DOCTORS PROFESSIONAL LIABILITY INSURANCE

A Exceptional Financial Stability Rating® Demotech, Inc.

TELEMEDICINE SUPPLEMENTAL APPLICATION

MEDICAL PROFESSIONAL LIABILITY INSURANCE

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.

1. Applicant's name and Address _____

_____

_____

2. Medical Specialty(ies) for Telemedicine Services

3. Technology used for Telemedicine Services

☐ Email ☐ Telephone _____ Other (Please Describe)

☐ Video Conferencing (please identify video software/platform application being utilized):

_____

4. Have you verified your video conferencing application area all HIPPA Compliant? ☐ Yes ☐ No

5. Who will be providing telemedicine services to your patients?

☐ Physicians ☐ Mid-Level Practitioners (nurse Practitioners, Physician Assistants

_____ Other (Please Describe)_____

_____

6. Please list all states from which patients receiving Telemedicine Services are located (where the patient is based (attached additional pages if needed)

	State	Patient Encounters/Week		State	Patient Encounters/Week		State	Patient Encounters/Week
1.			3.			5.		
2.			4.			6.		

7. Will you prescribe medications via email or a website? ☐ Yes ☐ No

8. Please attach a list of all providers and entities on whose behalf you will provide Telemedicine Services.

9. Please describe how follow-up care is rendered:

_____

_____

_____

10. Please describe informed consent procedures specific to Telemedicine patients (attached of copy of informed consent Document)._____

11. Please describe the type of incident Tacking/Event Management reporting system do you have in place:

12. Please describe the type of documentation practices that are in place for Telemedicine patients:

13. Please describe the training completed by the Applicant and any other member of the staff who will be providing Telemedicine Services with respect to HIPAA Compliance, Informed Consent, Types of permittable Equipment, Documentation, Confidentiality, as well as use of the software/platform:

14. What type of coordination is in place for sending a patient for testing?

15. What type of coordination is in place with local Health Departments should it become necessary to contact them?

WARRANTY STATEMENT
I warrant to the company that I understand and accept the notice stated above, and 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 the Applicant **Title**

Signature of the 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 applicant for insurance 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.