



TelMed
Products/Completed Operations and Professional Liability Application

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.

SECTION 1: APPLICANT INFORMATION

Entity Name: _____

Type of Organization: Partnership Corporation Joint Venture 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?

Yes No

List other associations: _____

2. Length of time in business: _____ Length of time under current mgmt: _____

SECTION 11: PRODUCT INFORMATION

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

Do you employ or contract any medical professionals (i.e. respiratory therapists, nurses, etc.)?

Yes No

2. Do you bill Medicare? Yes No (If yes, please enter your provider #) _____

3. Volume of business: _____

Please indicate projected annual receipts by product for the upcoming policy period; add separate page if necessary.

Product / Equipment

Gross Receipts

1. Product Name: _____
 Description: _____

 Where installed: Hospital Office Home Other
 Worn by patient: Yes No

2. Product Name: _____
 Description: _____

 Where installed: Hospital Office Home Other
 Worn by patient: Yes No

3. Product Name: _____
 Description: _____

 Where installed: Hospital Office Home Other
 Worn by patient: Yes No

Total number of units sold (or projected to sell) _____
 Total annual gross receipts (or projected gross receipts if a start up) _____

SECTION III: POLICY FORM INFORMATION

1. Requested limits of insurance:
 \$500,000 per occurrence/\$1,000,000 annual aggregate
 \$1,000,000 per occurrence/\$3,000,000 annual aggregate
 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?
 Yes
 No

SECTION 1V: RISK UNDERWRITING SECTION

1. Does applicant install, service, or demonstrate products? Yes
 No
If yes, please attach a detailed explanation listing such products and/or services.
2. Do you customize or modify any equipment? Yes
 No
If yes, please give a brief explanation: _____

3. Does applicant obtain a "Hold Harmless" from customers, either by a special "Hold Harmless" Agreement, or by "Hold Harmless" provisions in your rental or purchase agreement? Yes
 No
If yes, please attach a copy.
4. Does applicant directly import foreign products? Yes
 No
a. If yes, does your foreign supplier or manufacturer carry liability insurance? Yes
 No
b. If yes, provide a copy of their certificate of insurance indicating worldwide coverage or a manufacturers' rate will apply.
5. Do you sell or rent products manufactured by others under your own label? Yes
 No
If yes, please explain what products: _____

6. Are manufacturers' labels kept on products? Yes
 No
If no, please explain: _____

7. Do you provide any warranties or guarantees of your own (other than the manufacturers')? Yes
 No
If yes, please attach a copy or description.
8. Have any products been recalled, discontinued, or changed? Yes No
If yes, please explain: _____

9. Are you included as an "Additional Insured" under any manufacturers' liability policies? Yes No
If no, we suggest that you ask your supplier to add your firm as an additional insured under their products liability policy(ies).

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 Hanover Healthcare 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 Hanover Healthcare and my broker, agent or peer review.

Hanover Healthcare 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:

Integrated Insurance Services, Inc.
1316 SE 46th Lane #1
Cape Coral, FL 33904
Fax: (239) 549-7905
Integrated17@earthlink.net

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 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 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.