



Cybershield Increased Limits 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 2-6, if any answer is "No", please provide additional details on back.

- 2. Are you HIPAA compliant? Yes No
- 3. Does your company employ firewall protection? Yes No
- 4. If you store personal information on portable devices, is such data encrypted to industry standards? Yes No
- 5. Does your company use anti-virus software on all desktops/portable devices and mission critical servers, and is it updated in accordance with the software providers' recommendations? Yes No
- 6. Does your company have a formal process to disable or restrict access to information systems upon termination of employees? Yes No

For questions 7-8, if the answer is "Yes", please provide additional details on back.

- 7. Has the applicant ever received any complaints, claims or been subject to litigation involving matters of privacy, injury, identify theft, denial or service attacks, computer virus infections, theft of information, damage to third party networks or the applicant's customer's ability to rely on the applicant's network? Yes No
- 8. 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.

