MEDICAL BILLER & CODER PROFESSIONAL LIABILITY INSURANCE SHORT FORM APPLICATION

Return Applications To:
Fox Point Programs, Inc.
3001 Philadelphia Pike
Claymont, DE 19703
(800) 499 - 7242 / Fax: (302) 472 – 8529
MBCSubmissions@foxpointprg.com

NOTICE: THE POLICY FOR WHICH YOU ARE APPLYING IS WRITTEN ON A CLAIMS-MADE AND REPORTED BASIS. ONLY CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD ARE COVERED SUBJECT TO THE POLICY PROVISIONS. THE LIMITS OF LIABILITY STATED IN THE POLICY ARE REDUCED, AND MAY BE EXHAUSTED, BY CLAIMS EXPENSES. CLAIMS EXPENSES ARE ALSO APPLIED AGAINST YOUR DEDUCTIBLE, IF APPLICABLE.

IMPORTANT! The Medical & Coder Short Form Application is ONLY available to individuals with the following characteristics

- Generates no more than **$100,000** in revenues annually
- No Prior Professional Liability Claims
- Does not require Prior Acts Coverage
- Has not purchased Professional Liability insurance for their business in the past
- Not domiciled in North Carolina

☐ **BY CHECKING THE BOX TO THE LEFT, APPLICANT WARRANTS THAT HE/SHE UNDERSTANDS THE RESTRICTIONS LISTED ABOVE**
NOTE: NO APPLICATION WILL BE CONSIDERED FOR COVERAGE UNLESS THIS WARRANTY HAS BEEN PROVIDED.

STEP 1: DETERMINE LIMIT REQUIRED

SELECT LIMIT OPTION	LIMIT OF LIABILITY	RETENTION	ANNUAL PREMIUM	TAXES & FEES	TOTAL AMOUNT
☐	$100,000/$100,000	$1,000	$325.00	$75.00	$400.00
☐	$250,000/$250,000	$1,000	$385.00	$75.00	$460.00

STEP 2: SELECT OPTIONAL COVERAGE

SELECT COVERAGE	DESCRIPTION	PREMIUM CHARGE
☐ Independent Contractors	Expands coverage to include up to 4 independent contractors working under applicant's direction.	$100.00
☐ Network Security & Privacy Endorsement	Expands coverage to include additional sub-limits for security breaches and losses that arise from the failure to protect sensitive and confidential information. Sub-limits*: $50,000 Breach Costs (1st Party); $100,000 Privacy and Security; **$100,000 Aggregate limit applies*	$50.00

STEP 3: CALCULATE FINAL PREMIUM DUE

SELECTED COVERAGE FROM STEP 1		SELECTED OPTION(S) FROM STEP 2		TOTAL AMOUNT DUE
$	+ $		= $	

APPLICANTS POSSESSING RISK CHARACTERISTICS OTHER THAN THOSE OUTLINED ABOVE WILL NEED TO COMPLETE A FULL APPLICATION. THESE RISKS WILL BE UNDERWRITTEN INDIVIDUALLY. PLEASE CONTACT US FOR DETAILS.

1. GENERAL INFORMATION

Applicant Name:
dba Name:
Business Address:
City: State: Zip:
Phone: Fax:
E-Mail: Date Business Began:
Applicant does business as: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other (Explain):
Association Affiliation(s)
Applicant is a **Certified Medical Reimbursement Specialist (CMRS)** ☐ Yes ☐ No

*If **Yes**, please submit a copy of your CMRS certification with your application to receive your membership discount*

2. OPERATIONS

A What are the Applicant's expected revenues over the next 12 month period? $
B Does the Applicant always use a written contract or statement of work? ☐ Yes ☐ No
If "no" please explain on a separate sheet.

C Does the Applicant follow and enforce data and privacy rules with respect to Protected Health Information as set forth in the Health Insurance Portability and Accountability Act (HIPAA) and other related state and local regulaions? ☐ Yes ☐ No

D Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, error, omission, circumstance, or situation that might provide grounds for any claim under the proposed insurance? ☐ Yes ☐ No

E Is the Applicant providing any services other than Medical Billing or Coding? ☐ Yes ☐ No
*If **Yes** - Please describe* _____

F After inquiry, have any claims been made against any proposed Insured(s) during the past five (5) years? ☐ Yes ☐ No
If the answer to question 2c, 2d, 2e, or 2f is Yes, provide details on a separate sheet

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Date _____ Applicant's Authorized Signature _____

THE APPLICANT WARRANTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE TRUE AND COMPLETE. THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH A FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED.

If Paying by Check ☐ Check for Total Amount Due, payable to: **Fox Point Programs, Inc**

If Paying by Credit Card ☐ I hereby authorize the Total Amount Due to be charged to my credit card

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Credit Card Number: _____

CVV Code: _____

Expiration Date: _____

Amount: $_____

Signature (required) _____ Date: _____