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
_____	**Standalone** MedAssure™	**$500,000/$1,000,000**	$1,000
	- includes a 25% co-payment, that is waived for use of panel counsel -		
_____	**Standalone** SynGuard™		
	▪ Network Security & Privacy	**$500,000/$1,000,000**	$1,000
	▪ Patient Notification & Credit Monitoring Costs	See Chart*	$1,000
	▪ Data Recovery Costs	See Chart*	$1,000
_____	**Combined** MedAssure™ and SynGuard™ (Discounted Rate)		
	▪ MedAssure™ Regulatory Proceedings Insurance including Fines & Penalties	**$500,000/$1,000,000**	$1,000
	- includes a 25% co-payment, that is waived for use of panel counsel -		
	▪ SynGuard™		
	○ Network Security & Privacy	**$500,000/$1,000,000**	$1,000
	○ Patient Notification & Credit Monitoring Costs	See Chart*	$1,000
	○ Data Recovery Cost	See Chart*	$1,000

Requested effective date (no backdating): _____

Policy Sublimits	$500,000 Policy		$1,000,000 Policy	
Number of Physicians	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: _____

SURPLUS LINE FORM

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

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%.

The insurer with which the licensee places the insurance is not licensed by the Pennsylvania Insurance Department and is subject to its limited regulation; and In the event of insolvency of an eligible surplus lines insurer, losses will not be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association.

Name of Applicant _____

Surplus Lines License
Number for this filing: PA Resident Producer License #: 594174
PA Resident Surplus Lines License #: 594515

License Filing State: Pennsylvania

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 _____