PROFESSIONAL LIABILITY INSURANCE FOR
PHYSICIAN AND SURGEONS

TELEMEDICINE SUPPLEMENTAL APPLICATION

You agree that any coverage issued will be contingent upon the truth of the information provided in this application. If a policy is issued, this application will become a part of the policy, as if physically attached thereto.

Please fully complete this application as an incomplete application cannot be evaluated. 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. This application must be completed, dated and signed by an authorized representative of the applicant.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Aspen Specialty Insurance Company (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.

APPLICANT GENERAL INFORMATION

Full Name of Individual Applicant:_____

TELEMEDICINE PRACTICE INFORMATION

What percentage of your practice is devoted specifically to telemedicine services:_____%

Do you have a written agreement or contract to provide telemedicine services? ☐ Yes ☐ No

Please describe the telemedicine exposures of your practice:_____

_____

_____

Are all technologies utilized in your practice verified to be in compliance with HIPAA requirements? If No, please explain: ☐ Yes ☐ No

_____

_____

Do you prescribe medication(s) via e-mail, a website, by phone or other electronic means? ☐ Yes ☐ No

- If Yes, indicate which DEA Scheduled drugs you prescribe:
  ☐ I ☐ II ☐ III ☐ IV ☐ V
- Describe your prescription protocols as respects patient selection & follow-up:_____

_____

_____

List all states where telemedicine patients reside:	% of overall practice exposures	Are you licensed for these state exposures?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Do you obtain an ***Informed Consent*** for each & every patient? ☐ Yes ☐ No

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

Date (Mo./Day/Yr.)

Applicant Signature

Print or Type Name

Title

