Princeton Insurance
a MedPro/Berkshire Hathaway company

Cybershield Billing Errors & Omissions Application

Section One – Applicant Information

1. Applicant Information

Name of Applicant: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Email: _____

Website: _____ # years in business: _____

Number of Full Time Equivalent Physicians to be covered under policy*: _____

Policy #: _____

**One Full Time Equivalent is defined as 42 hours per week. Hours for physicians working less than 42 hours per week should be combined to determine approximate number of Full Time Equivalents.*

For questions 2-5, if any answer is "Yes", please provide additional details on back.

2. Does the group's gross annual revenue from Federal and State health care programs, such as Medicare and Medicaid, exceed an average of $1,000,000 per each physician in your group? ☐ Yes ☐ No

3. Has any physician in your group ever been investigated or sanctioned by a state medical licensing board? ☐ Yes ☐ No

4. Has the entity or any physician in your group ever been audited or investigated with regard to Medicare/Medicaid billing practices or the delivery of healthcare services or reimbursement thereof? If 'Yes', please provide outcome of audit or investigation. ☐ Yes ☐ No

5. Does the applicant have knowledge of any specific claims or facts, circumstances, situations, events or transactions (for the past 5 years) that may result in a claim which may be covered by the proposed policy? ☐ Yes ☐ No

Section Two – Notice to the Applicant

A. The applicant represents to the best of its knowledge and belief 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 review in order to either confirm or deny coverage. It is also agreed 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 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 Company of such a change, and the Company may modify or deny coverage.

Desired Billing Errors & Omissions Limit:

☐ $500,000 Limit ☐ $1,000,000 Limit

Requested effective date (no backdating): _____ (mm/dd/yyyy)

I understand that the increase in limits will apply to any services rendered on or after the approved effective date.

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts.

Princeton Insurance reserves the right to approve or reject change requests and/or effective dates based on the timing of your submission.

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Additional Comments:

NOTICES and AGREEMENTS

Any person who knowingly files an application for insurance or a statement of a 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any Attachments, shall be the basis of the contract with Princeton Insurance (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signed: _____ Date: _____
Insured or authorized signature of a Principal or Officer

Print Name: _____ Title: _____