SPG SPECIALTY PROGRAM GROUP

TELEMEDICINE SUPPLEMENTAL APPLICATION

PHYSICIANS, SURGEONS AND DENTISTS 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.

1. **Applicant's Name & 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 applications are all HIPAA Compliant? _____ Yes _____ No

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

   _____ Physicians _____ Mid-Level Practitioners (Nurse Practitioners, Physician Assistants

   _____ Other Personnel (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 Tracking/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 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