OLD REPUBLIC INSURANCE COMPANY
MISCELLANEOUS PROFESSIONAL LIABILITY

This Supplement should be submitted to:

Chicago Underwriting Group, Inc.
191 N. Wacker Drive
Chicago, IL 60606
(312) 750-8800

MEDICAL BILLING SUPPLEMENT

1. Name of Applicant: _____

2. What percentage of business is derived from the following services which the applicant performs on behalf of healthcare providers?
   - Coding of claims ___%
   - Accounts receivable ___%
   - Processing of claims ___%
   - Bad debt collections ___%
   - Other (describe): ___%

   Total must equal 100%

3. How many clients are currently served? _____

4. Please identify major clients:

_____
_____

5. What percentage of billings is for Medicare/Medicaid? ___%

6. For what types of medical services does the Applicant bill?

_____
_____

7. Is your compensation related to the dollar amount billed or collected?
   If Yes, explain. ☐ Yes ☐ No

_____
_____

8. Is the Applicant currently, and has the Applicant always been, in compliance with existing statutes and regulations? If No, explain: ☐ Yes ☐ No

_____
_____

9. Does the Applicant have written policies and procedures for standards of conduct? ☐ Yes ☐ No

10. Does the Applicant have a compliance officer and compliance committee? ☐ Yes ☐ No

11. Does the Applicant conduct training and education for all employees? ☐ Yes ☐ No

12. Does the Applicant have documented standards that are enforced? ☐ Yes ☐ No

13. Does the Applicant conduct internal monitoring and auditing? ☐ Yes ☐ No

14. Does the Applicant receive money directly from an insurance carrier? ☐ Yes ☐ No

15. Does the Applicant have crime coverage in place? ☐ Yes ☐ No
    If Yes, indicate the limit of insurance: $_____

16. Does the Applicant use a "fee splitting" procedure when charging providers? ☐ Yes ☐ No

17. Does the Applicant perform collection services on clients' patients accounts that are more than 90 days past due? ☐ Yes ☐ No
    If Yes, indicate the percentage of accounts which are more than 90 days past due: ___% ☐ Yes ☐ No

18. Does the Applicant have HIPAA compliance procedures in place? ☐ Yes ☐ No

It is understood and agreed that this supplemental application shall become part of the Application for the policy

THIS APPLICATION MUST BE SIGNED BY AN OWNER, OFFICER OR PARTNER.

Signature: _____ Date: _____

Name and Title (Please Print): _____