



**SynGuard™ / MedAssure™**  
**For Solo-Practitioners and Medical Groups**  
**for Healthcare Providers Insurance Exchange**

Healthcare Synergies's SynGuard™ / MedAssure™ program offers simplified underwriting for our two most popular healthcare products. Solo Physicians and small physician groups that meet the program qualifications can simply complete the short application and send in a bind request for their desired coverage. If both coverages are purchased together, there is a significant discount applied to the premium amount.

**Qualifications**

- Must not have experienced any related claims/incidents in the last 5 years.
- Must be a physician practice or medical group insured by HPIX.

**How To Purchase MedAssure™ / SynGuard™**

1. Fully complete the MedAssure™ / SynGuard™ Application below, including the Surplus Lines form.
2. Sign, date, and return the completed application to Healthcare Synergies with your check for the 25% down – payment plus the applicable state taxes and fees.
3. Complete the Premium Option Form and Premium Finance Agreement
4. Return all requested documents and check to:  
Natalie Gaudiosi  
113 N. Bread Street, Suite 6F  
Philadelphia, PA 19106



**MedAssure™ / SynGuard™ PROGRAM APPLICATION**

**Section One – Applicant Information**

1. Name of Applicant: \_\_\_\_\_  
(as it should appear on the policy)

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Web Site: \_\_\_\_\_ No. of years in business: \_\_\_\_\_

Number of Full Time Equivalent Physicians to be covered under policy: \_\_\_\_\_

**For questions 2-9, if the answer is “Yes”, coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside the program, please provide the details for the “Yes” answers.**

- 2. Have you acquired any practices in the last 5 years?  Yes  No
- 3. Do you handle billings for any hospitals or provider services not provided by your medical group?  Yes  No
- 4. 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
- 5. Has the entity or any physician in your group ever been investigated or sanctioned by any local, state or federal government or agency regarding the delivery of healthcare services or reimbursement thereof?  Yes  No
- 6. Has the entity or any physician in your group ever had to refund amounts to Public and/or Private payers in excess of \$10,000?  Yes  No
- 7. Has the entity or any physician in your group ever been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?  Yes  No
- 8. Has the entity or any physician in your group ever been accused of errors by any government agency or commercial payer?  Yes  No
- 9. 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

**For questions 10-15, if the answer is “No, coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside the program, please provide the details for the “No” answers.**

- 10. Do the entities and/or persons who perform billing services for you comply with standardized billing procedures?  Yes  No
- 11. Are you HIPAA compliant?  Yes  No
- 12. Does your company employ firewall protection?  Yes  No
- 13. If you store personal information on portable devices, is such data encrypted to industry standards?  Yes  No
- 14. 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 provider’s recommendations.  Yes  No
- 15. Does your company have a formal process to disable or restrict access to information systems upon termination of employees?  Yes  No



**For question 16, if the answer is “Yes”, coverage cannot be bound as per the terms and conditions of this program. If you desire an indication outside the program, please provide the details for the “Yes” answer.**

16. Has the applicant received any complaints, claims or been subject to litigation involving matters of privacy, injury, identity 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

**Section Two – Coverage Selection (Check coverage desired and circle requested limit):**

Coverage	Limit	Retention
<u>          </u> <b>Standalone</b> MedAssure™ <i>- includes a 25% co-payment, that is waived for use of panel counsel -</i>	<b>\$500,000/\$1,000,000</b>	\$1,000
<u>          </u> <b>Standalone</b> SynGuard™ <ul style="list-style-type: none"> <li>▪ Network Security &amp; Privacy</li> <li>▪ Patient Notification &amp; Credit Monitoring Costs</li> <li>▪ Data Recovery Costs</li> </ul>	<b>\$500,000/\$1,000,000</b> See Chart* See Chart*	\$1,000 \$1,000 \$1,000
<u>          </u> <b>Combined</b> MedAssure™ and SynGuard™ (Discounted Rate) <ul style="list-style-type: none"> <li>▪ MedAssure™ Regulatory Proceedings Insurance including Fines &amp; Penalties  <i>- includes a 25% co-payment, that is waived for use of panel counsel -</i></li> <li>▪ SynGuard™               <ul style="list-style-type: none"> <li>○ Network Security &amp; Privacy</li> <li>○ Patient Notification &amp; Credit Monitoring Costs</li> <li>○ Data Recovery Cost</li> </ul> </li> </ul>	<b>\$500,000/\$1,000,000</b>  <b>\$500,000/\$1,000,000</b> See Chart* See Chart*	\$1,000  \$1,000 \$1,000

**Requested effective date (no backdating):** \_\_\_\_\_

Policy Sublimits	\$500,000 Policy		\$1,000,000 Policy	
	Data Recovery	Patient Notification and Credit Monitoring	Data Recovery	Patient Notification and Credit Monitoring
1-10	\$50,000	\$50,000	\$150,000	\$150,000
11-50	\$100,000	\$100,000	\$250,000	\$250,000
51-100	\$200,000	\$200,000	\$500,000	\$500,000

**Section Three – 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, underwriters have two working days 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 that 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 underwriter of such a change, and the underwriter may modify or deny coverage.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized signature of a Principal or Officer**

**\*Must be signed and dated no more than 45 days prior to binding**

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_



## DELAWARE SURPLUS LINE DISCLOSURE NOTICE

THIS MUST BE COMPLETED IN FULL IN ORDER TO ISSUE THE POLICY  
INFORMATION REGARDING THE FILING AND PAYMENT OF SURPLUS LINE TAXES

### DISCLOSURE REGARDING SURPLUS LINES INSURANCE.

This insurance contract is issued pursuant to the Delaware Insurance Laws by an insurer neither licensed by nor under the jurisdiction of the Delaware Insurance Department.

This risk is subject to a non-refundable surplus line tax and stamping fee.

Written Policies are subject to a minimum earned premium of 25%.

Name of Applicant \_\_\_\_\_

Surplus Lines License  
Number for this filing: Non-Resident P&C / Surplus Lines License Number: 1123724

License Filing State: Delaware

Name of Individual  
or Company License Holder: Healthcare Synergies, LLC.

Address of License Holder: 113 N. Bread Street, Suite 6F

Philadelphia, PA 19106

Signature of Person  
Completing this Form \_\_\_\_\_  
(need not be license holder)

Date \_\_\_\_\_