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| Healthcare/Miscellaneous Facilities Liability Application |
| Virtual Health /Telemedicine Supplement |
| * Illinois Union Insurance Company * Westchester Surplus Lines Insurance Company |

**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use 🗷 for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice*: This supplement is part of the main Healthcare/Miscellaneous Liability Application and is subject to the same warranties, representations and conditions. All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer’s Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – General Information

1. Legal name of the parent entity to be first named insured exactly as it shall be shown on the policy.

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| First Named Insured | Street Address |
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| City, State, Zip Code | County |
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1. Please provide the following information:

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|  | Current 12 Months or Expiring Year | Projections for Requested Coverage Period |
| Total Annual Gross Revenue: |  |  |
| Total revenue from Treatment/Diagnosis Services: |  |  |
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| 1. a. Please provide a written description of the nature of your telemedicine practice:   b. Please describe the equipment, hardware and/or software used for delivery of telemedicine, if applicable: | |  |
| 1. Please state whether you developed or manufactured the technology   product/platform being used. Yes  No   1. Please state whether your services are used for diagnosis, treatment or   prevention of diseases. Yes  No Section B. – Medical Professional service/product profile Please provide the number of patient contacts in the current 12 months/expiring year and projections for requested coverage period:   |  |  |  | | --- | --- | --- | | Number of visits | Current 12 months or Expiring year:  annual period | Projections for Requested Coverage Period:  most recent, full-annual | | Clinic |  |  | | Laboratory |  |  | | Tele-visits (specify) |  |  | | Other (specify) |  |  | | Total visits |  |  |   Does the insured have any beds for overnight stays? Yes  No  If ‘Yes’, please list number of beds and average occupancy:  Has your facility been surveyed by an accreditation agency within the past three years? Yes  No  If ‘Yes’, please list date(s) of last survey:  Are medications prescribed? Yes  No  If ‘Yes’, list the states in which you are prescribing medications:  Are narcotics prescribed? Yes  No  If ‘Yes’, in which states?  Does the insured provide any services outside of the United States? Yes  No  If ‘Yes’, please explain:  Schedule of physicians, surgeons, psychiatrists or dentists on staff or contracted: (supply separate sheet if necessary)   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | Name | Specialty | Board Certified | Hours Worked | Volunteer, Contracted or Employed | Has own malpractice insurance | Medical Director | State physician holds a license in | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |   Would you like physicians to be covered under the facility’s policy? Yes  No  Do any of the above physicians have direct patient care responsibilities? Yes  No  If ‘Yes’, what is the physician’s role in providing services for the applicant’s facility?  Please provide details of all other staff utilized:   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Health professional | Number of Employed | | | Number of Contracted | | | | Full Time | Part Time | Hours | Full Time | Part Time | Hours | | Registered nurses |  |  |  |  |  |  | | Licensed practical nurses |  |  |  |  |  |  | | Nurse practitioners |  |  |  |  |  |  | | Physician assistants |  |  |  |  |  |  | | Certified nursing assistants |  |  |  |  |  |  | | Physical, occupation and speech therapists |  |  |  |  |  |  | | Home health aides |  |  |  |  |  |  | | Sitters/companions |  |  |  |  |  |  | | Surgical technicians |  |  |  |  |  |  | | Perfusionists |  |  |  |  |  |  | | Pharmacists |  |  |  |  |  |  | | X-ray technicians |  |  |  |  |  |  | | Other (please provide description) |  |  |  |  |  |  | | Total |  |  |  |  |  |  |   Check all that apply to your Telemedicine-Based Activities:  Telephone consultations with referring physicians (second opinions)  Remote patient monitoring  Review and render an opinion regarding images, slides, etc. sent from a distant or remote site  Real-time, interactive patient treatment, including consultation or supervision of onsite physician  Real-time, interactive patient treatment, including consultation or supervision of onsite healthcare worker (non-physician)  Render services in or on behalf of an electronic/virtual intensive care unit  Remote surgery and/or procedures on patients who are at a distant or remote site  Other (please specify) Section C. – Risk Management | | |
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| 1. Does the applicant have a written quality control program? | Yes  No |
| 1. Does the applicant have written contracts with all clients the Applicant performs work for? | Yes  No |
| 1. Do all service contracts with customers fully describe the scope of services to be provided? | Yes  No |
| 1. Do all service contracts include provisions for indemnification and mutual hold harmless? | Yes  No |
| 1. Does qualified legal counsel assist in the development of the applicants standard customer contracts? | Yes  No |
| 1. Does the applicant subcontract work to others?   If Yes, what percentage? \_\_\_\_\_ | Yes  No |
| 1. Does the applicant require that subcontractors carry professional liablity insurance with liability limits of at least $1,000,000? | Yes  No |
| 1. Are certificates of insurance obtained from all vendors/clients? | Yes  No |
| 1. Does the applicant obtain written contracts from subcontractors containing indemnification or hold harmless agreements in favor of the applicant? | Yes  No |
| 1. Does the applicant purchase Cyber or Privacy Liability Insurance? | Yes  No |
| 1. Does the applicant closely monitor the current status of licensing requirements in their respective state when authorizing providers to legally practice Telemedicine services? | Yes  No |
| 1. Does the applicant regularly evaluate all policies and procedures to ensure compliance with patient protection laws, inclduing applicable HIPAA, OSHA and state laws and regulations? | Yes  No |
| 1. Does the applicant prohibit the use of personal e-mail accounts for exchange of patient protected health information, and require the use of virtual private network based accounts? | Yes  No |
| 1. Are protocols in place to determine when an in-person visit is necessary? | Yes  No |
| 1. Do you obtain informed consent prior to providing Telemedicine services? | Yes  No |
| 1. Are written protocols in place regarding medical record documentation and necessary follow-up actions after the delivery of Telemedicine services? | Yes  No |

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form** **is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations, conditions AND FRAUD WARNINGS**.

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| Signature of Applicant |  |
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| Title |  |
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Date