



## TelMed Professional Liability Insurance

**Applicant's Instructions:**

1. Select coverage(s) for which you are applying. Answer all questions. If the answer requires detail, please attach separate sheets or use the "Additional Information" section on the final page of the application. If a question is not applicable, please specify "NOT APPLICABLE".
2. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

**Individual Professional Liability Coverage Inclusive of Telemedicine**  
*(Covers your overall medical practice, including % dedicated to telemedicine)*

**Individual Professional Liability Coverage – Telemedicine Only**  
*(Covers only the % of your practice dedicated to telemedicine)*

**SECTION I: APPLICANT INFORMATION**

- a. Full Name of Applicant (Include professional degree ): \_\_\_\_\_
- b. Name of Business Organization: \_\_\_\_\_
- c. Principal business address: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- d. Additional business address(es): \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- e. Primary Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- f. Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- g. Email: \_\_\_\_\_ Web address: \_\_\_\_\_
- h. Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_
- i. Please list all active medical licenses, and DEA license info:

	License #	Avg Hrs/Wk		License #	Avg Hrs/Wk		License #	Avg Hrs/Wk		License #	Avg Hrs/Wk
	AK		ID		MT		RI				
	AL		IL		NC		SC				
	AR		IN		ND		SD				
	AZ		KS		NE		TN				
	CA		KY		NH		TX				
	CO		LA		NJ		UT				
	CT		MA		NM		VA				
	DC		MD		NV		VT				
	DE		ME		NY		WA				
	FL		MI		OH		WI				
	GA		MN		OK		WV				
	HI		MO		OR		WY				
	IA		MS		PA		DEA				n/a

j. What is your medical or surgical specialty? \_\_\_\_\_

k. Do you have a sub-specialty?  Yes  No  
 If yes, please specify: \_\_\_\_\_

l. Volume of overall medical practice (eg, patients/consults per week or per year): \_\_\_\_\_

m. Volume of practice dedicated to telemedicine: (NOTE: If in start-up phase, please indicate first year projection)  
 \_\_\_\_\_

n. What is the approximate gross annual income from your individual medical practice? (check one)

less than \$50,000                       \$150,000 to \$199,999

\$50,000 to \$99,999                       \$200,000 or more (Please estimate) \$ \_\_\_\_\_

\$100,000 to \$149,999                       Other: \$ \_\_\_\_\_

o. Please indicate % of your gross annual income specified in question N above that is obtained from your telemedical practice: (NOTE: If in start-up phase, please indicate first year projection) \_\_\_\_\_ %

p. Do you anticipate any changes in your practice within the next year?  Yes  No  
 If yes, please explain on a separate sheet.

q. Hospitals/Outpatient Diagnostic Centers where you have privileges:

Hospital/Facility Name & City/State	Type & Extent of Privileges / Procedures Performed	Avg Hrs/Week

r. Please list prior professional liability insurance information for the past 3 years:

Carrier	Policy #	Liability Limits	Premium	Coverage Dates	Claims Made or Occurrence Form	Retro Date
					<input type="radio"/> CM <input type="radio"/> OCC	
					<input type="radio"/> CM <input type="radio"/> OCC	
					<input type="radio"/> CM <input type="radio"/> OCC	

r. Proposed Effective Date: \_\_\_\_\_ Retroactive Date, If Requested: \_\_\_\_\_

s. Coverage limits requested (Per Occurrence/Annual Aggregate):  
 \$100K/\$300K     \$250K/\$750K     \$500K/\$1.5M     \$1M/\$3M     Other: \$ \_\_\_\_\_

**Applicant Education**

Medical Degree:

Degree Obtained:	Institution:
Dates Attended:	Location (City/State):

If a graduate of a foreign medical school, are you certified by the Educational Council for Medical School Graduates?  Yes  No  
 If yes, indicate year of certification: \_\_\_\_\_

**Residency Training:**

Type:	Institution:
Inclusive Dates:	Location (City/State):
Type:	Institution:
Inclusive Dates:	Location (City/State):

1. Have you received any additional medical training (e.g., equipment or procedure-specific)?  Yes  No  
 If yes, please provide details on a separate sheet and include: Type of training; when/where training received; trainer’s name and credentials, as applicable.
2. Are you American Board Certified?  Yes  No  
 If yes, Medical Specialty: \_\_\_\_\_  
 Orig. Certification Date: \_\_\_\_\_ Recertification Date: \_\_\_\_\_

**SECTION II: TELEMEDICINE PRACTICE**

1. Are you a member of the American Telemedicine Association or other association?  Yes  No  
 List the other associations: \_\_\_\_\_
2. Is your telemedicine practice compliant with the HIPAA privacy rules regarding data security and electronic transmission of protected health information?  Yes  No
3. How are telemedicine services established or contracted, e.g., telephone, videoconference, or through a web-based telemedical source such as “ONRAD”? \_\_\_\_\_  
 \_\_\_\_\_
4. Please indicate if your telemedical specialization is different than the medical specialty you previously indicated in Section I of this application: \_\_\_\_\_
5. Please describe the equipment used for delivery of telemedicine, if applicable: \_\_\_\_\_  
 \_\_\_\_\_
6. Does your telemedicine practice include (check all that apply):
  - Offering prescriptions as a result of the telemedicine service
  - 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
  - Realtime, interactive patient treatment, including consultation or supervision of onsite physician
  - Realtime, 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/procedures on patients who are at a distant or remote site
  - Other (please specify): \_\_\_\_\_

Please provide any additional information that describes the nature of your telemedicine practice:

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**SECTION III: CLAIMS** (Attach a detailed explanation for any “yes” answers.)

- 1. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association?  
Attach a copy of the Complaint and Consent Order, if applicable.  Yes  No
- 2. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required that you be evaluated for any alleged mental condition and/or alcohol or drug addiction?  Yes  No
- 3. Have you 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
- 4. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?  Yes  No
- 5. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?.  Yes  No
- 6. Has any claim or suit for alleged malpractice been brought against you?  
If yes, provide a loss run from each carrier for the past ten (10) years.  Yes  No
- 7. Are you aware of any medical incidents, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?  
If yes, have they been reported to your prior insurance carrier?  Yes  No  
 Yes  No

**MANDATORY ATTACHMENTS**

(NOTE: You may submit your completed application without the following documents, however, please be advised these documents will be needed to finalize the underwriting process.)

- a) Curriculum Vitae (C.V.)
- b) Copy of Current Medical License(s)
- c) Copy of Board Certification Certificates
- d) Full Current Professional Liability Policy
- e) 5 Years of Loss Runs from Prior Carriers *\*these can be obtained directly from your prior insurance carrier(s)*

Additional Information From Applicant (*Optional*)

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**By my signature below:**

- 1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.
- 2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.
- 3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.
- 4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

**CAMPMED FRAUD STATEMENT**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

**Please see the attached specific Fraud Warnings required by some states.**

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

**PLEASE MAIL / FAX / EMAIL COMPLETED APPLICATION TO:**

Campania  
111 Berry Street SE, Vienna, VA 22180  
Fax (703) 242-3815  
sdean@thecampaniagroup.com

Thank you for choosing Campania for your insurance needs.

## FRAUD WARNINGS

**Notice to District of Columbia Applicants: WARNING:** 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 insurance company files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Notice to Kentucky Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Louisiana And West Virginia Applicants:** Any person who knowing presents a false or fraudulent claim for payment of 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 Maryland Applicants:** Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

**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 containing any materially false information or conceals, for the purpose of misleading, information or 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 North Carolina Applicants:** Any person who knowingly presents false information in an application for insurance is guilty of a felony and may be subject to fines and imprisonment.

**Notice to Ohio Applicants:** Any person who, with intent to defraud or knowing that he 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 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 and 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.