Professional Liability Association, LLC

RISK RETENTION GROUP, INC.

CARE Application Checklist

Please answer **ALL** questions; if question is not applicable state n/a.

- ☐ Complete Application
- ☐ Completed claim form for every previous medical malpractice claim
- ☐ Curriculum Vitae
- ☐ Declaration sheet from your current carrier
- ☐ Copy of your license(s)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state NOT APPLICABLE or N/A.
2. If space is insufficient to answer any questions fully, please use the Remarks Section.
3. The Application must be signed and dated by the applicant.
4. It the answer to any question is none, state "NONE".
5. Please do not complete the application earlier than 30 days before proposed effective date of coverage.

Preparers Signature x_____Date _____

This application asks you to provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.

CARE
Professional Liability Association, LLC
RISK RETENTION GROUP, INC.

TELEMEDICINE SUPPLEMENTAL QUESTIONNAIRE

Name (please print) _____ **Policy Number (if current CARE insured)** _____

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Please ensure that you sign and date the questionnaire on page 4.

SECTION ONE: GENERAL

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and patient constitutes telemedicine."

1. What percentage of your medical practice is or will be dedicated to telemedicine services? ____%
2. Do you have a written agreement or contact to provide telemedicine services? ___ Yes ___No
   If yes, please submit copies of your telemedicine agreements and contracts.
3. Please identify the type(s) of telemedicine services that you provide (check all that apply):
   ___ Review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.
   ___ Perform surgery and/or procedures on patients who are at a distant or remote site.
   ___ Render services in or on behalf of an electronic/virtual intensive care unit.
   ___ Other (please provide a detailed description in the Remarks section on page 4).
4. Are your procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA)? _____ Yes _____ No
   If no, please explain:

5. Do any of the following situations or actions occur in a state other than the one in which you maintain your primary practice location, or in a country other than the United States?

   Patients reside or present for diagnosis or treatment ___Yes ___No
   Specimens are taken or images are made? ___Yes ___ No
   Slides, images, etc. are sent from? ___Yes ___ No
   Slides, images, etc. are reviewed or interpreted? ___Yes ___ No

   If you answered yes to any one of the above, please complete the following table:

State or Country	Estimated # Occurring Weekly	State or Country	Estimated # Occurring Weekly

   Do you maintain an active medical license in each state or country? ___Yes ___ No
   If no, please explain and identify the states and/or countries in which you do not maintain an active medical license:

SECTION TWO: INTERPRETATION OF IMAGES, SLIDES, ETC.

NOTE: Please complete this section only if you indicated for question 3 in Section One that you review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.

1. Please complete the following table regarding all facilities from which the images, slides, etc., will be sent:

Name and location (city and state) of facility	Type of facility (for example, hospital of imaging center)	Are you credentialed at the facility?	Type(s) of items reviewed (for example, mammography)
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	

2. If any facility in question 1 is NOT a hospital, are the persons performing the x-rays, etc. at the sending site licensed and/or certified by the state in which they are located? ___Yes ___No
   If no, please explain:

3. If any facility identified in question 1 is NOT a hospital, please provide proof of the facility's professional liability insurance.

4. How do you transit the results of your reviews (for example, via email, the internet, a postal service) and to whom?

5. How do you confirm receipt of your reports?

6. When viewing images generated at distant or remote sites, do you digitize images or do you have access to the original absorption data to enable you to manipulate or reformat the images? ___Yes ___No
   If no, please explain:

7. Do you interpret images, slides, etc. generated at distant or remote sites in emergency situations?____Yes ___No
   If yes, does another physician perform an over read within 24 hours of your reading? ___Yes ___No
   If no, please explain:

SECTION THREE: OFF-HOURS COVERAGE ("NIGHTHAWK" SERVICES)

1. Do you provide nighthawk services on behalf of other physicians or medical groups? ___Yes ___No

   If yes, please complete the following:

   a. Please provide the name of each physician and/or medical group for whom you provide nighthawk services and the state or country of their practice location(s).

   b. Please provide proof of professional liability insurance for each physician and/or group.

   c. Does each physician and/or medical group for whom you are providing nighthawk services over read the studies that you have performed on its behalf within 24 hours of your reading?____Yes ___No

   If no, please explain:

   d. Who provides the official report to the ordering physician?_____

SECTION FOUR: TELESURGERY

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you perform surgery and/or procedures on patients who are located at a distant or remote site.

1. How many telesurgery procedures do you anticipate performing in the next 12 months? _____
2. Please provide the following items:
   a. Proof of your hospital privileges for telesurgery
   b. Proof of your training on the surgical device(s) (e.g. certificates of course completion)
   c. A copy of your consent form
3. Please provide the following on a copy of your letterhead:
   a. The procedures(s) to be performed via telesurgery.
   b. The name of each surgical device to be used and an indication as to whether each device has received FDA approval for the specific procedure(s) to be performed.
   c. A description of the proctoring procedure used during your training, including the credentials of the proctoring physician.
   d. The name and location of each facility at which you will be located when you perform the procedure and a description of each facility's experience in using the relevant surgical device.
   e. The name and location of each facility at which the patients will be located when the procedure is performed and a description of each facility's experience in using the relevant surgical device.

SECTION FIVE: ELECTRONIC/VIRTUAL ICU (eICU)

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you render services in or on behalf of an electronic/virtual intensive care site.

1. Please complete the following regarding each eICU on behalf of which you render services:

Name and location (city and state) of eICU	Names and addresses of ICUs monitored by eICU	Type of professional relationship with eICU
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____

   a. If the eICU monitors more than one ICU, are you personally responsible for monitoring more than one ICU at a time? ____Yes ___No
   If yes, what is the maximum number of ICUs that you will monitor at any one time? _____

   b. Are you credentialed at each facility monitored by the eICU? ____Yes ___No

   If no, please explain:

   c. Does each eICU identified above have an emergency backup power source. ____Yes ___No

   If no, please explain:

2. If each contract that you provided (as requested in Section One) does not specify your responsibilities and duties, please provide a detailed description of those responsibilities and duties on a copy of your letterhead.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b)

Page Number Section Number Question Number Remarks

_____

_____

_____

_____

_____

Please provide any additional information to further describe your telemedicine practice that has not been otherwise addressed in this questionnaire: ***Note, this step is mandatory***

REPRESENTATIONS AND WARRANTIES

Note: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify CARE Risk Retention Group, Inc. immediately if my practice changes in any way and of any changes in the information in this questionnaire.

Signature Date

Print Name

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND SURGEONS

THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY

I. YOUR INFORMATION

1. A. Full Name of Individual Applicant:_____MD___DO___

   B. Date of Birth:_____SS#:_____

   C. Are you a U. S. Citizen?_____If "no" please indicate your status and entry into the U.S. in the Remarks Section. Include a copy of your current or Permanent Visa.

   D. Email Address _____
   We will not sell, license, transmit or disclose your email information outside of CARE.

2. A. Principal Office Address:

   Street:_____

   City/State/Zip: _____

   County:_____ Phone #: _____

   B. Mailing Address: (All correspondence from CARE will be sent to the principal address unless otherwise noted)

   Street:_____

   City/State/Zip: _____

   County:_____ Phone #: _____

   C. Residence Address:

   Street:_____

   City/State/Zip: _____

   County:_____ Phone #: _____

   D. Other Offices: (Please attach the Remarks Section for additional office locations)

   Street:_____

   City/State/Zip: _____

   County:_____ Phone #: _____

   If more space is needed, please complete in remarks section.

   E. Limits of Liability Desired: _____
   (Limits in policy will govern coverage)

   Desired Effective Date: _____
   (12:01 a.m.)

II. PRIOR ACTS COVERAGE

1. Prior Acts Coverage would provide protection for claims made and asserted that 1) are first reported to CARE after the Policy Effective Date with CARE and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. Do not forfeit your right to purchase Extended Reporting Period Coverage ("Tail Coverage") from your current carrier.

   Please check one:

   ____I wish to apply for Prior Acts Coverage. (Please identify the Requested Retroactive Date below, **which must be the same as the Retroactive Date on your current policy**)

   ____I **do not** wish to apply for Prior Acts Coverage. I understand that if I do not obtain Prior Acts Coverage, I will have no coverage with CARE for claims arising from any acts or omissions that occurred prior to the Effective Date of my CARE policy, if issued.

   Requested Retroactive Date: _____/_____/_____

III. CURRENT PRACTICE

1. Provide the formal corporate, association, partnership or business name and Tax ID#:

   _____

2. Would you like vicarious liability coverage for the above entity? _____Yes _____No
3. List all states where you are licensed to practice:

   State_____ License #_____ Permanent or Temporary? _____

   State_____ License #_____ Permanent or Temporary? _____

   State_____ License #_____ Permanent or Temporary? _____

   If licensed in additional states, please use the Remarks Section.

4. Do you practice outside of your primary state?_____Yes_____No
   If yes, list additional states _____
5. Please indicate if you would like coverage for additional states?
   If yes, list each state_____
6. List hospitals at which you are currently a staff member and show % of work at each hospital:

   _____ % _____

   _____ % _____

   _____ % _____

7. Briefly describe type & extent of your hospital privileges: _____

   _____Temporary _____Permanent

8. Are you Chief or Head of a hospital department? _____Yes_____No
   If yes, please explain in detail. _____

9. Are you a medical director at any other facility other than a long-term care facility? ☐ Yes ☐ No
   If yes, please complete the Medical Directorship Supplement.

10. Do you own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____Yes _____ No
    If "yes" provide details, including name, location, size and number of beds in the Remarks Section.

11. Medical Specialty:_____% of Practice: _____

    Sub-Specialty:_____% of Practice: _____

    Average **weekly** patient load (Number of patients seen):

    Current policy year _____ Last policy year _____ Policy year before last _____

    Number of hours practiced **weekly**:

    Current policy year _____ Last policy year _____ Policy year before last _____

12. Do you practice **outside** of your main office location? ☐ Yes ☐ No
    If yes, please provide type of facility, (e.g. nursing home, rehab center, and location):

13. Number of years at current office location: _____

14. Have there been any significant changes in your practice during the past 5 years (i.e. changes in specialty, changes in location, addition or deletion of procedures, etc.)? ☐ Yes ☐ No
    If "Yes", please use the Remarks Section.

IV. LONG TERM CARE FACILITIES

1. Do you provide any services at a Long-Term Care facility? ☐ Yes ☐ No

   If yes, please complete the following:

   Skilled Nursing Facility ☐ Yes ☐ No If yes, what percentage of your practice? _____%

   Assisted Living Center ☐ Yes ☐ No If yes, what percentage of your practice? _____%

2. Are you a medical director at a long-term care facility such as a skilled nursing facility or independent living center? ☐ Yes ☐ No
   If yes, please complete the Medical Directorship Supplement

3. Does the nursing home have professional liability coverage? ☐ Yes ☐ No
   If yes, please provide a copy of the Certificate of Insurance.

I. MEDICAL PROCEDURES AND PATIENTCARE

1. Check the appropriate box, indicating the extent of surgery you perform:

   ☐ No Surgery except incisions of boils, cysts, or other superficial abscesses or suturing of minor lacerations — # Annually _____

   ☐ Minor Surgery – Includes circumcisions other than on newborns and vasectomies — # Annually _____

   ☐ Major Surgery – Includes all procedures done under general, spinal or caudal anesthesia — # Annually _____

   ☐ Assisting in surgery on your own patients — # Annually _____

   ☐ Assisting in surgery on patients other than your own — # Annually _____

   If any of the above applies, please complete the General Surgery & OB supplement to this application.

   ☐ Hospitalist — # Annually _____

   ☐ Perform obstetrical procedures — # Annually _____

2. Do you perform surgery in your office? _____Yes_____No
   If "yes" list surgical procedures in the remarks section.

3. Do you perform any type of pain management in your practice, i.e., the diagnosis, management and/or treatment of chronic pain including the prescribing of pain medications?_____Yes_____No
   If "yes" please explain in the remarks section.

4. If you answer "yes" to question 3 please answer a, b, & c below.
   a. What percentage of your patients are treated for pain management?_____%
   b. What percentage of those patients are prescribed schedule III controlled substances?_____%
   c. Please complete the Pain Management Supplement.

5. Do you practice any type of Addiction Medicine? _____Yes_____No
   If "Yes", please use the Remarks Section.

6. Do you prescribe medical marijuana? _____Yes_____No

7. Indicate number of hours per month devoted to hospital emergency room care, if any:
   a. Is this emergency room care:
      1. On your own patients only? _____
      2. Required for staff privileges? _____
      3. Other (details) _____

   If you are practicing emergency medicine, please complete the Emergency Medicine supplement

8. Do you perform surgery in other non-hospital facilities? _____Yes_____No
   If "yes" list facilities and surgical procedures

   a. In the course of surgery, is general anesthesia administered?_____Yes_____No
      1. By you?
      2. By others?

9. Do you practice weight reduction or control (other than by diet-exercise)?_____Yes_____No
   a. Do you prescribe or administer HCG?_____Yes_____No

   If "yes", please complete Bariatric supplement to this application only if you are a Bariatric Surgeon.

10. Do you participate in any activity, (e.g., newspaper columns, broadcasts, etc.,) whereby professional advice is offered to the public? _____Yes_____No
If "yes" please provide an explanation of this activity in the Remarks Section.

Primary	Assisting	
☐	☐	Acupuncture or Acupressure
☐	☐	Adenoidectomies
☐	☐	Angiography, Angioplasty, Arteriography, Cardiac Catheterization
☐	☐	Banding Hemorrhoids
☐	☐	Bronchoscopy
☐	☐	Circumcision – Other than newborn
☐	☐	Colonoscopy
☐	☐	Cryosurgery
☐	☐	Electro Convulsive Therapy
☐	☐	Endoscopic Procedures
☐	☐	Endoscopic Retrograde Cholangiopancreatography
☐	☐	Esophageal Gastro Dilation
☐	☐	Fertility / Infertility Treatment
☐	☐	Hemorrhoidectomy
☐	☐	Hyperbaric Chamber Treatment
☐	☐	Hypnosis
☐	☐	Insertion of intrauterine or subcutaneous contraceptive devices
☐	☐	Laparoscopy
☐	☐	Lasers – used in therapy or surgery
☐	☐	Lumbar Puncture - # per year _____
☐	☐	Needle Biopsy
☐	☐	MOHS Microscopic Surgery
☐	☐	Office x-rays – Over read: ☐ Yes ☐ No By whom: _____
☐	☐	Open Reductions of Fractures
☐	☐	Prenatal Care
☐	☐	Radial Keratotomy, LASIX, PRK, AKL, or PTK
☐	☐	Radiology Diagnostic

Reads/week_____. Mammograms: ☐Yes ☐No . If "yes", #/month_____.

☐ ☐ Radiation Therapy

☐ ☐ Spinal Anesthesia

☐ ☐ Spinal Surgery

☐ ☐ Thoracic Surgery_____%

☐ ☐ Trigger Point Injections (Neck and Spine: ☐ Yes ☐ No)

☐ ☐ Vasectomies

☐ ☐ Any procedures not customary to your specialty: _____

VI. EMPLOYEES

1. List number and type of professional employees: **If none, check here:** ☐

   _____ Physicians (other than yourself) _____Surgeons Assistants
   _____Nurse Practitioners _____Physicians Assistants
   _____Nurse Midwives _____Nurse Anesthetist
   _____Other (describe duties in detail, including extent supervised, in the Remarks Section)

2. Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____Yes _____No
   _____If "no", use the Remarks Section for explanation.
   _____Do you want coverage for any of the above employees?

   If "yes" please provide names in the Remarks Section.

   PROVIDE A DETAILED ANSWER TO ANY "YES" ANSWERS USING THE REMARKS SECTION.

3. Have you or any of the above employees:

   a. Ever been the subject of investigation or disciplinary proceedings or reprimand by a governmental or administrative agency hospital or professional association?
   b. Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? _____Yes _____ No
   c. Ever been treated for alcoholism, drug addiction or undergone personal psychiatric treatment? _____Yes _____No
   d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? _____Yes _____ No
   e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? _____Yes _____No
   f. Ever failed any medical licensing or specialty organization examination?_____Yes_____No
   g. Have any chronic physical illness or defect?_____Yes_____No
   h. In the last 2 years, have you been treated for any neurological, mental or emotional problems?

      _____Yes_____No

   i. In the last 2 years have you been diagnosed with any new medical condition that could affect your practice of medicine?_____Yes_____No
   j. In the last 2 years, have there been any significant changes in your vision?_____Yes_____No

Reminder: Please use the Remarks Section for any "yes" answers to the above

4. Do you supervise any individuals other than your own employees?_____If "yes" provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also indicate, by profession the number of individuals supervised.

TYPE OF PROFESSION	NUMBER
Physicians	_____
X-ray Technicians	_____
Laboratory Technicians	_____

Do you need coverage for any of these ancillaries?_____Yes_____No

5. Are you in the employ of any individual, firm or corporation other than your own? _____Yes _____No
   If "yes", please outline in the Remarks Section.

6. Are you under contract to any individual, firm or corporation other than your own? _____Yes _____No
   If "yes", please outline in the Remarks Section.
   If this contract contains a hold-harmless agreement, a copy of the contract must be attached to the application.

7. Are you in the employ of any governmental entity? _____Yes _____No
   If "yes", please outline in the Remarks Section.

8. Are you under contract to any government entity? _____Yes _____No
   If "yes", please outline in the Remarks Section.

9. Do you advertise your professional services in any manner (other than a simple listing in the telephone directory)? _____Yes _____No
   If "yes", please explain in the Remarks Section.

10. Are you associated with any agency or organization that engages in any kind of advertising for solicitation of patients? _____Yes _____No
    If "yes", please explain in the Remarks Section.

11. Do you treat any professional athletes or celebrities? _____Yes _____No

VII. EDUCATION

1. From what medical school did you graduate? _____
   Degree:_____ Year: _____
   Location of Medical School (City, State, Country): _____

2. If foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates?_____Yes_____No
   If "yes". state year and describe: _____

3. Residency?_____If "yes" complete the following for each residency served:

   Location:_____From:_____To:_____
   Type:_____Did you complete?_____

   Location:_____From:_____To:_____
   Type:_____Did you complete?_____

   Location:_____From:_____To:_____
   Type:_____Did you complete?_____

VIII. PRACTICE LOCATIONS

1. Do you practice in a surgi-center, abortion clinic, drug control clinic, emergi-center, extended hours walk in clinic or birthing center?

   If "yes.", state location and describe: _____

   _____

   _____

IX. PROFESSIONAL AFFILIATIONS

1. Indicate membership in professional societies:
   a. American Board of Medical Specialties: _____
   b. Special Medical Societies: _____
   c. Specialty Colleges: _____
   d. County Medical and Others: _____

X. CLAIMS AND COVERAGE HISTORY

1. Have you received any communication/request for information from an attorney, a court of law, patient, patient family member or patient representative regarding medical services you performed?

   _____Yes_____No

   If "yes" A Supplemental Claims Information Form MUST be completed for each incident or occurrence.

   a. Have any claims or suits for alleged malpractice ever been brought against you? _____Yes_____No

      Total Number of Claims: _____ Open: _____ Closed: _____

   b. Have you reported all circumstances, medical incidents or records requests that may reasonably give rise to a complaint, claim or a suit to your current carrier? _____Yes _____No _____None to report

   If "no", please explain. If "yes", please complete a Supplemental Claims Information Form for each incident or occurrence explaining the circumstances.

XI. PRIOR COVERAGE SUMMARY

1. List prior professional liability insurance carried for each of the past ten years. If none, list none.

Insurer	Policy Limit	Deductible	Expiration	Claims Made or Occurrence

2. Does your practice require or ask your patients to sign an arbitration agreement? _____Yes _____No

   If "yes", please attach a copy of that agreement.

VII. REMARKS

Beneath "Question Number," please indicate the question number, and, if applicable, the letter (e.g. XI, 2, 3b) Please copy this page if additional space is necessary.

Page Number	Question Number	Remarks

FRAUD WARNING

General Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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. In certain jurisdictions, insurance benefits may also be denied.

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Arizona Applicants: All Statements and descriptions in any application for an insurance policy or in negotiations therefore, by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless: 1. Fraudulent; 2. Material either to the acceptance of the risk, or to the hazard assumed by the insured; 3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

Notice to Colorado Applicants: This Notice is A Part of Your Application for Professional Liability Insurance: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Applicants: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Georgia and North Carolina Applicants: By statute, warranties are deemed representations.

Notice to Hawaii Applicants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Indiana Applicants: Any person who knowingly and with intent to defraud an insurer files an application for coverage or a statement of claim containing any false, incomplete, or misleading information commits a felony.
Notice to Kentucky Applicants: By statute, warranties are deemed representations. Misrepresentations, omissions, and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; or 2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required by the application for the policy.
Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Notice to Michigan Applicants: Any person who knowingly and with intent to defraud any insurance company or another person files an application for coverage 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.
Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
Notice to New York 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of any insurance policy containing any false, incomplete, or misleading information is guilty of a felony.
Notice to Pennsylvania 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 such person to criminal and civil penalties.
Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **Notice to Texas Applicants**: Pursuant to Chapter 705 of the Texas Insurance Code, the company may void the policy only in the event of material misrepresentations in the application, and it must be shown at trial that such misrepresentations were material.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 3 of this application to present date have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY
These warranties are material to the acceptance of coverage by the insurer and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy. Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED: _____

APPLICANT (Signature Required):_____Date: _____

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AND ASSERTED AGAINST THE INSURED while the policy is in force. Furthermore, the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense unless otherwise stated in the policy documents. The applicant, by signing this application above confirms (his/her) understanding of all provisions represented by the Insurer.

ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?

☐ Yes ☐ No

If "yes", please read and approve the following statement:

By my signature, I assign to the following employer or named third party (include name and address) both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to 1-502-895-6406 or sending written notice to CARE Risk Retention Group, Inc., 9300 Shelbyville Road, Suite 204, Louisville KY 40222.

Name: _____

Street:_____

City:_____State:_____Zip: _____

Signature of Insured:_____Date: _____

PLEASE NOTE: YOUR RIGHT TO CANCEL AND RECEIVE A PREMIUM REFUND WILL AUTOMATICALLY BE ASSIGNED THROUGH YOUR AGENT TO A THIRD-PARTY FINANCE COMPANY IF IT PAYS YOUR PREMIUM ON YOUR BEHALF.

CARE
Professional Liability Association, LLC
RISK RETENTION GROUP, INC.

Professional Liability Claims Information

(Must be printed or typed)

Complete one form for each case. Copies may be made as needed

Insurance Carrier:_____**Patient Name:**_____

Date of Occurrence:_____**Date of Suit**: _____

Location of Incident: _____

Relationship to Patient (attending physician, surgeon, consultant, etc.)

_____

Primary Defendant:_____**Co-Defendant**: _____

Patient Outcome: _____

_____

Allegations made about care rendered: _____

_____

_____

_____

_____

Claim Status (Open, Closed, Pending):_____**Date**: _____

If closed, indicate method of closing: **(Circle below)**

DISMISSAL ☐ **SETTLED** ☐ **JUDGMENT** ☐ **CASE-DROPPED** ☐

Amount of settlement/judgment:_____**Date:** _____

Physician (print name):_____**Date:** _____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant:_____Date: _____

CARE
Professional Liability Association, LLC
RISK RETENTION GROUP, INC.

TELEMEDICINE SUPPLEMENTAL QUESTIONNAIRE

Name (please print) _____ **Policy Number (if current CARE insured)** _____

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Please ensure that you sign and date the questionnaire on page 4.

SECTION ONE: GENERAL

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and patient constitutes telemedicine."

1. What percentage of your medical practice is or will be dedicated to telemedicine services? ____%
2. Do you have a written agreement or contact to provide telemedicine services? ___ Yes ___No
   If yes, please submit copies of your telemedicine agreements and contracts.
3. Please identify the type(s) of telemedicine services that you provide (check all that apply):
   ___ Review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.
   ___ Perform surgery and/or procedures on patients who are at a distant or remote site.
   ___ Render services in or on behalf of an electronic/virtual intensive care unit.
   ___ Other (please provide a detailed description in the Remarks section on page 4).
4. Are your procedures for ensuring privacy and security of patient information in compliance with the Health Insurance Portability and Accountability Act (HIPAA)? _____ Yes _____ No
   If no, please explain:

5. Do any of the following situations or actions occur in a state other than the one in which you maintain your primary practice location, or in a country other than the United States?

   Patients reside or present for diagnosis or treatment ___Yes ___No
   Specimens are taken or images are made? ___Yes ___ No
   Slides, images, etc. are sent from? ___Yes ___ No
   Slides, images, etc. are reviewed or interpreted? ___Yes ___ No

   If you answered yes to any one of the above, please complete the following table:

State or Country	Estimated # Occurring Weekly	State or Country	Estimated # Occurring Weekly

   Do you maintain an active medical license in each state or country? ___Yes ___ No
   If no, please explain and identify the states and/or countries in which you do not maintain an active medical license:

SECTION TWO: INTERPRETATION OF IMAGES, SLIDES, ETC.

NOTE: Please complete this section only if you indicated for question 3 in Section One that you review and render an opinion regarding images, slides, etc. that are sent from a distant or remote site.

1. Please complete the following table regarding all facilities from which the images, slides, etc., will be sent:

Name and location (city and state) of facility	Type of facility (for example, hospital of imaging center)	Are you credentialed at the facility?	Type(s) of items reviewed (for example, mammography)
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	
		___Yes ___No	

2. If any facility in question 1 is NOT a hospital, are the persons performing the x-rays, etc. at the sending site licensed and/or certified by the state in which they are located? ___Yes ___No
   If no, please explain:

3. If any facility identified in question 1 is NOT a hospital, please provide proof of the facility's professional liability insurance.

4. How do you transit the results of your reviews (for example, via email, the internet, a postal service) and to whom?

5. How do you confirm receipt of your reports?

6. When viewing images generated at distant or remote sites, do you digitize images or do you have access to the original absorption data to enable you to manipulate or reformat the images? ___Yes ___No
   If no, please explain:

7. Do you interpret images, slides, etc. generated at distant or remote sites in emergency situations?____Yes ___No
   If yes, does another physician perform an over read within 24 hours of your reading? ___Yes ___No
   If no, please explain:

SECTION THREE: OFF-HOURS COVERAGE ("NIGHTHAWK" SERVICES)

1. Do you provide nighthawk services on behalf of other physicians or medical groups? ___Yes ___No

   If yes, please complete the following:

   a. Please provide the name of each physician and/or medical group for whom you provide nighthawk services and the state or country of their practice location(s).

   b. Please provide proof of professional liability insurance for each physician and/or group.

   c. Does each physician and/or medical group for whom you are providing nighthawk services over read the studies that you have performed on its behalf within 24 hours of your reading?____Yes ___No

   If no, please explain:

   d. Who provides the official report to the ordering physician?_____

SECTION FOUR: TELESURGERY

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you perform surgery and/or procedures on patients who are located at a distant or remote site.

1. How many telesurgery procedures do you anticipate performing in the next 12 months? _____
2. Please provide the following items:
   a. Proof of your hospital privileges for telesurgery
   b. Proof of your training on the surgical device(s) (e.g. certificates of course completion)
   c. A copy of your consent form
3. Please provide the following on a copy of your letterhead:
   a. The procedures(s) to be performed via telesurgery.
   b. The name of each surgical device to be used and an indication as to whether each device has received FDA approval for the specific procedure(s) to be performed.
   c. A description of the proctoring procedure used during your training, including the credentials of the proctoring physician.
   d. The name and location of each facility at which you will be located when you perform the procedure and a description of each facility's experience in using the relevant surgical device.
   e. The name and location of each facility at which the patients will be located when the procedure is performed and a description of each facility's experience in using the relevant surgical device.

SECTION FIVE: ELECTRONIC/VIRTUAL ICU (eICU)

NOTE: Please complete this section ONLY if you indicated for question 3 in Section One that you render services in or on behalf of an electronic/virtual intensive care site.

1. Please complete the following regarding each eICU on behalf of which you render services:

Name and location (city and state) of eICU	Names and addresses of ICUs monitored by eICU	Type of professional relationship with eICU
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____
		__ Employee __ Independent Contractor __ Other (please specify): _____

   a. If the eICU monitors more than one ICU, are you personally responsible for monitoring more than one ICU at a time? ____Yes ___No
   If yes, what is the maximum number of ICUs that you will monitor at any one time? _____

   b. Are you credentialed at each facility monitored by the eICU? ____Yes ___No

   If no, please explain:

   c. Does each eICU identified above have an emergency backup power source. ____Yes ___No

   If no, please explain:

2. If each contract that you provided (as requested in Section One) does not specify your responsibilities and duties, please provide a detailed description of those responsibilities and duties on a copy of your letterhead.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b)

Page Number Section Number Question Number Remarks

_____

_____

_____

_____

_____

Please provide any additional information to further describe your telemedicine practice that has not been otherwise addressed in this questionnaire: ***Note, this step is mandatory***

REPRESENTATIONS AND WARRANTIES

Note: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify CARE Risk Retention Group, Inc. immediately if my practice changes in any way and of any changes in the information in this questionnaire.

Signature Date

Print Name