MD ADVANTAGE™ INSURANCE COMPANY OF NEW JERSEY

Supreme Advantage®
Application for Medical Practice Administration Insurance (MPAI)
And
Privacy Data Security Insurance (PDSI)

THIS APPLICATION IS FOR A CLAIMS-MADE AND REPORTED POLICY. COVERAGE IS LIMITED TO CLAIMS MADE AGAINST THE INSURED DURING THE TERM OF THE POLICY AND IS SUBJECT TO ALL POLICY PROVISIONS.

Section One – Applicant Information

1. Name of Applicant: _____
   (as it should appear on the policy)

   Are you insured with MDAdvantage for your Professional Liability Coverage? ☐ **Yes** ☐ **No**

   If yes, please provide your Policy Number:

   Office Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Email: _____

   Web Site: _____ No. of years in business: _____

   Billing Address: _____

   City: _____ State: _____ Zip Code: _____

   Residence Address: _____

   City: _____ State: _____ Zip Code: _____

   Preferred Mailing Address? Please check one: ☐ Office ☐ Billing ☐ Residence

2. Organization's Legal Structure: Corporation: _____ Partnership: _____ LLC: _____

   Other (Describe):_____

   Please note: If Applicant is an Entity/Corporation, how many Physicians are with the Group? _____Please provide Physician information (see last page of Application).

3. Do you own any subsidiaries? ***(If Yes, please attach a schedule)*** ☐ **Yes** ☐ **No**

4. Description of operations: _____

5. Date operations commenced under current ownership: _____

6. Have you acquired any practices in the last 5 years? ☐ **Yes** ☐ **No**

7. Do you handle billings for any hospitals or provider services not provided by your medical group? ☐ **Yes** ☐ **No**

8. Does your medical group's billings from federal and state health care programs, such as Medicare and Medicaid, exceed an average of $1,000,000 per each physician in the group? ☐ **Yes** ☐ **No**

9. Has the entity or any physician in your medical group ever been audited, investigated, sanctioned or placed on prepayment review by any local, state or federal government agency or any private or commercial payer regarding the delivery of healthcare services or reimbursement thereof? ☐ **Yes** ☐ **No**

10. Has the entity or any physician in your medical group ever had to refund amounts to public and/or private payers in excess of $10,000? If yes, please provide details regarding the amount refunded, who received the refund, and whether the amount refunded was the result of an audit, allegation of improper billing or voluntary self-disclosure. ☐ **Yes** ☐ **No**

11. Has the entity or any physician in your medical group ever been audited, investigated, or placed on prepayment review with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ☐ **Yes** ☐ **No**

12. Has the entity or any physician in your medical group ever been accused of billing errors by any government agency or commercial payer? ☐ **Yes** ☐ **No**

13. Has the entity or any physician in your medical group paid a regulatory or administrative fine or penalty as a result of a billing error, HIPAA, EMTALA, or Stark Proceeding? If yes, please provide details regarding the fine or penalty amount paid, the party that received the payment, and specific details of the situation. ☐ **Yes** ☐ **No**

14 Does the Applicant have knowledge of any specific facts, circumstances, situations, events or transactions (within the past 5 years) that may result in a regulatory investigation, regulatory action, or demand for restitution? ☐ **Yes** ☐ **No**

Please provide details below for any "Yes" answers to questions 6-14.

_____

_____

_____

15. Do the entities and/or persons who perform billing services for you comply with current standardized billing procedures? ☐ **Yes** ☐ **No**

16. Are you HIPAA compliant? ☐ **Yes** ☐ **No**

17. Does your company use anti-virus software and firewall protection on all desktops, portable devices and mission critical servers, and is this software updated in accordance with the software provider's recommendations? ☐ **Yes** ☐ **No**

18. If you store personal information on portable devices, is such data encrypted to industry standards? ☐ **Yes** ☐ **No**

If You do not store personal information on portable devices, check here ☐

19. Does your company have a formal process to disable or restrict access to information systems upon termination of employees? ☐ **Yes** ☐ **No**

20. Does your company enforce privacy and security policies that must be followed by all employees, contractors, or other individuals or organizations with access to patient information? ☐ **Yes** ☐ **No**

21. Do your privacy and security policies include mandatory training for all employees? ☐ **Yes** ☐ **No**

Please provide details below for any "No" answers to questions 15-21.

_____

_____

_____

22. In the last five (5) years, have you received any complaints, claims or been the subject of litigation involving matters of privacy injury/privacy breaches, security breaches, identity theft, denial or service attacks, computer virus infections, theft of information, damage to third party networks or your patients' ability to rely on your network.? ☐ **Yes** ☐ **No**

Please provide details below for a "Yes" answer to question 22.

_____

23. Have you applied for similar coverage with any insurance company, including MDAdvantage, in the past 5 years? ☐ **Yes** ☐ **No**

24. If you answered "Yes" to question 23, were you declined coverage? ☐ **Yes** ☐ **No**

25. If you answered "Yes" to question 23 and were offered coverage, did you decline to accept the offer of coverage? ☐ **Yes** ☐ **No**

26. Have you had similar coverage in force in the past 5 years that was canceled or non-renewed, or voluntarily discontinued? ☐ **Yes** ☐ **No**

Please provide details below for any "Yes" answer to questions 23-26.

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Section Two: - Coverage Selection (*Check option desired*)

Coverage: ☐ **MPAI & PDSI** ☐ **MPAI Only** ☐ **PDSI Only**

Requested effective date (no backdating): _____

Section Three – Notice to the Applicant

A. The Applicant represents that the statements set forth herein are true and complete.

B. The Applicant agrees that after receipt of the completed application form, the Company will either confirm or deny coverage. It is also agreed that this application shall be the basis of insurance and will be attached to and made part of the policy should a policy be issued.

C. The Applicant further represents that if the information supplied on this application changes between the date of the application and the inception date of the policy period, the applicant will immediately notify the underwriter of such a change, and the underwriter may modify or deny coverage.

Signed: _____ Date: _____

Authorized signature of a Principal or Officer
Must be signed and dated no more than 45 days prior to binding)

Print Name: _____Title:_____

Physician's Name	Full-Time/ Part-Time	Medical Professional Liability Insurer	Policy Number	Policy Expiration Date