirement of binding coverage. Please check the following box to affirm that the **Applicant** has an Information Security Policy in place: ☐ YES.

   If an Information Security Policy is NOT in place, to be eligible for coverage the **Applicant** must fulfill this requirement by registering with Chubb's eRisk Hub loss control portal.

   To access Chubb's eRisk Hub go to: https://eriskhub.com/chubb.php and complete the self-registration form. Enter access code: 11823

   Provide date of registration: ____ / ____ / ____

   (Month) (Day) (Year)

V. WRITTEN RECORDS MANAGEMENT:

1. Regarding the collection of sensitive information (including Protected Health Information, PHI, and Personally Identifiable Information, PII) through written documents, such as applications, forms, chart notes:

   a. Does the **Applicant** shred written documents after entering the information into their computer system or when they are ultimately disposed of? ☐ Yes ☐ No

   b. Does the **Applicant** retain written documents in secured files? ☐ Yes ☐ No

VI. MOBILE DEVICE SECURITY:

1. Does the **Applicant** store personally identifiable or other confidential information (including Protected Health Information, PHI) on any mobile devices? ☐ Yes ☐ No

   If "YES", Mobile Device Security controls as described in the questions below are a minimum requirement of binding coverage. Please check the following boxes to affirm that the **Applicant** has these controls in place:

   a. Does the **Applicant** encrypt data on any mobile devices, including data at rest and external memory devices? ☐ Yes

   b. Does the **Applicant's** information security policy include policies for the use and storage of personally identifiable or other confidential information (including Protected Health Information - PHI) on laptops? ☐ Yes

   If these controls are NOT in place, to be eligible for coverage the **Applicant** must fulfill this requirement by registering with Chubb's eRisk Hub loss control portal.

   If the **Applicant** has not already registered in response to previous questions, go to: https://eriskhub.com/chubb.php and complete the self-registration form. Enter access code: 11823

   Provide date of registration: ____ / ____ / ____

   (Month) (Day) (Year)

VII. INCIDENT RESPONSE PLAN:

1. An Incident Response Plan is a minimum requirement of binding coverage. Please check the following box to affirm that the **Applicant** has an Incident Response Plan in place: ☐ YES.

   If an Incident Response Plan is NOT in place, in order to be eligible for coverage the **Applicant** must fulfill this requirement by registering with Chubb's eRisk Hub loss control portal.

   If the **Applicant** has not already registered in response to previous questions, go to: https://eriskhub.com/chubb.php and complete the self-registration form. Enter access code: 11823

   Provide date of registration: _____ / _____ / _____

   (Month) (Day) (Year)

VIII. HIPAA/HITECH COMPLIANCE:

1. Does the **Applicant** collect, store or process Protected Health Information (PHI) or Personally Identifiably Information (PII) for the **Applicant's** patients, customers or employees? ☐ Yes ☐ No

   If "YES", how many individuals' Protected Health Information (PHI) or Personally Identifiably Information (PII) does the **Applicant** collect, store or process? _____

2. Is the **Applicant** in full compliance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic & Clinical Health (HITECH) Act? ☐ Yes ☐ No

3. Is the **Applicant** a covered entity under the Health Insurance Portability and Accountability Act (HIPAA)? ☐ Yes ☐ No

4. HIPAA and HITECH Encryption tools as described below are a minimum requirement of binding coverage. Please check the following box to affirm that the **Applicant** has these controls in place:

   Does the **Applicant** have encryption tools to enhance the integrity and confidentiality of confidential information, including but not limited to protected health information (PHI) or personally identifiably information (PII)? ☐ Yes

   If "YES", in which scenarios is data encrypted (check all that apply):

   ☐ Data at rest ☐ Data in transit ☐ Data transferred to removable or portable media (CDs, Backup Tapes, USB Devices, Laptops, etc.)

   If these tools are NOT in place, in order to be eligible for coverage the **Applicant** must fulfill this requirement by registering with Chubb's eRisk Hub loss control portal.

   If the **Applicant** has not already registered in response to previous questions, go to: https://eriskhub.com/chubb.php and complete the self-registration form. Enter access code: 11823

   Provide date of registration: _____ / _____ / _____

   (Month) (Day) (Year)

IX. SECURITY INCIDENT AND LOSS HISTORY:

1. Has the **Applicant** experienced an "event", including any unauthorized access or exceeding authorized access to any computer, system, database or data; in the last two (2) years that either did or did not rise to the level of an actual data "breach" under HIPAA or HITECH and for which the **Applicant** notified customers, patients, or other third parties? ☐ Yes ☐ No

If YES, please describe (attach additional sheets, if needed):

_____

_____

_____

X. REPRESENTATION: PRIOR KNOWLEDGE OF ACTS/CIRCUMSTANCES/SITUATIONS:

1. The Applicant must complete the Warranty Statement below:

   No person or entity proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage:

   NONE ☐ or, except

   _____

   _____

   Without prejudice to any other rights and remedies of the Company, the **Applicant** understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed in response to question 1 above, any claim or action arising from such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

XI. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Dentists Benefits Corporation Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

XII. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES:

The **Applicant's** submission of this Dentists Benefits Corporation Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Dentists Benefits Corporation Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Dentists Benefits Corporation Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Dentists Benefits Corporation Application and in any attachments or other documents submitted with this Dentists Benefits Corporation Application are true and complete. The undersigned agree that this Dentists Benefits Corporation Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

The information requested in this Dentists Benefits Corporation Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Arkansas, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana and Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine, Tennessee, Virginia and Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date	Signature*	Title
_____	_____	_____

*****This Dentists Benefits Corporation Application must be signed by an owner of the **Dental Practice** and all subsidiaries acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

Submitted By:

Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____