eHealth

Application form

United States

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: MM / DD / YY

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: MM / DD / YY

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:

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

	%
	%
	%
	%
	%
	%
	%
	%

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%:

AL:	%	AK:	%	AZ:	%
AR:	%	CA:	%	CO:	%
CT:	%	DE:	%	FL:	%
GA:	%	HI:	%	ID:	%
IL:	%	IN:	%	IA:	%
KS:	%	KY:	%	LA:	%
ME	%	MD:	%	MA:	%
MI:	%	MN:	%	MS:	%

MO:	%	MT:	%	NE:	%
NV:	%	NH:	%	NJ:	%
NM:	%	NY:	%	NC:	%
ND:	%	OH:	%	OK:	%
OR:	%	PA:	%	RI:	%
SC:	%	SD:	%	TN:	%
TX:	%	UT:	%	VT:	%
VA:	%	WA:	%	WV:	%
WI	%	WY	%	Other overseas US territories:	%
Other:	%	**TOTAL**:	%		

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:

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

If yes, please provide details:

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 reply upon to provide critical business services:

Adobe	☐	Amazon web services	☐	Dropbox	☐
Google Cloud	☐	IBM	☐	Microsoft 365	☐
Microsoft Azure	☐	Oracle Cloud	☐	Salesforce	☐
SAP	☐	Workday	☐		

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	☐	Application Whitelisting	☐	Asset Inventory	☐
Custom Threat Intelligence	☐	Database Encryption	☐	Data Loss Prevention	☐
DDoS Mitigation	☐	DMARC	☐	DNS Filtering	☐
Employee Awareness Training	☐	Incident Response Plan	☐	Intrusion Detection System	☐

Mobile Device Encryption	☐	Penetration Tests	☐	Perimeter Firewalls	☐
Security Info & Event Management	☐	Two-Factor Authentication	☐	Vulnerability Scans	☐
Web Application Firewall	☐	Web Content Filtering	☐		

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

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:

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:

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:

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.

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: _____

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ADDITIONAL INFORMATION: