



# Net Protection PLUS/Regulatory Defense PLUS Coverage Program Application

**NOTICE: THIS APPLICATION IS FOR CLAIMS-MADE AND REPORTED INSURANCE. THE COVERAGE PROVIDES THAT THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENTS, SETTLEMENTS OR ANY OTHER LOSS WILL BE REDUCED AND MAY BE COMPLETELY EXHAUSTED BY DEFENSE COSTS. DEFENSE COSTS WILL BE APPLIED TO THE RETENTION AMOUNT. READ THE ENTIRE APPLICATION CAREFULLY.**

**I. APPLICANT INFORMATION** (“You” or “Your” identified in this application shall mean the Applicant)

Name of Applicant (Legal Entity Name): \_\_\_\_\_

*(as it should appear on the policy)*

Principal Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Website: \_\_\_\_\_

1. Current or prospective Arch Specialty Insurance Company insured?  YES  NO

2. Arch Specialty Insurance Company policy number (if available): \_\_\_\_\_

3. Date operations commenced under current ownership: \_\_\_\_\_

4. Description of operations: \_\_\_\_\_

5. Annual Gross Revenues: Current Year Annual Projection: \_\_\_\_\_ Prior Year: \_\_\_\_\_

6. Do You own any subsidiaries<sup>1</sup>?.....  YES  NO

If You answered “YES” to question 6 above, please provide a list of Your subsidiaries on a separate page, with a description of each subsidiary’s a) nature of operations, b) relationship to You, and c) percentage of ownership by You and Your stockholders/partners.

7. Is coverage requested for any entity or organization other than the Applicant and its Subsidiaries?....  YES  NO

If You answered “YES” to question 7 above, please provide details of each entity or organization on a separate page, including the a) nature of operations, b) relationship to You, and c) percentage of ownership by You and Your stockholders/partners.

**II. COVERAGE SELECTION**

Type of Coverage:  Excess **Net Protection PLUS**  Excess **Regulatory Defense PLUS**

Excess **Combined Net Protection PLUS & Regulatory Defense PLUS**

Total Limit Desired<sup>2</sup>:  \$100K  \$250K  \$500K  \$1M

Requested Effective Date (mm/dd/yyyy): \_\_\_\_\_ *(coverage may not be backdated)*

<sup>1</sup> As used in this application, “Subsidiary” means any legal entity in which You own, directly or indirectly, more than 50% of the issued or outstanding voting securities.

<sup>2</sup> \$50,000 Combined Net Protection Plus and Regulatory Defense Plus is included

**III. REGULATORY DEFENSE PLUS QUESTIONS**

**Please complete Section III only if Excess Regulatory Defense PLUS or Excess Combined Net Protection PLUS & Regulatory Defense PLUS coverage is desired.**

**For question 8, if the answer is “NO”, please provide an explanation on a separate sheet of paper and submit with this Application.**

8. Are You utilizing a current edition of the CPT manual to ensure billing compliance?..... YES NO

**For questions 9-16, if the answer is “YES”, please provide an explanation on a separate sheet of paper and submit with this Application.**

9. Do Your billings from federal and state health care programs, such as Medicare and Medicaid, exceed an average of 50% of your total annual billings?..... YES NO

If “YES”, please provide details on a separate page regarding your billings (including the nature of products or services being billed).

10. Have You ever been audited or investigated, or received a request for records or other documentation by or on behalf of a commercial payer or government entity?..... YES NO

11. Have You ever been placed on pre-payment review with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?..... YES NO

12. Have You had to refund amounts to Public and/or Private payers in excess of \$10,000 within the last seven years?..... YES NO

a. If You answered “YES” to question 12, were these refunds due to an audit, allegation of improper billing, or voluntary self-disclosure?..... YES NO

b. If You answered “YES” to question 12.a., please provide details on a separate page regarding the total amount of each refund, the name of the payer, and the reason for each refund.

13. Have You ever been accused of billing errors by any government agency or commercial payer?..... YES NO

14. Have You ever:  
a. Been involved in a Stark/anti-kickback investigation?..... YES NO  
b. Been sued or deselected from a private commercial payer?..... YES NO  
c. Been investigated for EMTALA violations?..... YES NO  
d. Been investigated for HIPAA violations?..... YES NO  
e. Voluntarily disclosed any billing errors or irregular billing practices?..... YES NO

15. Have You ever been non-renewed, placed on extension, or declined for similar regulatory/billing errors insurance?..... YES NO

16. Are You or any individual proposed for this insurance aware of any acts, errors, omissions, facts, circumstances, allegations, situations, events or incidents that could give rise to a regulatory investigation, regulatory action, or demand for restitution?..... YES NO

**IV. NET PROTECTION PLUS QUESTIONS**

**Please complete Section IV only if Excess Net Protection PLUS or Excess Combined Net Protection PLUS & Regulatory Defense PLUS coverage is desired.**

**For questions 17–20, if the answer is “NO”, please provide an explanation on a separate sheet of paper and submit with this Application.**

- 17. Do You have a HIPAA compliance program in place?..... YES NO
- 18. Do You use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers?..... YES NO
- 19. Do You enforce privacy and security policies, including mandatory employee training, that must be followed by all employees, contractors, or other individuals or organizations with access to patient information?..... YES NO
- 20. Does Your organization store personal and/or confidential data on portable devices, including laptops, PDAs, back-up tapes, USB thumb drivers and external hard drives?..... YES NO
  - a. If “YES”, is such data encrypted to industry standards?..... YES NO
  - b. If “NO”, to question 20.a., please describe on a separate page the type of devices used, the nature of data/information stored, and the security measures You have in place to protect such data/information.

**For questions 21-24, if the answer is “YES”, please provide an explanation on a separate sheet of paper and submit with this Application.**

- 21. Does the number of records You store, either electronic or paper, exceed 100,000 records?..... YES NO  
If “YES”, please provide the total number of records stored by the Applicant(s): \_\_\_\_\_
- 22. Have You received any complaints or claims or been the subject in litigation involving matters of privacy injury, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third-party networks or Your customer’s ability to rely on Your network?..... YES NO
- 23. Are You aware of any security breaches, privacy-related events or incidents, or allegations of breach of privacy?..... YES NO
- 24. Have You ever been non-renewed, placed on extension, or declined for similar privacy/security liability coverage?..... YES NO

**V. NOTICE TO APPLICANT**

The Undersigned acknowledges and understands that, with respect to questions 16 and 24 above, if knowledge of any such act, error, omission, fact, circumstance, allegation, situation, event or incident exists, whether or not disclosed, any claim or action against You , or any other entity or person proposed for this insurance, arising therefrom is expressly excluded from coverage under the proposed insurance.

**VI. WARRANTY AND REPRESENTATIONS**

- A. The Undersigned warrants and represents that the statements, representations and information contained in or attached to this application are true and complete, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this application.
- B. The Undersigned acknowledges and recognizes that the statements, representations, and information contained in or attached to this application are material to the risk assumed by the insurer; that any policy will have been issued in reliance upon the truth thereof; and that this application and all written statements and materials furnished to the Insurer in conjunction with this application shall be deemed incorporated into and made a part of the policy, should a policy be issued.
- C. The Undersigned acknowledges and agrees that if the information supplied on this application or in any attachments changes between the date of the application and the inception date of the policy period, the Applicant will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or agreement to bind the insurance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized signature of the President, CEO or COO of the Applicant  
Must be signed and dated no more than 60 days prior to binding coverage.**

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_