IRONSHORE COMPANIES
175 Powder Forest Drive
Weatogue, CT 06089

MEDICARE REPORTING &
SECONDARY PAYER ACT LIABILITY
APPLICATION

YOU ARE APPLYING FOR A CLAIMS MADE LIABILITY POLICY WITH DEFENSE EXPENSE INCLUDED WITHIN THE LIMIT OF LIABILITY- PLEASE READ THE ENTIRE POLICY CAREFULLY

[*For Organizations with fewer than 50 claims reportable annually to CMS*]

Named Insured(s)& Address:	☐ USA, ☐ - Other – _____
Additional Insureds & Address:	☐ See attached list.
Location Listing:	☐ See attached list.
Policy Period:	_____to_____ Both days at 12:01 am local time at the principal address of the Named Insured.
Risk Management Contact Information:	
Type of Entity:	☐ For-Profit, ☐ Not-for-Profit, ☐ Taxable, ☐ Non-Taxable
Organizational Type:	☐ Individual, ☐ Partnership, ☐ Corporation, ☐ Limited Liability Company ☐ Joint Venture, Ownership ☐ Public, ☐ Private
Describe your business products &operations:	
SIC Code:	
Your Internet Website:	
Comments or Special Instructions:	

Retroactive Date(s), Limits of Liability & Co-Participation Percentages

Insuring Agreement	Retroactive Date	Limits	Co-Participation %
a) Medicare Medicaid and SCHIP Extension Act Reporting Liability….....		$	%
b) Medicare Medicaid and SCHIP Extension Act – Section 111 Fines……..		$	%
c) Medicare Secondary Payer Act Liability……		$	%
d) Medicare Billing Errors Liability……..		$	%
e) Public Relations Expense……		$	%
f) Personal Information Protection Expense Reimbursement ……..		$	%
g) Medical Payments Expense Reimbursement……		$	%
h) Policy Aggregate Limit of Liability……..		$	%

Self-Insured Retention (SIR)	
☐ - Include for all Insuring Agreements	
☐ - Include only for identified Insuring Agreements	
Per Claim – Self-Insured Retention:	$
Aggregate – Self-Insured Retention:	$

Basic Limits Premium Calculation			
Deposit Premium Calculation Based On Your Estimated Number of Reportable (MSP & MMSEA) Claims to the Centers for Medicare and Medicaid Services annually by group:			
	# of Claims	*Rate Per Claim*	*Premium*
All Liability Coverage:			*$*
All Workers' Compensation, Non-Subscriber, or No-Fault Claims:			*$*
All Group Health Claims:			*$*
Medicare Billings [amount]:	$		*$*
Allied Coverage Premium:			*$*
Estimated & Deposit Premium:		*Total:*	*$*

General Underwriting Information

1) Your Responsible Reporting Entity (RRE) organizational type for Medicare Compliance is:
   - ☐ Self-Insurer (including Private Payments and Write-offs),
   - ☐ Insurance Pool (such as Assigned Risk), ☐ Captive Insurance Company,
   - ☐ Risk Retention Group, ☐ Commercial Insurer, ☐ Joint Underwriting Association
   - ☐ Third Party Claims Administrator (Health Plans Only)
   - ☐ Trusts – (Including Commercial Insurance Trusts)
   - ☐ Other – Describe:_____

2) Are you familiar with your responsibilities to comply with Medicare compliance obligations?
   ☐ Yes, ☐ No.

3) Identify who performs the Medicare compliance procedures review(s) and include a brief description of their qualifications.

4) Does your Parent Organization or any subsidiary currently have directors' and officers' liability insurance?
   ☐ Yes, ☐ No.

5) As part of this application, please attach the following (where applicable):

   - ☐ - Latest Audited Financial Statements
   - ☐ - Annual Report
   - ☐ - A copy of the indemnification provisions of the by-laws, charter or articles of incorporation.
   - ☐ - Latest proxy statement.

Third Party Claims Administration

1) Do you utilize a Third Party Claims Administrator (TPA)?
   ☐ Yes, ☐ No.

2) Please attach a copy of the Third Party Claims Administration agreement(s) and redact any confidential information.

3) Have you signed a waiver or hold harmless agreement with any TPA for Medicare compliance responsibilities?
   ☐ Yes, ☐ No.

   Please include a copy of the agreement. Confidential information may be redacted.

4) Is your TPA responsible for determining the Medicare eligibility status of claimants?
   ☐ Yes, ☐ No.

   If no, please explain.

5) Do you writeoff medical bills due to bodily injury events involving third parties?
☐ Yes, ☐ No.

How do you identify the medical bill write-offs? Is there a formal process to communicate medical bill write-offs to Risk Management?
☐ Yes, ☐ No.

Medicare Medicaid and SCHIP Extension Act of 2007 Compliance

1) Have you registered with CMS as an RRE?
☐ Yes, ☐ No.

2) Date you registered with CMS as an RRE.

3) Please provide your RRE ID numbers and if more than one RRE ID, please explain how each RRE ID is to be utilized for your organization.

4) Who is your RRE Authorized Representative?

5) Who is your RRE Account Manager?

6) Is your RRE Account Manager your employee?
☐ Yes ☐ No.

If no, please provide a copy of your contract or engagement letter. (Confidential information may be omitted)

7) Have you registered any Account Designees with CMS?
☐ Yes, ☐ No.

If yes, are your Account Designees your employees?
☐ Yes, ☐ No.

If yes, list your employed Account Designees.

8) If your Account Designees are employees of others, please indicate by whom they are employed.

9) Do you understand that compliance with Medicare, Medicaid, and SCHIP requirements are a non-delegable duty? ☐ Yes, ☐ No.

10) Describe your process for compliance with your responsibilities under MMSEA Section 111. (If you have a manual, guide or established procedures for staff members to follow in reporting to Medicare, you may attach a copy.)

11) Have the individuals responsible for MMSEA Section 111 compliance reporting reviewed and do they understand the most current version of CMS's Users Guide?
☐ Yes, ☐ No.

12) Describe the training and experience of the individual performing the ICD-9 \ ICD-10 coding skills for your MMSEA Section 111 reports.

13) Have you investigated all open claims to determine the Medicare eligibility status of all potential claimants?
☐ Yes, ☐ No. If yes, how many?_____

Medicare Billing Errors

1) Do you bill ☐ Medicare, ☐ Medicaid, or ☐ State Children's Health Insurance Plans for medical services you perform?
☐ Yes, ☐ No.

2) If so, what is the amount of your annual billings to each?

Medicare $
Medicaid $
Children's Health Insurance Plans $

Prior Insurance

1) Does the Named Insured or a subsidiary currently have coverage that would respond to a Medicare Reporting or Medicare Secondary Payer Act loss?
☐ Yes, ☐ No.

If yes, please provide the following information:

Insurer:
Limits:
Deductible or Retention:
Policy Period:

2) Has the Named Insured, a subsidiary or any Insured under this proposed coverage, given written notice under the provisions of any prior or current coverage that would respond to a Medicare Reporting and Secondary Payer Act loss, of specific facts or circumstances which might give rise to a claim being made against any Insured?
☐ Yes, ☐ No. If yes, describe.

Continuity with Prior Coverage

(only applies if you currently have coverage and request continuity of coverage)

1) Attach a copy of your prior application with which continuity of coverage is to be maintained.

2) The Underwriter will be relying upon the declarations and statements contained in such prior application and those declarations and statements shall be considered to be incorporated in and form part of the policy by the Underwriter.

Medicare Compliance Loss Information

1) For the period, 5 years prior to the date of this application, has your organization received verbal or written notice, from the Centers for Medicare and Medicaid Services (CMS), Coordination of Benefits Recovery Contractor (COBRC), a Medicare Beneficiary, a RAC Audit Contractor (representing CMS), The Office of the Inspector General or the Attorney General in reference to any actual or alleged failure to comply with Medicare laws, rules or regulations? ☐ Yes, ☐ No.

   If yes, describe each instance.

2) Has your organization be the subject of a RAC?
   ☐ Yes, ☐ No.

   If so, describe the outcome(s)?

3) In the past 5 years, have any loss payments been made on behalf of any Insured under any coverage that would respond to aMedicare Reporting or Secondary Payer Act loss or regulatory action?
   ☐ Yes, ☐ No.

   If yes, describe each instance.

Prior Knowledge Warranty

1) No person proposed for coverage is aware of any facts or circumstances which he or she has reason to suspect might give rise to a future claim that would fall within the scope of the proposed coverage, except (if no exceptions, state none).
   ☐ - None

   (It is agreed that if such facts or circumstances exist, whether or not disclosed, any claim arising from them is excluded from this proposed coverage.)
   Exceptions:

False Information

Any person who, knowingly and with the intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance by the Underwriter upon the Application, and the Application will be the basis of the contract.

The information contained in and submitted with this Application is on file with the Underwriter, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand that:

a) If any portion of the policy to be issued is written on a "Claims-Made" basis, then such portion(s) shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Underwriter in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and
b) The limit of liability available under the policy to be issued is available to pay damages, settlements, or judgments may be reduced, and may be exhausted, by payment of "Defense Expense," and "Defense Expense" also shall be applied against the Co-Participation Clause.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR

CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING - IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/ OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO THE CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON, WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO MINNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON, WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSUANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSUANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURY, DEFRAUD OR DECEIVE ANY INSURER MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant	Signature of Producer
Printed Name	Printed Name
Title (Chief Executive Officer or President only)	Date Signed
Date Signed	Name Of Producing Agency
	Agent License Number & State of Issuance
Producer or Agency Address	National Producer Number
Producer or Agency Email Address & Telephone	Signed by Licensed Surplus Lines Producer (Where Required By Law)

Note: This application must be signed by the Chief Executive Officer or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance. This application will form part of your policy if issued.

The applicant understands and agrees that they are obligated to report any changes in the information provided in this application which occur after the date of the application.

Forward your completed Medicare Reporting and Secondary Payer Act Liability application to:

FOR HEALTHCARE ORGANIZATIONS

IronHealth Submissions
175 Powder Forest Drive, 1st Floor
Weatogue, Connecticut 06089 USA
IronHealthSubmissions@Ironshore.com

FOR NON-HEALTHCARE ORGANIZATIONS

Ironshore Casualty Submissions
175 Powder Forest Drive, 1st Floor
Weatogue, Connecticut 06089 USA
IronshoreCasualty@Ironshore.com

Your Medicare Reporting& Secondary Payer Act Liability Insurance coverage is serviced on behalf of:
Ironshore Insurance Specialty Insurance Company, by:

MGU Specialty Risk Services, LLC
3959 Van Dyke Road, #385
Lutz, Florida 33558-8025
USA
MMSEA@MGUSpecialtyRiskServices.com