beazley

BEAZLEY VIRTUAL CARE APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CAN BE WRITTEN ON A CLAIMS MADE AND REPORTED BASIS OR ON A CLAIMS MADE/OCCURRENCE COMBINED BASIS, WHICH MEANS THAT SOME COVERAGES UNDER THE POLICY APPLY ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE UNDERWRITERS DURING THE POLICY PERIOD OR THE EXTENDED REPORTING PERIOD, IF APPLICABLE OR ACCIDENTS TAKING PLACE DURING THE POLICY PERIOD. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

Requested Attachments:

1. Loss History for the last FIVE years.
2. Most Recent Financial Statements.
3. Sample copy of contract, used by the Applicant in the provision of professional services.
4. Most recent local and/or State accreditation agency reports (if applicable).
5. Any marketing brochures or literature detailing services provided.

I. GENERAL INFORMATION

1. APPLICANT INFORMATION

1.a) Name of Applicant/Entity(s)_____

1.b) Date of Incorporation/Start of Operation_____

1.c) Physical Address (City, State, Zip Code) _____

1.d) Telephone _____ Website _____

1.e) Legal Structure: ☐ Individual ☐ Partnership ☐ LLC
☐ Corporation ☐ Joint Venture ☐ Other_____

1.f) Tax Status: ☐ For Profit ☐ Not for Profit ☐ Governmental ☐ Other _____

1.g) List names, location, and descriptions of all legal entities, including subsidiaries for which Applicant is a part (continue on a separate sheet if necessary).

Loc. #	Business Name and Address	Description	Date Acquired	Ownership %	Retroactive Date

1.h) Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to in the upcoming year? (Please list including name of entity and date acquired)

□ Yes □ No

_____

_____

1.i) List all licenses held by your facility including type and expiration dates.

_____

1.j) List any/all accreditation from governmental agencies/clients (JCAHO, AABB, AATB, FACT, ABC, CLIA, AOPO, EBAA, CAP, ASHI, etc.) and association memberships held by your facility and include a copy of your most recent report.

_____

_____

1.k) Are you a member of the American Telemedicine Association or other telemedicine association?

□ Yes □ No

2. COVERAGE HISTORY

2.a) Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

2.b) Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

2.c) Please provide details of cyber liability coverage purchased in the last five (5) years to date:

_____

_____

2.d) Do you currently carry employee benefits liability coverage? □ Yes □ No
If "Yes," what is the employee count limit, deductible, and retroactive date?

_____
_____

2.e) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? □ Yes □ No

If "Yes," please explain.

_____
_____

3. PROFESSIONAL SERVICE/PRODUCT PROFILE

3.a) Please provide a full description of services rendered.

_____
_____
_____
_____

3.b) Operations: (for the previous 12 months please provide a breakout of the services provided, and the percentage of total gross revenues. Total must equal 100%.)

Service	Revenue	Percentage

3.c) Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months? □ Yes □ No

If "Yes," please explain:

_____
_____

3.d) Does the insured sell or lease any products? □ Yes □ No
If "Yes," please explain:

_____
_____

3.e) Please state the Applicant's revenue percentage from payment cards in the most recent twelve (12) months: ____%

3.f) Please complete the following:

	Projected, next Fiscal/Annual Period	Past 12 months; Most recent, full-annual	First Year Prior Financial Year:
Total Assets:			
Net Assets/Equity:			
Long Term Debt:			
Gross Revenues:			
Net Revenues/Income:			
Total Cash and Cash Equivalents			

II. MEDICAL PROFESSIONAL

1. PROFESSIONAL SERVICE/PRODUCT PROFILE

1.a) Please provide the number of patient contacts in the previous 12 months and current projection:

(number of visits)	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Clinic			
Laboratory			
Tele-visits (specify)			
Other (specify)			
TOTAL VISITS			

1.b) Does the insured have any beds for overnight stays? □Yes □ No
If "Yes," please list the number of beds and average occupancy:

1.c) Has your facility been surveyed by an accreditation agency within the past three years? □ Yes □ No
If "Yes", please list date(s) of last survey: ____/_____/_____

1.d) Does the insured provide any services outside of the United States? □ Yes □ No
If "Yes, please explain:
_____

1.e) Are medications prescribed? □ Yes □ No
If "Yes," please list the states in which you are prescribing medications:
_____

1.f) Are narcotics prescribed? □ Yes □ No
If "Yes," in which states?
_____

2. MEDICAL STAFF PROFILE

2.a) Schedule of Physicians, Surgeon, Osteopath, Podiatrist, Orthodontist, Chiropractor, Psychiatrist, Psychologist or Dentist – on Staff or Contracted that need to be scheduled under this policy: (supply separate sheet if necessary)

Name	Specialty	Board Certified	Hours Worked	Volunteer, Contracted or Employed	Has own Malpractice Insurance	Medical Director	State Physician Holds a License In
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	

2.a.i. Would you like physicians to be covered under the facility's policy
□ Yes □ No

2.a.ii. Do any of the above physicians have direct patient care responsibilities?
□ Yes □ No

If "Yes," what is the physician's role in providing services for the applicant's facility?

_____

2.b) Please provide details of all other staff utilized:

Health Professional	Employed			Contracted		
	Full Time	Part Time	Hours	Full Time	Part Time	Hours
Registered Nurses						
Licensed Practical Nurses						
Licensed Vocational Nurses						
Nurse Practitioners						
Physician Assistants						
Certified Nursing Assistants						
Physical, Occupational, and Speech Therapists						
Home Health Aides						
Sitters/Companions						
Emergency Medical						
Paramedics						
Pharmacists						
Technicians						
Social Workers						
Other (please provide description)						

3. CREDENTIALING

3.a) Are all health professionals credentialed prior to hiring? □ Yes □ No

3.b) Is physician credentialing and privileging formalized and documented? □ Yes □ No

3.c) Are physicians required to be board certified in their specialty? □ Yes □ No

3.d) How often are physicians re-credentialed? _____

3.e) Prior to hiring any employee, does the applicant verify:

3.e.i. Education background and training □ Yes □ No
3.e.ii. Employment references with at least two previous employers? □ Yes □ No
3.e.iii. Criminal record, on a Local, State and National scale? (Please indicate which apply)_____
3.e.iv. Driving record? □ Yes □ No
3.e.v. Credit record? □ Yes □ No
3.e.vi. Drug tests? □ Yes □ No
3.e.vii. Sex Offender Registry? □ Yes □ No

3.f) Does the applicant keep all information on file and verify its completion prior to employment commencement? □Yes □ No

4. EXPOSURE DATA

4.a) Please indicate the % or # of patient encounters for each state and type of encounter:

	%/# and Type of Encounters		%/# and Type of Encounters		%/# and Type of Encounters		%/# and Type of Encounters
AK		**ID**					
AL		**IL**		**NC**		**SC**	
AR		**IN**		**ND**		**SD**	
AZ		**KS**		**NE**		**TN**	
CA		**KY**		**NH**		**TX**	
CO		**LA**		**NJ**		**UT**	
CT		**MA**		**NM**		**VA**	
DC		**MD**		**NV**		**VT**	
DE		**ME**		**NY**		**WA**	
FL		**MI**		**OH**		**WI**	
GA		**MN**		**OK**		**WV**	
HI		**MO**		**OR**		**WY**	
IA		**MS**		**PA**			

5. TELEMEDICINE PRACTICE

5.a) Please describe the equipment, hardware and/or software used for delivery of telemedicine, if applicable:

_____
_____
_____
_____

5.b) Check all that apply to your Telemedicine-Based Activities:

□ Telephone consultations with referring physicians (second opinions)
□ Remote patient monitoring
□ Review and render an opinion regarding images, slides, etc. sent from a distant or remote site
□ Real-time, interactive patient treatment, including consultation or supervision of onsite physician
□ Real-time, interactive patient treatment, including consultation or supervision of onsite healthcare worker (non-physician)
□ Render services in or on behalf of an electronic/virtual intensive care unit
□ Remote Surgery and/or procedures on patients who are at a distant or remote site
□ Other (please specify) _____

5.c) Please provide a written narrative that describes the nature of your telemedicine practice:

_____

_____

III. TECHNOLOGY BASED SERVICES

1. TECHNOLOGY BASED SERVICES

1.a) Please describe in detail 1) the nature and types of professional and/or technology services the Applicant is engaged in; and 2) the types of Technology Products developed, manufactured, licensed or sold by the Applicant.

_____
_____
_____
_____

1.b) Please indicate the Applicant's four largest jobs/projects during the past two (2) years:

Client	Product/Service	Contract Revenues for this year/total contract
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

1.c. Indicate the percentage of the Applicant's revenue expected this year from the following: (Please answer for all that apply.) Please note that the total must equal one hundred percent (100%).

	Revenue %		Revenue %		Revenue %
a. Packaged Software Development and Licensing	_____	g. IT and Business Process Outsourcing	_____	m. Other internet services (please explain)	_____
b. Custom Software Development	_____	h. Media Content and Data Sales, Subscriptions and Licenses	_____	n. Technology Products sales and maintenance (other than software)	_____
c. Software Maintenance and Support	_____	i. Revenues from ISP and Email services	_____	o. Application Service Provider	_____
d. Computer and Software	_____	j. Website hosting and collocation services	_____	p. Other services or products (please explain)	_____
e. IT Consulting, Including Consulting on	_____	k. Advertising and Referral Revenues	_____		

Hardware and/Software System Design/Purchase			
f. Data and Transaction Processing	_____	l. Telecommunication Services	_____

1.d) What is the Applicant firm's average size contract in terms of total contract revenue?
_____

1.e) Does the Applicant have any contracts that represent more than five percent (5%) of the Firm's annual revenues? □ Yes □ No
If "Yes," attach details.

2. OPERATIONAL CONTROLS

2.a) Does the Applicant have written contracts with all clients the Applicant performs work for or provides products to? □ Yes □ No
If "Yes," what percentage of the time are they used? _____%

2.b) Do all services contracts with customers fully describe the scope of services to be provided? □ Yes □ No

2.c) Do all contracts include how any disputes between the Applicant and the customer will be handled? □Yes □ No

2.d) Do all services and products contracts include provisions for the following?
2.d.i. Damages Caps □ Yes □ No
2.d.ii. Disclaimer of Implied Warranties □ Yes □ No
2.d.iii. Guarantees □ Yes □ No
2.d.iv. Full Disclaimer of Consequential Damages □ Yes □ No
If "No," please explain circumstances when a full disclaimer of consequential damages is not provided:
_____
_____

3. MANAGEMENT OF CONTENT AND PRIVACY EXPOSURES

3.a) Does the Applicant collect, process, or maintain private or personal information as part of its business activities? □ Yes □ No
If "Yes:"
3.a.i. Is any of this information regulated by HIPAA, GLB, the Data Protection Act or other laws or legislation protecting private or personal information? □ Yes □ No

3.a.ii. Does the Applicant have written procedures in place to comply with laws governing the handling and/or disclosure of such information? □ Yes □ No
3.a.iii. Does the Applicant have an appointed privacy officer? □ Yes □ No
3.a.iv. Does the Applicant have a legally reviewed privacy policy? □ Yes □ No
3.a.v. Does the Applicant share private or personal information gathered from customers (by the Applicant or others) with third parties? □ Yes □ No

3.b) Is your practice compliant with the HIPAA privacy rules regarding data security and electronic transmission of protected health information? □ Yes □ No

4. MEDIA

4.a) Does the Applicant have a procedure for responding to allegations that content created, displayed or published by the Applicant is libelous, infringing, or in violation of a third party's privacy rights? □ Yes □ No

4.b) Does the Applicant have a qualified attorney review all content prior to posting? □ Yes □ No

If "Yes," does the review include screening the content for the following:

4.b.i. Copyright Infringement? □ Yes □ No

4.b.ii. Trademark Infringement? □ Yes □ No

4.b.iii. Invasion of Privacy? □ Yes □ No

4.c) Has the Applicant ever received a complaint or cease and desist demand alleging trademark, copyright, invasion of privacy, or defamation with regard to any content published, displayed or distributed by or on behalf of the Applicant? □ Yes □ No

If "Yes," how did the Applicant respond to such complaints and in what time frame?

_____

4.d) Is your practice complaint with the HIPAA privacy rules regarding data security an electronic transmission of protected health information? □ Yes □ No

IV. COMPUTER & NETWORK SECURITY

1. COMPUTER SYSTEMS CONTROLS

1.a) Has the Applicant suffered any known intrusions (i.e., unauthorized access) of its Computer Systems in the most recent past twelve (12) months? □ Yes □ No □ N/A
If "Yes," how many intrusions occurred? _____
If any damage was caused by any such intrusions, including lost time, lost business income, or costs to repair any damage to systems or to reconstruct data or software, describe the damage that occurred, state value of any lost time, income and the costs of any repair or reconstruction.

_____

Describe the response taken by the Applicant to the intrusions.

_____

1.b) Please indicate which of the following written information systems Policies and Procedures the Applicant has published and distributed to employees:

- Information system access regulations and controls,
- "Acceptable Use" standards,
- The company's right to monitor employee computer use and activity, including reading e-mails and monitoring website activities,
- Acceptable e-mail use,
- Acceptable internet use,
- Password discipline,

- Remote access,
- Incident response, handling, and reporting,
- Standards of communication for proprietary, sensitive, and confidential materials, and responses to threatening, malicious, or unprofessional communications,
- Phishing.

1.c) Does the Applicant conduct training for every employee user of the information systems in security issues and procedures for its Computer Systems? □ Yes □ No
If "Yes," indicate how frequent such training is provided:
_____

1.d) Are the Applicant's internal networks and/or Computer Systems subject to third party audit or monitoring (including ethical hacking for security purposes)? □ Yes □ No
If "Yes," please summarize the scope of such audits and monitoring:
_____

1.e) Has the Applicant undergone any business merger or acquisition that resulted in the merger of information systems in the most recent past three (3) years?
□ Yes □ No
If "Yes," describe:
_____

2. COMPUTER SYSTEM ACCESS PROTECTION

2.a) Does the Applicant provide remote access to its Computer Systems? □ Yes □ No
If "Yes,"
How many users have remote access? _____
Is remote access restricted to Virtual Private Networks (VPNs)? □ Yes □ No
Do you require multi-factor authentication for remote connections to your computer systems? □ Yes □ No
If "No," describe the extent to which other remote access is allowed, such as modem dial-in accounts, Remote Access Servers (RAS), or dedicated Frame Relay (FR) communications.
_____

2.b) Please indicate which of the following password disciplines the Applicant enforces via automated system or software settings:
- Passwords must contain at least eight (8) characters. If not, what is the minimum number of characters? _____
- Passwords must contain a mix of letters and one or more numbers and/or special characters (*()&%$#).
- Passwords must be changed at least every thirty (30) days. If not, how often?_____
- Old passwords may not be re-used.
- Passwords may not be a word found in a standard dictionary of the English language.

2.c) Does the Applicant terminate all associated computer access and user accounts as part of the regular exit process when an employee leaves the company? □ Yes □ No

2.d) Does the Applicant regularly compare all associated computer access and user accounts with some comprehensive employee record, such as payroll lists, to identify unauthorized or "extra" user accounts? □ Yes □ No
If "No," describe any procedures used to assure that user accounts are valid:
_____

2.e) Does the Applicant use commercially available firewall protection systems to prevent unauthorized access to internal networks and computer systems? □ Yes □ No

2.f) Does the Applicant use intrusion detection software to detect unauthorized access to internal networks and Computer Systems? □ Yes □ No

2.g) Does the Applicant employ Anti-Virus software? □ Yes □ No
If "Yes," is it company policy to up-grade the software as new releases/improvements become? □ Yes □ No
If "No," how often does the Applicant upgrade its Anti-Virus software with new releases?

_____

3. DATA BACKUP PROCEDURES

3.a) Is all valuable/sensitive data backed-up by the Applicant every day? □ Yes □ No
If "No," please describe exceptions:

_____

3.b) Is at least one complete back up file generation stored and secured off-site from the Applicant's main operations in a restricted area? □ Yes □ No
If "No," describe the procedure used by the Applicant, if any, to store or secure copies of valuable/sensitive data off site.

_____

4. DATA ENCYRPTION PROCEDURES

4.a) Does the Applicant have and enforce policies concerning when internal and external communication should be encrypted? □ Yes □ No
If "Yes," describe the types of 1) internal and 2) external communications which are encrypted.

_____

4.b) Does the applicant have and enforce policies concerning encryption for data at rest? □ Yes □ No

4.c) Does the applicant have and enforce policies concerning encryption for mobile devices and media (backup tapes)? □ Yes □ No

5. LEGAL PROCEEDINGS

5.a) Has the Applicant or any director, officer, partner or principle been involved in any of the following:

5.b) Criminal action or administrative proceeding charging violation of a federal, state or foreign or regulation? □ Yes □ No

5.c) Been a party to any lawsuit or other legal proceeding within the past five (5) years? □ Yes □ No

5.d) Been subject to disciplinary action as a result of professional activities? □ Yes □ No

If '"Yes," please provide (on Attachment 'A') a description which includes the venue of the action, the parties, the amount at dispute, the nature of the claim(s), the status of the action(s) and how the action(s) was resolved as to the Applicant, including all costs incurred; including defense expenses.

V. PCI COMPLIANCE

1. PCI COMPLIANCE

Please complete the following if you accept payment cards:

1.a) How many transactions do you process each year:
□ more than 6 million
□ 1 million to 6 million
□ 20,000 to 1 million
□ less than 20,000

1.b) What percent of card transactions are: Card Not Present ____% Card Present___%

1.c) Are you required to submit a Report on Compliance (ROC) or a Self-Assessment Questionnaire (SAQ) to document compliance with the PCI Data Security Standards?
□ ROC
□ SAQ – Type A
□ SAQ – Type A-EP
□ SAQ – Type B
□ SAQ – Type B-IP
□ SAQ – Type C
□ SAQ – Type C-TV
□ SAQ – Type D
□ None of the above

1.d) When was your last ROC or SAQ report submitted? _____

1.e) Are you currently compliant with the PCI Data Security Standards version 3.0?
□Yes □ No
If "No," when do you anticipate being compliant with PCI version 3.0?
_____

1.f) Is a 3rd party payment processing application being used? □ Yes □ No
Has the application undergone PA-DSS validation? □ Yes □ No
If "No," please list the name and version of software application(s) here:
_____
_____

1.g) Is cardholder data (PAN, CVV) stored or otherwise retained for any purpose after a transaction? □ Yes □ No
If so, for how long is card data stored in your system after a transaction?
_____
Do you store consumer card data in your systems for future transactions? □ Yes □ No

1.h) Do you employ any of the following: tokenization or end-to-end encryption including encryption of databases) to protect payment card data?
□ Tokenization
□ End to end encryption

1.i) Are employees, administrators, or vendors, with remote access to payment systems or applications authenticated using a 2-factor authentication mechanism? □ Yes □ No

1.j) When did you last check your POS system for malware?
_____

How often do you check your POS systems for malware?
_____

Have you discovered any malware on your POS system in the last 12 months?

_____

1.k) Please describe your procedures in place to prevent physical tampering of POS terminals:

_____

1.l) Please provide a general description of the areas where you are out of compliance?

_____

1.m) Please describe your remediation efforts to attain compliance with the issues noted above:

_____

1.n) Please describe any compensating controls that you have implemented:

_____

1.o) By what date do you plan to attain compliance?

_____

VI. CLAIMS INFORMATION

1. CLAIMS INFORMATION

1.a) Has any claim or suit ever been made against you or your organization or any employees/staff working on your behalf which it would be subject of this proposed insurance? □ Yes □ No

If "Yes," how many? _____ Complete a copy of our Supplemental Claim form for each.

1.b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which it would be subject of this proposed insurance?

□ Yes □ No

If "Yes," has each of these been reported to the current or any prior insurer?

□ Yes □ No

How many? _____Complete a copy of our Supplemental Claim form for each.

1.c) Has the applicant or any staff:

1.c.i. ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? □ Yes □No

1.c.ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? □ Yes □ No

1.c.iii. ever been treated for alcoholism or drug addiction? □ Yes □ No

1.c.iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? □ Yes □ No

If "Yes," please provide an explanation on any/all incidents.

_____

1.d) Have any Loss payments (as defined under the proposed insurance) been made on behalf of any proposed Applicant under the provisions of any prior or current errors or omissions, professional liability, media or network security policy or similar insurance?

□ Yes □ No

If "Yes," complete a copy of our Supplemental Claim form for each Loss.

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO 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 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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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 KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR 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 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 KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND 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 CLAIMS 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. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

Signed: _____

Date: _____

Print Name: _____

Title: _____
(Owner, Partner, Authorized Officer)

If this Application is completed in Florida, please provide the Insurance Agent's name and license number. If this Application is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: _____

Florida Agent's License Number: _____

Agent's Signature: _____

APPLICATION SUPPLEMENTAL CLAIM INFORMATION

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT, INCIDENT OR LOSS.

1. Applicant Name _____
2. Claimant Name _____
3. Name of Individual(s) at your firm/Company involved in Claim: _____
4. Indicate whether: _____ Claim/Suit _____
   Incident_____
5. Date of alleged error: _____ Date claim made against applicant: _____
6. Additional defendants: _____
7. Current Disposition of claim:
   [ ] DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
   [ ] ABANDONED (no activity from claimant for over 3 years)

[ ] WON by defense
[ ] WON by claimant Total Paid $_____ Amount Paid on your behalf $_____
Indicate whether : [ ] Court judgment, or [ ] Out of court settlement
[ ] OPEN Claimant's settlement demand $_____
Defendant's offer for settlement? $_____

Insurer's loss reserve $_____

8. Name of Insurer: _____

9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)

a. Alleged act, error or omission upon which Claimant bases claim: _____

_____

b. Description of cases and events: _____

_____

c. Description of the type and extent of injury or damage allegedly sustained: _____

_____

d. If a medical claim provide type of injury claimed:

[ ] Emotional Only [ ] Temporary Disability [ ] Death [ ] Cosmetic
[ ] Permanent Disability [ ] Other (describe) _____

10. Explain what action has been taken by you to prevent recurrence of the same type of claim.

_____

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO 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 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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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 KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR 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 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 KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND 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 CLAIMS 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. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

I understand information submitted herein becomes a part of my Beazley Virtual Care Policy Application and is subject to the same warranty and conditions.

_____	_____
Name of Applicant*	Title (Officer, Partner, etc.)
_____	_____
Signature of Applicant	Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.