Chubb Group of Insurance Companies
15 Mountain View Rd.
Warren, NJ 07059

ForeFront Portfolio 3.0SM
For Health Care Organizations
NEW BUSINESS APPLICATION
(For Organizations with up to 250 Employees)

BY COMPLETING THIS NEW BUSINESS APPLICATION THE APPLICANT IS APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

NOTICE: THE LIABILITY COVERAGE PARTS PROVIDE CLAIMS MADE COVERAGE, 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 AMOUNT. IN NO EVENT WILL THE COMPANY BE LIABLE FOR "DEFENSE COSTS" OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT IN EXCESS OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE NEW BUSINESS APPLICATION CAREFULLY BEFORE SIGNING.

NEW BUSINESS APPLICATION INSTRUCTIONS

1. Whenever used in this New Business Application, the term "**Applicant**" shall mean the parent organization 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.

   Directors & Officers and Entity Liability Coverage, please attach the following:
   (a) Most recent annual financial statement, audited if outside audits are performed.
   (b) List of directors and senior executive officers by name and outside affiliation, if applicable.

   Partnerships:
   If the Applicant is a formed as a partnership, limited partnership or acts a general partner for another organization, attach the following:
   (a) The partnership agreement on file with the Secretary of State for each partnership.
   (b) An organization chart, including ownership percentage of all partner owners.

3. All **Applicants** must complete the relevant sections of this Application and of the Supplemental Application in accordance with the specific coverages being requested.

I. NAME, ADDRESS AND CONTACT INFORMATION

1. Name of **Applicant**: _____

2. Address of **Applicant**: _____

   City: _____ State: _____ Zip Code: _____

3. **Applicant's** Web Site: _____

4. Name and address (if different than above) of Primary Contact (Executive Officer authorized to receive notices and information regarding the proposed policy):

   Name: _____ Title: _____ Address: _____

   City: _____ State: _____ Zip Code: _____ Telephone: _____

   E-Mail: _____

5. For Employment Practices Loss Prevention eligibility, indicate the individual responsible for human resources or employment law matters:

   Name: _____ Title: _____ Telephone: _____

   E-Mail: _____

II. INSURANCE INFORMATION

1. Please indicate below, by placing an "X" in the box, which coverages are being requested and complete relevant portions of this Application and the Supplemental Application as applicable.

Application	Coverage Requested	Limit Requested	Limit Currently Purchased	Retention Currently Purchased	Current Insurer
New Business Application	☐ Directors & Officers and Entity Liability	$	$	$	
	☐ Employment Practices Liability	$	$	$	
	☐ Fiduciary Liability	$	$	$	
	☐ Crime	$	$	$	
	☐ Kidnap Ransom and Extortion	$	$	$	
	☐ CyberSecurity	$	$	$	

Application	Coverage Requested	Limit Requested	Limit Currently Purchased	Retention Currently Purchased	Current Insurer
Supplemental Application	☐ Employed Lawyers	$	$	$	
	☐ Workplace Violence	$	$	$	

2. If the **Applicant** is applying for any Liability Coverage Part(s) as indicated in Question II. 1. above, please attach a copy of all applications containing a signed warranty and any other warranty statements completed in the past 3 years and submitted to any prior insurers. Please note, CyberSecurity includes a Liability Coverage Part.

III. GENERAL RISK INFORMATION

1. State of incorporation: _____ Years of operation: _____
2. Nature of the **Applicant's** business: _____
3. Primary SIC Code: _____
4. **Applicant** is a: ☐ Not-For-Profit Tax Exempt Corp. ☐ For-Profit Corp. ☐ Partnership
   ☐ Not-For-Profit Taxable Corp. ☐ Limited Liability Company
   ☐ Other (describe): _____

   (a) Does the **Applicant** now have tax exempt status under applicable federal, state, and local law, including the U.S. Internal Revenue Code of 1986, as amended? ☐ Yes ☐ No

   (b) If this organization is a Not-For Profit Tax Exempt Corp., is any challenge to the **Applicant's** tax-exempt status pending or anticipated by any party, private or governmental? ☐ Yes ☐ No

   If "Yes", please explain: _____

Partnership Questions: If this organization is formed as a partnership or limited partnership or any of its subsidiaries act as a general partner for another partnership answer questions 5-9, otherwise skip to Question 10.

5. Is the **Applicant** formed as a partnership or limited partnership, or if it or any of its subsidiaries act as a general partner for another organization? ☐ Yes ☐ No

   If "Yes", answer questions 6-9.

6. Nature of the partnership(s)' business, if different than **Applicant**: _____

7. Indicate type of partnership:

   (a) Limited Partnership (LP) ☐ Yes ☐ No

   (b) Limited Liability Partnership (LLP) ☐ Yes ☐ No

   (c) Limited Liability Limited Partnership (LLLP) ☐ Yes ☐ No

   (d) General Partnership ☐ Yes ☐ No

   (e) Other (please specify): _____

8. If this organization is formed as a limited partnership:

   (a) List the name of the general partner: _____

   (b) Indicate the percentage ownership the general partner has in the limited partnership: _____ %.

9. Does the **Applicant** have a mandatory retirement policy? ☐ Yes ☐ No

   If "Yes", please attach details.

10. Does the **Applicant** have any subsidiaries**,** joint ventures or affiliates or control any other entity or organization? ☐ Yes ☐ No

    If "Yes", please attach a description of the operations, ownership, and the tax status of each such entity, and indicate whether coverage is requested for each such entity.

11. **Applicant's** Accreditation (note all that apply): ☐ JCAHO ☐ NCQA ☐ American Hospital Association ☐ Other: _____

12. (a) Please indicate REVENUE at most recent fiscal year end: _____

    (b) Additional Financial Information: Please provide the following information for the **Applicant** for the most recent fiscal year end (indicate month/year): _____ Month _____Year

Current Assets	$
Total Assets	$
Current Liabilities	$
Current Portion of Long Term Debt	$
Interest Expense	$
Amortization & Depreciation	$
Long Term Debt	$
Total Liabilities	$
Retained Earnings	$
Shareholder's Equity	$
Net Income	$
Cash Flow From Operating Activities	$

13. (a) Has the **Applicant** in the past twelve (12) months completed any:

    (i) Merger, acquisition, or divestment? ☐ Yes ☐ No

    (ii) Change in outside auditors? ☐ Yes ☐ No

    (iii) Reorganization or arrangement with creditors under federal or state law? ☐ Yes ☐ No

(iv) Branch, location, facility, office, or subsidiary closings, consolidations or layoffs or reductions in workforce? ☐ Yes ☐ No

(b) Is the **Applicant** currently anticipating any of the above? ☐ Yes ☐ No

If the **Applicant** answered "Yes" to any part of Question 13, please describe the essential terms of each such transaction as an attachment.

14. Other than the direct provision of medical services, does the **Applicant** or any subsidiary perform any professional services for a fee? ☐ Yes ☐ No

If "Yes", please explain: _____

IV. COVERAGE SPECIFIC RISK INFORMATION

A. DIRECTORS AND OFFICERS LIABILITY INFORMATION

1. Ownership

(a) Please complete the following information for the **Applicant** (attach separate sheets if needed):

Total number of outstanding shares or ownership instrument equivalent:	
Names of director or officer shareholders, indicate name and title	Voting Shares Owned
	%
	%
List any shareholders (include individual and corporate names) who are not directors and not officers	Voting Shares Owned
☐	%
☐	%
☐	%

Please indicate, by checking the box (☐) in the table above, if related by family to another shareholder or to a director or officer of **Applicant**.

(b) Number of: members on board of directors; trustees; member managers; or equivalent: _____

(c) Are they elected or appointed? _____

2. Recent, Pending or Contemplated Changes

(a) Is the **Applicant** currently (or during the past 12 months has the **Applicant** been) in breach or in violation of any debt covenant? ☐ Yes ☐ No

If "Yes", please attach an explanation.

(b) In the past twenty-four (24) months has the **Applicant** completed any:

(i) Public or private offering of securities? ☐ Yes ☐ No

(ii) Unplanned change in directors or senior executive officers other than due to illness? ☐ Yes ☐ No

(iii) Issuance of debt? ☐ Yes ☐ No

(c) Is the **Applicant** currently anticipating any of the above? ☐ Yes ☐ No

If "Yes" to either of the above in Question 2(b) or 2(c), please attach a full description with details, including any private placement memoranda or any documents filed with the Securities and Exchange Commission and a description including the: type and amount of the offering; method of solicitation or advertising and the verification method of investor qualification, if applicable.

(d) Are the **Applicant's** securities traded on any online trading platform or portal? ☐ Yes ☐ No
If "Yes", please attach details.

3. Past Activities

(a) Has the **Applicant** or any person proposed for coverage been the subject of, or been involved in, any of the following during the past five (5) years:

(i) Anti-trust, copyright or patent litigation? ☐ Yes ☐ No

(ii) Deceptive trade practices or consumer fraud? ☐ Yes ☐ No

(iii) Civil, criminal or administrative proceeding alleging violation of any federal or state securities laws? ☐ Yes ☐ No

(iv) Any other criminal actions? ☐ Yes ☐ No

If the **Applicant** answered "Yes" to any of the above in Question 3(a), please attach a full description of the details.

(b) Other than those identified in your response to Question 3 (a), has any claim been brought at any time during the last five (5) years against (i) any **Applicant** or (ii) any proposed insured individual in his or her capacity as a director or officer of any entity? ☐ Yes ☐ No

If "Yes", please attach a full description of the details.

4. Does the **Applicant** have any exclusive contracts with any providers? ☐ Yes ☐ No

If "Yes", provide details by separate attachment.

5. Does the **Applicant** control more than twenty percent (20%) of the market in any given geographical area of:

(a) providers in any given field of practice, or ☐ Yes ☐ No

(b) health care services? ☐ Yes ☐ No

If "Yes" to Question 5 (a) or (b), please provide market share percentages by separate attachment.

6. Does the **Applicant** perform Provider Selection (i.e. peer review and credentialing of medical practitioners)? ☐ Yes ☐ No

If "Yes", please complete the following questions. If "No", skip to question 8.

7. Does the **Applicant** have written policies and procedures in place for Provider Selection, (i.e. peer review, and credentialing)?

(a) for self? (If "No", provide details by separate attachment) ☐ Yes ☐ No

(b) for others for a fee? (If "Yes", provide details by separate attachment) ☐ Yes ☐ No

(c) are such policies and procedures that are in place in compliance with JCAHO or NCQA guidelines? (If "No", provide details by separate attachment) ☐ Yes ☐ No

8. (a) Within the last two (2) years has the **Applicant** closed or restricted staff admissions of a provider to any patient service department for reasons other than professional competence, including but not limited to a conflict of interest? ☐ Yes ☐ No

If "Yes", provide details including the number of providers impacted. _____

_____

_____

_____

(b) Are there any formal plans for future closings or restrictions? ☐ Yes ☐ No

If "Yes", provide details by separate attachment.

A(I). HEALTH CARE FRAUD & ABUSE INFORMATION

If the Applicant wishes to apply for Health Care Fraud & Abuse coverage, please complete the information requested below.

1. (a) Name of individual responsible for Compliance and title: _____

   (b) Does this individual have direct access to the CEO or board? ☐ Yes ☐ No

2. Does the **Applicant** outsource the billing and/or coding of medical bills to an outside firm? ☐ Yes ☐ No

3. Does the **Applicant** provide compliance training and education to all new employees? ☐ Yes ☐ No

4. Does the **Applicant** provide annual training and education to employees who do billing and coding? ☐ Yes ☐ No

   If "No", please explain: _____

5. Is there a Compliance Program in effect? ☐ Yes ☐ No

   If "Yes", date implemented? _____

   If "Yes", please submit copy of Compliance Program.

6. In the past 5 years, has any **Applicant** proposed for this insurance:

   (a) received any notice or contact letter from any government entity or agency including the Department of Justice (DOJ) or the Office of Inspector General (OIG) or an audit contractor (including a Recovery Audit Contractor (RAC), Zone Program Integrity Contractor (ZPIC) or Medicaid Integrity Contractor (MIC)? ☐ Yes ☐ No

   (b) been subjected to any type of audit investigating whether it allegedly:

      (i) received overpayments for services provided? ☐ Yes ☐ No

      (ii) received payments for services not provided? ☐ Yes ☐ No

      (iii) violated any health care fraud and abuse law? ☐ Yes ☐ No

   (c) entered into a criminal or civil settlement with the United States or with some party acting on behalf of the United States by which claims against such **Applicant** were resolved? ☐ Yes ☐ No

   If "Yes" to Question 6 (a), (b) or (c), please explain: _____

   _____

7. Is the **Applicant** in Compliance with all aspects of HIPAA regulation? ☐ Yes ☐ No

A(II). WARRANTY: HEALTH CARE FRAUD & ABUSE

1. To be considered for qualification for Health Care Fraud and Abuse coverage under the Directors and Officers Liability Coverage Part, the **Applicant** must complete items four (4) and five (5) of the warranty statement below.

2. The statement applies to those coverage types for which no coverage is currently maintained, and/or for which any larger limits of liability may be requested.

3. For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, South Dakota, Virginia, Washington and West Virginia Residents ONLY: the title of this section and any other reference to "Warranty" is deleted and replaced with "**Applicant** Representation".

4. During the past five (5) years, neither the **Applicant** nor any individual or entity proposed for coverage has submitted any claims or given notice of any fact, circumstance, situation, transaction, event, act, error, or omission which they had reason to believe might or could reasonably be foreseen to give rise to a claim that might fall within the scope of insurance with any insurer or self-insurance instrument of which the requested coverages would be a direct or indirect replacement, except as follows:

   If the answer is none, so state: _____

   _____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 4 IS EXCLUDED FROM THE PROPOSED INSURANCE, AND THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 4 IS EXCLUDED FROM THE PROPOSED INSURANCE.

5. Neither the **Applicant** nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance, except as follows:

If the answer is none, so state: _____

_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE COMPANY, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 5 IS EXCLUDED FROM THE PROPOSED INSURANCE.

B. EMPLOYMENT PRACTICES LIABILITY INFORMATION

1. Please complete the following information:

(a) Total worldwide employees:_____ Number of in-house counsel:_____

	Current Year	Prior Year
(b) Full-time employees (excluding employed Medical Practitioners*):		
(i) Full-time employed Medical Practitioners*:		
(c) Part-time employees (including leased and seasonal, excluding employed Medical Practitioners*):		
(i) Part-time employed Medical Practitioners*:		
(d) Volunteers:		
(e) Independent Contractors (excluding Medical Practitioners*):		
(i) Independent Contractor Medical Practitioners*:		
(f) Employees located in California (included in (a) and (b) above):		
(g) Employees located outside of the U.S.:		

2. Please complete the following information:

U.S. Salary Ranges (should total 100%)

Salary Ranges	Medical Practitioner*% in Range Current Year	Non-Medical Practitioner % In Range Current Year	Medical Practitioner* % in Range Previous Year	Non-Medical Practitioner % in Range Previous Year
Up to $60,000				
$60,001 to $120,000				
Over $120,000				

*Only respond regarding Medical Practitioners employed by the **Applicant**. **"Medical Practitioner"** means a clinical professional, including a physician, physician assistant, surgeon, intern, extern, resident, registered nurse practitioner, certified registered nurse anesthetist, osteopathic physician or surgeon, podiatrist, dentist, orthodontist, endodontist, or any other dental surgeon.

3. Policies and Procedures

(a) Does the **Applicant** have written procedures in place regarding:

(i) Equal Opportunity Employment ☐ Yes ☐ No

(ii) Anti-discrimination ☐ Yes ☐ No

(iii) Anti-sexual harassment ☐ Yes ☐ No

If any of the above answers are no, please attach a full explanation.

4. Are employed physicians required to maintain credentials at any other institution as a contingency of their employment with the **Applicant** (e.g. are employed physicians required to maintain credentials at any affiliated organization)? ☐ Yes ☐ No

5. Does the **Applicant** have established policies and procedures outlining employee conduct when dealing with third parties, including responding to complaints? ☐ Yes ☐ No

6. Past Activities

(a) During the past three years has any **Applicant**, in any capacity, been involved in any of the following matters?

(i) EEOC or other similar administrative proceeding? ☐ Yes ☐ No

(ii) Employment-related civil suit or claim (including any EEOC charge) resulting in payment (including defense costs) over $10,000? ☐ Yes ☐ No

(iii) Any action or civil suit brought against them by a customer, client or third party alleging harassment, discrimination or civil rights violations? ☐ Yes ☐ No

(iv) Any violations of, or paid any claims related to "Wage and Hour" laws? ☐ Yes ☐ No

If "Yes" to any of the above in Question 6, please attach a full description of the of the details including date, type of claim, allegations, current status, defense costs incurred and any judgment or settlement amounts.

C. FIDUCIARY LIABILITY COVERAGE INFORMATION

1. Plan Information

(a) Please list the names and types of **Applicant's** employee benefits plan(s). Attach additional pages if needed. If the **Applicant** has an ESOP, please complete the Supplemental ESOP Application.

Plan names (Do not include health & welfare plans)	Plan assets (Current Year)	Plan assets As of Date (List Below)	Type of plan*	(DB only) What is the current funded % under the Pension Protection Act? Indicate if "at risk"	Number of plan participants

*Defined Contribution (DC), Defined Benefit (DB), Employee Stock Ownership (ESOP), Excess Benefit or Top Hat (EBP)

(List any additional Plans by attachments. If there is an attachment, check here ☐.)

(b) Does the **Applicant** handle any investment decisions in-house? ☐ Yes ☐ No

If "Yes," please describe: _____

(c) Are any plans NOT in compliance with plan agreements or ERISA? ☐ Yes ☐ No

If "Yes," please explain: _____

2. Past Activities

(a) In the past three years, has the **Applicant** merged, terminated, or frozen any plan(s)? ☐ Yes ☐ No

If yes, please attach details including transaction date, status of asset distribution, whether similar benefits are being offered, and name of insurance carrier if terminated plan benefits are secured by insurance.

(b) Has any fiduciary been:

(i) accused, found guilty or held liable for a breach of trust? ☐ Yes ☐ No

(ii) convicted of criminal conduct? ☐ Yes ☐ No

(c) Has there been any assessment of fees, fines or penalties under any voluntary compliance resolution program or similar voluntary settlement program administered by the IRS, DOL or other government authority against any plan? ☐ Yes ☐ No

(d) Have any claims (other than for benefits under 29 C.F.R. § 2560.503-1(h) or similar procedures pursuant to applicable law) been made during the past five years against:

(i) any **Applicant**; ☐ Yes ☐ No

(ii) any benefit program; or ☐ Yes ☐ No

(iii) any past or present individual in his or her capacity as a fiduciary of any employee benefit plan? ☐ Yes ☐ No

If "Yes" to any of the above in Question 2, please attach a full description of the details.

D. CRIME COVERAGE INFORMATION

1. Number of: U.S. locations: _____ Outside U.S. locations: _____

List countries:

_____

_____

2. Internal Controls

(a) Does the **Applicant**:

(i) Allow the employees who reconcile the monthly bank statements to also sign checks or handle deposits? ☐ Yes ☐ No

If "Yes," please explain: _____

(ii) Perform pre-employment reference checks for all its potential employees? ☐ Yes ☐ No

If "No", please explain: _____

If applicable to the **Applicant's** business, please answer Questions 2 (b) through 2 (d).

(b) Does the **Applicant** have physical inventory (such as pharmaceuticals, medical supplies or equipment)? ☐ Yes ☐ No

If "Yes", how often does the **Applicant** perform physical inventory checks (i.e., reconciliations) of stock and equipment)? _____

(c) Who performs these reconciliations? _____

(d) Does the **Applicant**:

(i) Maintain a list of authorized vendors? ☐ Yes ☐ No

(ii) Have a procedure in place to verify the existence and ownership of new vendors prior to adding them to the authorized master vendor list? ☐ Yes ☐ No

(iii) Allow the same individual who verifies the existence of vendors to also have the authority to edit the authorized master vendor list? ☐ Yes ☐ No

(iv) Verify invoices against a corresponding purchase order, receiving report and the authorized master vendor list prior to issuing payment? ☐ Yes ☐ No

(v) Strictly comply with dual recorded authorization for all outgoing wire transfers? ☐ Yes ☐ No

3. Independent Contractors

(a) Number of independent contractors (natural persons only): _____

(b) Are reference checks performed for independent contractors? ☐ Yes ☐ No

If "No", please explain: _____

(c) Do independent contractors have custody or control over any funds, accounts or property of the **Applicant**? ☐ Yes ☐ No

If "Yes", please explain: _____

(d) Are independent contractors subject to the same internal control procedures that apply to the **Applicant's** employees? ☐ Yes ☐ No

If "No", please explain: _____

4. Client Services

(a) Please describe the services the **Applicant** provides for clients:

_____

_____

(b) Does the **Applicant** have custody or control over any funds, accounts, or materials of any of its clients? ☐ Yes ☐ No

If "Yes", please describe (attach separate sheet if necessary): _____

5. Past Activities

(a) Please attach a list all employee theft, forgery, computer fraud or other crime losses discovered by the **Applicant** in the last five years, itemizing each loss separately. Include date of loss, description and total amount of loss; or indicate NONE ☐.

E. KIDNAP RANSOM & EXTORTION COVERAGE INFORMATION

1. Please complete the following information regarding the **Applicant's** risk profile

Country	Number of employees	Number of Independent Contractors	Type of operation or, if no in-country operations, average stay	If no in-country operations, number of annual trips	Number of Locations

For Question 1 above, please attach a separate schedule of locations/travel if needed.

2. Past Activities

List all kidnapping, extortion threats, cyber extortion, hijacking, wrongful detention, or political threats discovered by the **Applicant** in the last five years which would have been covered under the Policy for which this Application is made, itemizing each loss separately: Check if "None" ☐

_____

_____

F. CYBERSECURITY COVERAGE INFORMATION

1. Please indicate below, by placing an "X" in the box, which coverages are being requested. If coverage is currently purchased, please indicate current limits and current carrier. If coverage is currently not purchased, please so indicate.

Coverage Requested	Limit of Liability Requested	Retention Requested	Limit of Liability Currently Purchased	Current Insurer
Cyber Liability coverage	$_____	$_____	$_____	_____
Optional Coverages:				
☐ Privacy Notification and Crisis Management Expenses Coverage	$_____	$_____	$_____	_____
☐ Reward Expenses Coverage	$_____	$_____	$_____	_____
☐ E-Business Interruption and Extra Expenses	$_____	$_____	$_____	_____
☐ E-Threat Expenses Coverage	$_____	$_____	$_____	_____
☐ E-Vandalism Expenses	$_____	$_____	$_____	_____

2. Does the **Applicant** anticipate in the next twelve months establishing or entering into any related or unrelated ventures which are a material change in operations? ☐ Yes ☐ No

   If "Yes", please provide full details on a separate sheet.

3. Please indicate the **Applicant's** GROSS annual revenue from on-line sales or services:_____

4. How many servers does the **Applicant** either own or otherwise have dedicated to their use?_____

5. What is the **Applicant's** total number of IP addresses?_____

6. Does the **Applicant** collect, store or process personally identifiable, protected health or other confidential information? ☐ Yes ☐ No

   (a) If "Yes", is it encrypted? ☐ Yes ☐ No

   (b) If "Yes", how many records are held, including the **Applicant's** prospective, current and former customers anemployees?_____

7. Is the **Applicant** subject to any of the following:

   (a) The Payment Card Industry (PCI) Security Standard? ☐ Yes ☐ No

   If "Yes", complete PCI Compliance section of this Application.

   (b) The Gramm, Leach, Bliley Act? ☐ Yes ☐ No

   (c) Red Flags Rule? ☐ Yes ☐ No

   (d) Any other federal or state law or regulation concerning privacy or the safeguarding of personally identifiable or other confidential information (other than state "breach notification" laws)? ☐ Yes ☐ No

   If "Yes" to 7. (d), please indicate what law(s) or regulation(s): _____

If "Yes", to any of the above in Question 7, is the **Applicant** compliant with the selected rules and standards? ☐ Yes ☐ No

If "No", please explain the **Applicant's** lack of compliance:

_____

8. Does the **Applicant** process or store personally identifiable, Protected Health Information (PHI) or other confidential information for third parties? ☐ Yes ☐ No

   a) If "Yes", is it encrypted? ☐ Yes ☐ No

   If "Yes" to any of the above, please attach an explanation.

9. Does the **Applicant** shred all written or printed personally identifiable, Protected Health Information (PHI) or other confidential information when it is being discarded? ☐ Yes ☐ No

HIPAA COMPLIANCE

1. Is the **Applicant** a Covered Entity under the Health Insurance Portability and Accountability Act (HIPAA), HITECH, or any applicable state law? ☐ Yes ☐ No
2. Is the **Applicant** a Business Associate under any of the laws in Question 1. ☐ Yes ☐ No

   If "Yes" to 1 or 2 above, approximately how many individuals' protected health information (PHI) does the **Applicant** collect, store or process?

   _____

   If "Yes" to 1 or 2 above, is the **Applicant** in full compliance with the provisions of any applicable law(s) outlined in Question 1? ☐ Yes ☐ No

   If the **Applicant** is not in full compliance with any of the applicable law(s) in Question 1, when will the **Applicant** be in full compliance_____

3. Has the **Applicant** been audited by The Department of Health and Human Services (HHS), or any other agency under the authority of HHS, for their compliance with the either the HIPAA

   Privacy Rule or Security Rule? ☐ Yes ☐ No

   If "Yes", was the **Applicant** found to be in compliance? ☐ Yes ☐ No

   If "No", please indicate in which areas the **Applicant** was found not to be in compliance:

   _____

   (Attach a separate explanation if necessary)

   If "No", have all areas of non-compliance been rectified? ☐ Yes ☐ No
4. Does the **Applicant** conduct regular audits of their HIPAA Privacy and Security controls and procedures? ☐ Yes ☐ No
5. Does the **Applicant** remediate any areas in which they are found not to be in compliance within:

   (a) 30 days; ☐ Yes ☐ No

   (b) 90 days; ☐ Yes ☐ No

   (c) 180 days; ☐ Yes ☐ No

   (d) more than 180 days. ☐ Yes ☐ No
6. In the **Applicant's** contracts with any of their Business Associates does the **Applicant** require that the business associates indemnify the **Applicant** for any liability the **Applicant** incurs as a result of the business associates' non-compliance with HIPAA, the HITECH Act or any failure or alleged failure to keep the **Applicant's** information secure?

   ☐ Yes ☐ No

7. **WRITTEN RECORDS MANAGEMENT**

1. Does the **Applicant** collect sensitive information through hand written applications, forms or notes? ☐ Yes ☐ No

   (a) If "Yes" to 1, does the **Applicant** shred such documents after entering the information into their computer system? ☐ Yes ☐ No

   (b) If "No" to 1, does the **Applicant**:

   (i) Retain the documents in secured encrypted files? ☐ Yes ☐ No

   (ii) Store such documents in secure areas that minimize access by persons not authorized to view such documents? ☐ Yes ☐ No

   (iii) Enforce a clean desk policy? ☐ Yes ☐ No

   (iv) Shred such documents when they are ultimately disposed of? ☐ Yes ☐ No

2. Is sensitive information in *any written form* (handwritten, typed, or printed) stored with a third party? ☐ Yes ☐ No

   (a) If "Yes" to 2:

   i) Does the **Applicant** have a written contract with the respective service provider(s) or vendor(s)? ☐ Yes ☐ No

   ii) Are third party service provider(s) or vendor(s) required to have or do they have E&O or Cyber Insurance to respond to a breach? ☐ Yes ☐ No

   If "No", please attach an explanation.

   (b) If "Yes" to 2, does the **Applicant's** contract with the service provider(s) state that the service provider:

   i) Has primary responsibility for the security of the **Applicant's** information? ☐ Yes ☐ No

   ii) Has a contractual responsibility to indemnify the **Applicant** for any losses or expenses associated with any failure to safeguard the **Applicant's** electronic data? ☐ Yes ☐ No

   (c) If "Yes" to 2, does the **Applicant** review their most recent information security audit (i.e. SAS 70)? ☐ Yes ☐ No

   If "No", please attach an explanation.

PCI COMPLIANCE

(Please answer the questions in this section if the Applicant is subject to the PCI Security Standard)

1. How many credit or debit card transactions does the **Applicant** process annually? _____

2. Does the **Applicant**:

   (a) Mask all but the last four digits of a card number when displaying or printing cardholder data? ☐ Yes ☐ No

   (b) Ensure that card-validation codes are not stored in any of the **Applicant's** databases, log files or anywhere else within their network? ☐ Yes ☐ No

   (c) Encrypt all account information on the **Applicant's** databases? ☐ Yes ☐ No

   (d) Encrypt or use tokenization for all account information at the point of sale? ☐ Yes ☐ No

INFORMATION SECURITY POLICIES

1. Has the **Applicant** implemented a formal information security policy which is applicable to all of the **Applicant's** business units? ☐ Yes ☐ No

If "Yes",

(a) Does the **Applicant** test the security required by the security policy at least annually? ☐ Yes ☐ No

(b) Does the **Applicant** regularly identify and assess new threats and adjust the security policy to address the new threats? ☐ Yes ☐ No

(c) Does the **Applicant's** information security policy include policies for the encryption, use and storage of personally identifiable or other confidential information on laptops? ☐ Yes ☐ No

WEB SERVER SECURITY

1. Does the **Applicant** store personally identifiable or other confidential information on their web servers? ☐ Yes ☐ No
2. Do the **Applicant's** web servers have direct access to personally identifiable or other confidential information? ☐ Yes ☐ No
3. Does the **Applicant** have firewalls that filter both inbound and outbound traffic? ☐ Yes ☐ No

VIRUS PREVENTION, INTRUSION DETECTION & PENETRATION TESTING

1. Are anti-virus programs installed on all of the **Applicant's** PC's and network systems? ☐ Yes ☐ No

   If "Yes", how frequently are the virus detection signatures updated?_____

2. Does the **Applicant** employ intrusion detection or intrusion protection devices on their network, or IDS or IPS software on the **Applicant's** hosts? ☐ Yes ☐ No

   If "Yes", how frequently are logs reviewed? _____

3. Does the **Applicant** run penetration tests against all parts of their network? ☐ Yes ☐ No

   If "Yes", how often are the tests run? _____

4. Has the **Applicant** been the target of any computer or network attacks (including virus attacks) in the past 2 (two) years? ☐ Yes ☐ No

   If "Yes", did the number of attacks increase? ☐ Yes ☐ No

MOBILE DEVICE SECURITY

1. Does the **Applicant** store personally identifiable or other confidential information on mobile devices? ☐ Yes ☐ No

   If "Yes", does the **Applicant** encrypt such information? ☐ Yes ☐ No

2. Is the **Applicant** alerted, or can the **Applicant** otherwise identify, when personally identifiable or other confidential information is:

   (a) Downloaded to a mobile memory device? ☐ Yes ☐ No

   (b) Sent in email, or added as an attachment to an email? ☐ Yes ☐ No

BUSINESS CONTINUITY

1. Does the **Applicant** have a Business Continuity Plan [BCP] specifically designed to address a network related denial-of-service attack? ☐ Yes ☐ No

   If "Yes":

   (a) Is the BCP reviewed and updated at least bi-annually? ☐ Yes ☐ No

   (b) Is the BCP tested at least annually? ☐ Yes ☐ No

   (c) Have any problems been rectified? ☐ Yes ☐ No

SECURITY ASSESSMENTS

1. Has an external system security assessment, other than vulnerability scans or penetration tests, been conducted within the past (twelve)12 months? ☐ Yes ☐ No

   If "Yes", please indicate who conducted the assessment, attach copies of the result, and indicate whether all critical recommendations been corrected or complied with. If "No", please attach explanation.

BACKUP & ARCHIVING

1. How frequently does the **Applicant** back up electronic data? _____
2. Does the **Applicant** store back up electronic data with a third party service provider? ☐ Yes ☐ No

   (a) If "Yes",

   i) Does the **Applicant** have a written contract with the respective service provider(s) or vendor(s)? ☐ Yes ☐ No

   ii) Are third party service provider(s) or vendor(s) that store back up electronic data required to have or do they have E&O or Cyber Insurance to respond to a breach? ☐ Yes ☐ No

   If "No", please attach an explanation.

   (b) If "Yes" to 2, does the **Applicant's** contract with the service provider(s) state that the service provider:

   i) Has primary responsibility for the security of the **Applicant's** information? ☐ Yes ☐ No

   ii) Has a contractual responsibility to indemnify the **Applicant** for any losses or expenses associated with any failure to safeguard the **Applicant's** electronic data? ☐ Yes ☐ No

   (c) If "Yes" to 2, does the **Applicant** review their most recent information security audit (i.e. SAS 70)? ☐ Yes ☐ No

   If "No", please attach an explanation.

SERVICE PROVIDERS

1. Does the **Applicant** use third-party technology service providers? ☐ Yes ☐ No

   (a) If "Yes",

   i) Does the **Applicant** have a written contract with the respective service provider(s) or vendor(s)? ☐ Yes ☐ No

   ii) Are third party service provider(s) or vendor(s) required to have or do they have E&O or Cyber Insurance to respond to a breach? ☐ Yes ☐ No

   If "No", please attach an explanation.

   (b) If "Yes" to 1, does the **Applicant's** contract with the service provider(s) state that the service provider:

   i) Has primary responsibility for the security of the **Applicant's** information? ☐ Yes ☐ No

   ii) Has a contractual responsibility to indemnify the **Applicant** for any losses or expenses associated with any failure to safeguard the **Applicant's** electronic data? ☐ Yes ☐ No

   (c) If "Yes" to 1, does the **Applicant** review their most recent information security audit

   (i.e. SAS 70)? ☐ Yes ☐ No

   If "No", please attach an explanation.

INCIDENT RESPONSE PLAN

1. Does the **Applicant** have a formal incident response plan that addresses network security incidents or threats? ☐ Yes ☐ No

SECURITY INCIDENT AND LOSS HISTORY:

Has the **Applicant** had any computer or network security incidents during the past two years? Incident includes any unauthorized access or exceeding authorized access to any computer, system, data base or data; intrusion or attack; the denial of use of any computer or system; intentional disruption, corruption or destruction of electronic data, programs or applications; or any other incidents similar to the foregoing? ☐ Yes ☐ No

Note: if the answer to this Question 1 is "Yes", please attach a complete description of the incident(s), including whether the **Applicant** reported the incident(s) to law enforcement and/or the **Applicant's** insurance carrier.

V. WARRANTY: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS

1. The **Applicant** must complete the warranty statement below:

   - For any **Liability** Coverage Part for which coverage is requested and is not currently purchased, as indicated in Section II, INSURANCE INFORMATION, Question 1 of this Application; or
   - If the **Applicant** is requesting larger limits than are currently purchased, as indicated in Section II, INSURANCE INFORMATION, Question 1 of this Application.

   Except for Health Care Fraud & Abuse coverage for which a separate warranty must be completed in **Section IV. A.(II)** of this Application if the **Applicant** applies for such coverage, the statement applies to those coverage types for which no coverage is currently maintained; and any larger limits of liability requested.

   For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, South Dakota, Virginia, Washington and West Virginia Residents ONLY: the title of this section and any other reference to "Warranty" is deleted and replaced with "**Applicant** Representation".

   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 Liability Coverage Part(s):

   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.

VI. MATERIAL CHANGE

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

VII. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The **Applicant's** submission of this New Business Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this 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 New Business Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this 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 New Business 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 Alabama and 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 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 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: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete 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 New Business Application must be signed by the chief executive officer, president, or chief financial officer of the **Applicant's** parent organization acting as the authorized representative(s) of the person(s) and entity(ies) proposed for this insurance.

Produced By:

Agent (Print & Sign): _____ _____

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: _____