



## Cyber Solutions™ for Physicians Application for Higher Limits

**Instructions:**

This application is to be used for all physician groups with more than 50 physicians for all higher limit requests. This application is to be used for all higher limit requests above \$1,000,000 regardless of physician size.

Name of Applicant:		MMIC Policy Number:
Number of Years in Business:	Number of Full Time Equivalent Physicians to be Covered:	Requested Effective Date:
Requested Limit of Coverage:		Operating Revenue:

For questions 1 through 5, please explain any “No” responses in the comments section on page 2.

1. Are you HIPAA compliant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does your organization employ firewall protection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If you store personal information on portable devices, is such data encrypted to industry standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does your organization 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does your organization have a formal process to disable or restrict access to information systems upon termination of employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the last five (5) years, has your organization experienced any claims or are you aware of any circumstances that may give rise to a claim that would have been covered by this policy? If “yes”, please explain in the comments section on page 2.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I, the undersigned, agree and represent that:

- I. To the best of my knowledge and belief, the statements set forth herein are true and complete.
- II. I acknowledge this application shall be the basis of insurance and will be attached to and made part of the policy.
- III. If the information supplied on this application changes between the date of the application and the inception date of the policy period, I will immediately notify the underwriter of such a change, and MMIC may modify or deny coverage.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 Authorized Signature of a Principal or Officer

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

This Application must be signed and dated no more than 30 days prior to binding. Backdating coverage is not permitted.



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COMMENTS SECTION: