TelMed
General and Professional Liability Application
(ENTITY)

Applicant's Instructions:
1. Select coverage(s) for which you are applying. Answer all questions. If the answer requires detail, please attach separate sheets or use the "Additional Information" section on the final page of the application. If a question is not applicable, please specify "NOT APPLICABLE".
2. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

O **Entity Professional Liability Coverage Inclusive of Telemedicine**
(Covers vicarious liability for the organization and non physician staff)

O **Entity and Individual Professional Liability Coverage Inclusive of Telemedicine**
(Covers vicarious liability for the organization and all staff including physicians)

O **Entity Professional Liability Coverage – Telemedicine Only**
(Covers vicarious liability for the organization and non physician staff)

O **Entity and Individual Professional Liability Coverage – Telemedicine Only**
(Covers vicarious liability for the organization and all staff including physicians)

SECTION I: APPLICANT INFORMATION

Entity Name: _____

Type of Organization: O Partnership O Corporation O Joint Venture O Other: _____

Federal I.D. Number/EIN: _____ Website: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Principle office address (if different than mailing address): _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

1. Are you a member of the American Telemedicine Association or any other association? O Yes O No
   List other associations: _____
2. Length of time in business: _____ Length of time under current mgmt: _____

SECTION II: TELEMEDICINE PRACTICE

1. Please describe the nature of your business/scope of telemedicine or telehealth services provided:

_____

_____

_____

2. Volume of business (expressed in total # of consults/year, or # of images/slides read per year, etc.):

_____ O Actual O Projected (e.g., if start-up)

Gross Annual Revenue: $_____ O Actual O Projected

3. Are prescriptions offered as a result of the telemedicine service? O Yes O No

4. Please describe the equipment entity uses for delivery of telemedicine, if applicable:

_____

_____

_____

5. List hospitals or other medical entities with which your business has privileges or other ongoing relationships, contractual or otherwise. If applicable, please describe the nature of these relationships:

_____

_____

_____

_____

6. a. Are Physicians, Nurse Practitioners, and/or Physician Assistants employed by or work as independent contractors for the entity? O Yes O No

If YES to the above, please complete the following for each individual to be listed as named insureds for professional liability coverage. Attach additional pages if needed.

Name/Professional Designation	# Hrs or Consults Worked Per week for Entity		List All Active Licenses Held (States with corresponding license #s)	Employee	Indep. Contractor
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O
	Hrs	Cons		O	O

b. If a you are seeking "slot" policy (rather than each individual practitioner being listed as a named insured), please provider the following information:

i. Total number of practitioners to be covered under policy: _____

ii. Total (combined) number of professional hours per week worked by all practitioners to be covered: _____

7. Do you employ any of the following health care providers? O Yes O No

If yes, indicate number of each:

_____	Nurse/RN	_____	X-ray Technician
_____	Nurse/LPN	_____	Medical Technician
_____	Nurse Anesthetist	_____	Laboratory Service Technician
_____	Ultrasound Technician	_____	Occupational Therapist
_____	Psychologist	_____	Respiratory Therapist
_____	Other (please specify): _____		

8. Please describe in detail the procedures used to credential physicians or otherwise check the qualifications of new employees or independent contractors.
Note: If credentialing service is used, please specify name and location of service:

_____

_____

9. Please list all entity accreditations, if applicable: _____

_____

10. Do you anticipate any sale of assets, mergers, acquisitions, consolidation or change in operations or services within the next twelve (12) months? O Yes O No

If "Yes," please explain: _____

11. Do you anticipate a change in the scope of business and/or expansion of services within the next twelve months? O Yes O No

If "Yes," please explain: _____

SECTION III: POLICY FORM INFORMATION

1. Requested limits of insurance:

O $500,000 per occurence/$1,000,000 annual aggregate

O $1,000,000 per occurence/$3,000,000 annual aggregate

O Other (occurrence/aggregate): _____

Requested Effective Date of Coverage: _____ Retroactive Date, if applicable: _____

2. Beginning with the most recent or current insurer, please list all current and prior liability insurers for this entity:

Name of Insurer	Coverage Type (Claims Made or Occurrence)	Policy Number	Policy Period

3. Have you ever had liability insurance declined, cancelled, issued with reduced limits or a deductible, issued with a special surcharge, or any other special terms, or has renewal been refused or not offered for this entity? O Yes O No

SECTION IV: CLAIMS HISTORY

1. Has any claim or suit been brought against entity? O Yes O No
If yes, please provide a loss run from each carrier for the past five (5) years

2. Do you have knowledge of any claims, potential claims, or suits in which this entity may become involved? O Yes O No
If yes, please explain: _____

_____

3. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against entity? O Yes O No

If yes, please explain: _____

_____

4. Has any claim or suit been made against entity that has not been reported to a prior insurer?

   O Yes O No

5. Has any physician or other healthcare provider employed by or independently contracted with entity applicant had any claim brought against them within the last five (5) years? O Yes O No

MANDATORY ATTACHMENTS:

(NOTE: You may submit your completed application without the following documents, however please be advised these documents may be needed to finalize the underwriting process.)

1. **Financial Statement or Business Plan (for start up organizations)**
2. **Curriculum Vitae (CV) for each physician**
3. **Copies of medical and DEA licenses for all physicians to be listed as named insureds**
4. **State(s) where services are provided**
5. **Copy of Board Certifications for all physicians**
6. **Current liability policy if the coverage for which you are applying will be replacement coverage**
7. **Five (5) year loss runs for each Entity (Company) and physician to be listed as a named insured**
8. **Copy of contract(s)**
   i. **Proforma, or if individual, copy of contract with each client**
   ii. **System support and product contracts**
9. **Copy of informed consent form used**
10. **Documentation Policy**
    i. **Form(s) of Documentation: electronic, video, paper**
    ii. **Ownership of Records**
11. **Privacy and Confidentiality Policy**
    1. **HIPPA Compliance**

By my signature below:

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.

2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.

3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.

4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

CAMPMED FRAUD STATEMENT
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 and denial of insurance benefits.
Please see the attached specific Fraud Warnings required by some states.

APPLICANT SIGNATURE:_____ DATE: _____

PRINT NAME:_____ TITLE: _____

PLEASE MAIL / FAX / EMAIL COMPLETED APPLICATION TO:

Hanover
12100 Sunset Hills Road, Suite 300, Reston, VA 20190-3295
Fax (703) 880-3801
lycarter@hanover.com

Thank you for choosing Hanover for your insurance needs.

FRAUD WARNINGS

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 a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or any application containing any false, incomplete 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 materially false information or conceals, for the purpose of misleading, information or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana And West Virginia Applicants: Any person who knowing 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 fines and confinement in prison.

Notice to Maryland Applicants: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information or 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 North Carolina Applicants: Any person who knowingly presents false information in an application for insurance is guilty of a felony and may be subject to fines and imprisonment.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he 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.

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.

Notice to Tennessee and Virginia 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 include imprisonment, fines and denial of insurance benefits.