



CYBER & PRIVACY APPLICATION FORM FOR HEALTHCARE PROFESSIONALS

PLEASE COMPLETE THIS FORM ELECTRONICALLY TO ENSURE THAT WE CAN RESPOND TO YOUR REQUEST QUICKLY.

Company name:			
Address:			
City:			
State:	ZIP code:		
Telephone:	Email address:		
Total revenue: \$	Employees:		

Please select **one** of the following activities that best describes your business:

- Addiction Treatment Provider
 Dentist
 Home Healthcare
 Nurse
 Physician
 Therapist

Required package: Required inception date:

STATEMENT OF FACT FOR CYBER & PRIVACY LIABILITY COVERAGE

Do you and your subsidiaries comply with all the requirements detailed in the Statement of Fact below? Yes No

1. You have anti-virus software installed and enabled on all desktops, laptops and servers (excluding database servers) and it is updated on a regular basis.

2. You have firewalls installed on all external gateways.

3. You take regular back-ups (at least weekly) of all critical data and store the same offsite or in a fire-proof safe, or your outsourced service provider meets this requirement.

If you store medical records or Protected Health Information (PHI), you comply with the following:

4. You have conducted a review of the business to ensure compliance with all relevant HIPAA legislation.

5. You ensure that all PHI transmitted over open networks and/or stored on portable devices is encrypted.

If you process or store credit card information (where this is not outsourced to a third party that accepts full responsibility for PCI compliance), you comply with the following:

6. You have been certified as being PCI compliant within the last 12 months, or have successfully completed a self-assessment audit.

CLAIMS INFORMATION

In regards to claims, are both of the below statements true? Yes No

1. After full inquiry, you are not aware of any circumstances, complaints, claims, loss, or penalties/fines levied against you in the last five years, in relation to the risks that this application relates to.

2. You are not aware of any circumstances or complaints against you in relation to data protection or security, or any actual security violations or security breaches either currently or in the past five years.

DECLARATION

I declare that after proper enquiry the statements and particulars given above are true and that I have not mis-stated or suppressed any material fact.

I agree that this application form, together with any other material information supplied by me shall form the basis of any contract of insurance effected thereon.

I undertake to inform underwriters of any material alteration to these facts occurring before completion of the contract.

Full name: Date:

Position: Signature:

PLEASE NOTE: DO NOT PRINT AND SCAN THIS FORM. PLEASE COMPLETE THIS FORM ELECTRONICALLY, SIGN USING A DIGITAL SIGNATURE, SAVE A COPY FOR YOUR RECORDS, AND SUBMIT VIA EMAIL. THIS WILL ENSURE WE PROCESS YOUR APPLICATION QUICKLY.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF INSURANCE, PLEASE IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES. THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORISATIONS OR AGREEMENTS TO BIND THE INSURANCE.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED INTO THIS APPLICATION.