DOCTORS professional liability

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# COVID-19 SUPPLEMENTAL APPLICATION

## MEDICAL PROFESSIONAL LIABILITY INSURANCE
## CLAIMS MADE AND REPORTED COVERAGE

**Please type or print all answers in ink. Answer all questions that apply or state "not applicable" to those that do not apply. Sign and date by Applicant.**

***PLEASE PROVIDE DETAILS TO ALL QUESTIONS ANSWERED 'No"***

**Applicant's Name & Address** _____

_____

_____

**Applicable to All Applicants:**

1. Does Applicant have a written infection prevention and control policies & procedures that are based on current CDC Guidelines? _____ Yes _____No

2. Does Applicant have a designated individual(s) that maintains ongoing specialized training in infection control training? _____ Yes _____No

3. Please attach a copy of Policies & Procedures in place for Infection Prevention, Hand Hygiene, Transmission-Based Precautions, Disinfection & Deep Cleaning of Premises. If copies are not available, please attach separate page(s) that describe each.

4. How are staff and employees being trained in each of the areas referenced in Question 3 above. Please attach separate page(s) with descriptions.

5. Does applicant require patients to practice "Social Distancing" at all times to help avoid spread of COVID-19? _____ Yes _____No

6. How often is equipment shared among staff or patients (i.e., blood pressure cuffs, stethoscopes, etc.) cleaned? _____

7. Does Applicant have alcohol-based hand sanitizer in readily accessible areas such as entrances to location, entrances to patient/exam rooms, and at staff workstations? _____ Yes _____No

8. Does Applicant have any restrictions as to who is permitted to enter the premises? _____ Yes _____No

9. Please provide details if a patient arrives with possible COVID-19 symptoms. Please attach separate page(s) with response.

10. Is Applicant expanding services to include telemedicine options for patients? If so, please complete the separate **Telemedicine Supplemental Application**.


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11. Has Applicant had any patients who have tested positive or suspect they may have COVDI-19 who have been at your location? _____Yes _____No
    If Yes, on a separate page, please provide steps Applicant has taken since that date.

12. Does Applicant have a Plan in place to optimize your supply of Personal Protective Equipment (PPE)?
    _____Yes _____No

**Applicable to Physician/Allied Provider Applicants:**

1. How are you protecting yourself and your staff from potential infection?

   _____
   _____
   _____

2. Is Applicant planning to add additional staff to handle an increased patient load? If so, please describe:
   _____
   _____
   _____

3. Does Applicant screen patients, visitors, and employees for symptoms of acute respiratory disease (fever, cough, difficulty breathing) before entering the office, including family/friends accompanying the patient, as well as employees? _____Yes _____No

4. If a person arrives with a COVID-19 symptoms, what protocols are then followed:
   _____
   _____
   _____

5. Are your or do you plan to test patients in your office practice for COVID-19?
   _____Yes _____No
   If Yes, please attach separate page(s) to describe protocols, including all required notifications.

**Applicable to Healthcare Facility Applicants:**

1. If Applicant has beds for overnight care, please provide details as to how you will safely triage and manage patients with respiratory illness. Please attach separate page(s) to describe protocols.

2. Are facemasks and proper waste receptacles readily available for staff _____Yes _____No

3. Are all symptomatic patients who need to be seen in a clinical setting asked to call before they leave home so staff are ready to receive them using appropriate infection control practices and PPE?
   _____Yes _____No

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4. Is applicant able to separate patients with respiratory symptoms from other patients in waiting/exam areas as well as overnight care areas? _____Yes _____ No

5. Are all patients, visitors and employees screened for symptoms of acute respiratory illness (fever, cough, difficulty breathing) before entering the Healthcare facility?

**WARRANTY STATEMENT**

**I warrant to the Company that I understand and accept the notice stated above, and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.**

**Must be signed by the Applicant within 60 days of the proposed effective date.**

_____ _____
**Name of Applicant** **Title**

_____ _____
**Signature of Applicant** **Date**

**Signing this form does not bind the Applicant or the Company to complete the Insurance.**

**Notice to 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 the person to criminal and civil penalties.



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