



### INTRODUCTION

The purpose of this application form is for us to find out more about you.

You must provide us with all information which may be material to the cover you wish to purchase and which may influence our decision whether to insure you, what cover we offer you or the premium we charge you.

### HOW TO COMPLETE THIS FORM

The application form must be completed by a member of senior management of the company who must make all the necessary enquiries of their fellow senior management, employees and persons responsible for arranging the insurance to enable our questions to be answered.

If you require extra space to answer the questions or provide any other material information, please use the additional information section at the back of the form. Once you have completed the application form please return it directly to your insurance broker.

## SECTION 1: COMPANY DETAILS

1.1 Please state the name and address of the principal Company for whom this insurance is required. Cover is also provided for the subsidiaries of the principal Company, but only if you include the data from all of these subsidiaries in your answers to all of the questions in this form.

Company:	_____
Address:	_____
State:	_____
ZIP code:	_____
Website:	_____

1.2 Please state the date the business was established:

1.3 Please state the number of employees:

1.4 Please state your gross revenue in respect of the following years:

	Last complete financial year	Estimate for current financial year	Estimate for next financial year
Domestic revenue:	_____	_____	_____
Other territory revenue:	_____	_____	_____
Total gross revenue:	_____	_____	_____
Profit (Loss):	_____	_____	_____

Date of company financial year end:



SECTION 2: ACTIVITIES

2.1 Please describe in detail 1) the nature and types of professional and/or technology services you are engaged in and 2) the types of technology products developed, manufactured, licensed or sold:

Empty text box for describing services and products.

2.2 Please state whether your technology services are used for diagnosis, treatment or prevention of diseases or other conditions  Yes  No

2.3 Please provide an approximate breakdown of how your revenue is generated from your products and services

Table with 2 columns for revenue breakdown and percentage.

2.4 Please indicate the estimated number of patient encounters for the next 12 months:

2.5 Please provide a full breakdown of your services offered by state:

The total of all activities should equal 100%:

Grid of state abbreviations (AL, AR, CT, GA, IL, KS, ME, MI, AK, CA, DE, HI, IN, KY, MD, MN, AZ, CO, FL, ID, IA, LA, MA, MS) with percentage input boxes.



MO:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	MT:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	NE:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
NV:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	NH:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	NJ:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
NM:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	NY:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	NC:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
ND:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	OH:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	OK:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
OR:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	PA:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	PI:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
SC:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	SD:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	TN:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
TX:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	UT:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	VT:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
VA:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	WA:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	WV:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
WI:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	WY:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	Other overseas US territories:	<input style="width: 50px; height: 20px;" type="text" value="%"/>
Other:	<input style="width: 50px; height: 20px;" type="text" value="%"/>	TOTAL:	<input style="width: 50px; height: 20px;" type="text" value="%"/>		

2.6 Please state whether all professionals are subject to background checks (criminal, federal, state, sexual offender registry etc.)  Yes  No

*If no, please provide details:*

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2.7 Please state whether any physician has had a board action brought against them in the last 5 years:  Yes  No

*If no, please provide details:*

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2.8 Please state whether medications are prescribed through your services:  Yes  No



SECTION 3: CONTRACT & RISK MANAGEMENT INFORMATION

3.1 Please complete the following in respect of your 3 largest projects in the past 3 years:

Name of client	Nature of your work undertaken	Your annual income from this contract	Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3.2 Please state approximately how many customers you have:

3.3 Please state whether you always carry out work under a written contract signed by every client:

 Yes  No

3.4 Please describe how, if at all, you limit your liability for consequential loss or financial damages under a written contract:

  
  

3.5 Please describe your legal review process, if any, before entering into new contracts or agreements:

  
  

3.6 Please describe the impact on your clients if your products or services failed or you were unable to deliver your products or services:

  
  

3.7 Do you employ subcontractors?

 Yes  No

If yes, please state:

a) what approximate percentage of your revenue, in your current financial year, will be paid to subcontractors:

 %

b) whether you sign reciprocal hold harmless agreements:

 Yes  No

c) whether you ensure that subcontractors have their own errors and omissions and general liability insurance:

 Yes  No



d) if you answered yes to c) above, what is the limit of liability that subcontractor must purchase:

SECTION 4: CYBER SECURITY RISK MANAGEMENT

4.1 Please describe the type of sensitive information you hold (including PII/PHI) and provide an approximate number of unique records that you store or process:

  
  

4.2 Please describe the most valuable data assets you store:

  
  

4.3 Please state whether you are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

 Yes  No

4.3 Please tick all the boxes below that relate to companies or services where you store sensitive data or who you rely upon to provide critical business services:

Adobe	<input type="checkbox"/>	Amazon web services	<input type="checkbox"/>	Dropbox	<input type="checkbox"/>
Google Cloud	<input type="checkbox"/>	IBM	<input type="checkbox"/>	Microsoft 365	<input type="checkbox"/>
Microsoft Azure	<input type="checkbox"/>	Oracle Cloud	<input type="checkbox"/>	Salesforce	<input type="checkbox"/>
SAP	<input type="checkbox"/>	Workday	<input type="checkbox"/>		

4.5 Please tick all the boxes below that relate to controls that you currently have implemented within your IT infrastructure (including where provided by a third party). If you're unsure of what any of these tools are, please refer to the explanation on the final page of this document.

Advances Endpoint Protection	<input type="checkbox"/>	Application Whitelisting	<input type="checkbox"/>	Asset Inventory	<input type="checkbox"/>
Custom Threat Intelligence	<input type="checkbox"/>	Database Encryption	<input type="checkbox"/>	Data Loss Prevention	<input type="checkbox"/>
DDoS Mitigation	<input type="checkbox"/>	DMARC	<input type="checkbox"/>	DNS Filtering	<input type="checkbox"/>
Employee Awareness Training	<input type="checkbox"/>	Incident Response Plan	<input type="checkbox"/>	Intrusion Detection System	<input type="checkbox"/>



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|----------------------------------|--------------------------|---------------------------|--------------------------|---------------------|--------------------------|
| Mobile Device Encryption         | <input type="checkbox"/> | Penetration Tests         | <input type="checkbox"/> | Perimeter Firewalls | <input type="checkbox"/> |
| Security Info & Event Management | <input type="checkbox"/> | Two-Factor Authentication | <input type="checkbox"/> | Vulnerability Scans | <input type="checkbox"/> |
| Web Application Firewall         | <input type="checkbox"/> | Web Content Filtering     | <input type="checkbox"/> |                     |                          |

Please provide the name of the software or service provider that you use for each of the control highlighted above:

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**SECTION 5: INTELLECTUAL PROPERTY RIGHTS RISK MANAGEMENT**

5.1 Please describe below your procedures for:

- a) preventing infringing on third party intellectual property rights; and
- b) obtaining licenses to use and the monitoring of third party intellectual property rights:

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5.2 Please state whether you have ever sent or received the following relating to intellectual property rights:

- a) a cease and desist letter:  Yes  No
- b) notification of an actual or potential claim letter:  Yes  No

*If yes to a) or b) above, please provide full details:*

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5.3 Please describe your procedures for managing intellectual property rights issues, including responding to an allegation of infringement and how the individual responsible for intellectual property rights issues is qualified for the role:

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## SECTION 6: CLAIMS EXPERIENCE

6.1 Please state whether you are aware of any incident:

- a) which may result in a claim under any of the insurance for which you are applying to purchase in this application form;  Yes  No
- b) which resulted in legal action being made against any of the companies to be insured within the last 5 years?  Yes  No

If you have answered yes to a) or b) above then please describe the incident, including the monetary amount of the potential claim or the monetary amount of any claim paid or reserved for payment by you or by an insurer. Please include all relevant dates, including a description of the status of any current claim which has been made but has not been settled or otherwise resolved.

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## SECTION 7: ADDITIONAL INFORMATION

Please provide the following information when you send the application form to us:

- directors or principals resumes if the company has been trading for less than 3 years;
- the organization chart or group structure if any subsidiaries are to be insured; and
- the standard form of contract, end user license agreement or terms of use issued by the company.

## SECTION 8: DECLARATION

- I declare that AFTER FULL INQUIRY the information provided in this application form is true and complete and that I have not mis-stated or suppressed any material fact.
- I undertake to inform underwriters of any material alteration to these facts occurring before the inception date of the Policy.

Signed: _____	Full name: _____
Date: _____ MM / DD / YY	Position in company: _____

**Data Protection Act** – All personal information supplied by you will be treated in confidence by CFC Underwriting Limited and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of CFC Underwriting Limited or our agents or subcontractors.



ADDITIONAL INFORMATION: