ProAssurance
Treated Fairly

Excess & Surplus Lines Division

VIRTUAL Medicine Corporate Healthcare Liability Application

Applicant Name

Business Address (Street, City, State, Zip Code) County

Mailing Address (if different than above)

Agent Name

Agent Address

Type of Organization ☐For Profit ☐Not for Profit ☐Joint Venture ☐Other_____

☐Internet Virtual Provider Network
☐Telemedicine Patient (follow up care only)
☐ Concierge Medicine

1. Who will be the organization's designated contact person:
   Name_____ Title:_____

2. Has the organization ever been declined or non-renewed for liability coverage? ☐Yes ☐No
   If yes, please list carrier and reason:

3. Does the organization have any previous claims or suits not previously reported to PRA? ☐Yes ☐No
   If yes, please provide details of each on a separate sheet.

4. Does the organization have a claim(s) or suit(s) currently pending? ☐Yes ☐No
   If yes, please provide details of each on a separate sheet.

5. Is the organization or any employee of the organization aware of an incident which may give rise to a claim or suit in the future? ☐Yes ☐No
   If yes, please provide details on a separate sheet.

***Please provide a copy of the organization's current liability policy and declarations page; any excess professional liability policy and declarations page and a five-year claims loss run.**

II. GENERAL INFORMATION

1. Are there any additional entities to be included in this coverage? ☐Yes ☐No
   If yes, please list:

Entity Name	Description of Operations	% of Ownership	Date Acquired

a If the additional entity is not solely owned by the organization, please provide details of other owners and percentages owned by each.

b. Does the organization and any additional entities comply with all mandated federal, state and local licensing requirements? If no, please list reasons: ☐Yes ☐No

2. Does the organization own, operate or supervise a medical facility (hospital, clinic, pharmacy, etc.)? If yes, please list. ☐Yes ☐No

3. Does the organization sell or lease medical equipment, prosthetic devices or other products? If yes, please describe the extent, including revenue generated. ☐Yes ☐No

4. Does the organization endorse the use of any brand name medical products? If yes, please list product and the manufacturer: ☐Yes ☐No

5. Does the organization adhere to the guidelines established by the ATA "Core Standards for Telemedicine Operations" or ACR "Practice Guidelines for Digital Radiology? ☐Yes ☐No

6. Does the provider obtain written and verbal informed consent prior to delivering health care via telemedicine and maintain that in each medical record? ☐Yes ☐No

7. Does the organization have established written protocols for network security, web cams, and web based portals, patient encounters, and privacy maintenance? ☐Yes ☐No

Please explain any no answers:

***Please include:**
1. **Articles of Incorporation, By-Laws and Tax ID number.**
2. **Description of all operations, including an organizational chart, detailing organization operations and states of operation.**

III. ACTIVITY LEVELS OF ORGANIZATION

1. What were the annual revenues for the previous twelve months?

Gross: Net:

2 What are the estimated annual revenues for the next twelve months?

Gross: Net:

3. Total number of clients or members or patients utilizing services:
   Previous 12 months_____ Next 12 months_____

   Total the number of employed and contracted physicians:
   Previous 12 months_____ Next 12 months_____

4. Are consumer satisfaction surveys conducted? ☐Yes ☐No
   a. If yes, how often?_____
   b. How are complaints handled?

   _____

   _____

5. Utilization Review: (if contracted to a third party, please provide copy of contract)
   a. Number of cases reviewed:
      Previous 12 months_____ Next 12 months_____
   b. Number of cases reviewed over previous 12 months in which payment or treatment was denied?_____
   c. Number of physician reviewers?_____
   d. Number of nurse reviewers?_____
   e. Are physician and nurse reviewers contracted or employed?_____

***Please provide copies of organizations' utilization review procedures, customer compliant procedures and benefit administration procedures.**

IV. SALES AND MARKETING

1. Is any sales or marketing material bearing the name or identity of the organization distributed to:
   Enrollees/beneficiaries? ☐Yes ☐No Providers? ☐Yes ☐No Payors? ☐Yes ☐No
   If yes to any part of this question, please provide copies of such materials.

2. Does the organization have marketing material reviewed by legal counsel ? ☐Yes ☐No

3. Number of sales and marketing personnel:_____

V. Credentialing

1. On the chart, please list, by specialty, the number of health care professionals by specialty either employed by or under contract with the organization.

Specialty	Employed	Contract	Specialty	Employed	Contract	Specialty	Employed	Contract
Administrative Medicine			Gynecology (surgery)			Peripheral Vascular		
Allergy			Hand Surgery			Phys Med/Rehab No Nrv Blk		
Anesthesiology			Internal Medicine			Phys Med/Rehab w/Nrv Blk		
Cardiology Interventional			Medical Genetics			Plastic Surgery		
Cardiology w/Angiography			Neonatology			Psychiatry No ETC		
Cardiology w/Intervent Procs			Neurology			Psychiatry w/ETC		
Colon and Rectal Surgery			Neurosurgery			Pulmonary Medicine		
Dermatology No Surgery			Nuclear Medicine-Radiology			Pulmonary Med w/Spec Proc		
Derm w/Cosmetic Proc			Occupational Medicine			Radiology Diag w/Spec Proc		
Emergency medicine			Oncology			Radiology w/Intervent Proc		
FP/GP Minor Surgery			Ophthalmology Major Surg			Radiology-Therapeutic		
FP/GP No surgery			Ophthalmology w/Spec Proc			Rheumatology		
FP OB Noncomp			Orthopedics			Thoracic Surg. (with pump)		
FP OB High Risk			Otolaryngology Major Surg			Urgent Care		

Gastroenterology			Otolaryngology w/Cosmetics			Urology		
General Preventive Medicine			Pathology			Chiropractic		
General Surgery			Pediatrics No Surgery			Optometry		
General Surg w/Cosmetics			Perinatology			Oral Surgery		
Podiatry								

2. Does the organization specify minimum levels of professional liability to be carried by health care professionals? ☐Yes ☐No

   $_____ per claim/aggregate

3. Does the organization require proof of coverage? ☐Yes ☐No

4. a. How are health care professionals credentialed?

   _____

   _____

   _____

   b. Does the organization access the National Practitioners Data Bank or any authorized state agency during the credentialing process? ☐Yes ☐No

   c. How often are health care professionals re-credentialed?

   d. Does the organization provide credentialing services to others? ☐Yes ☐No
   If yes, what were revenues generated?

   Previous 12 months_____ Next 12 months_____

5. On the chart, please indicate the number of paramedicals (aside from physicians, surgeons, etc.) and whether they are employed or contracted.

	# of Employees	# of Contracted
Certified Nurse Anesthetists		
Physicians' Assistants		
Surgical Assistants		
Nurse Practitioners		
Midwives		
RNs		
LPNs/LVNs		
Occupational Therapists		
Physical Therapists		
Speech Therapists		
Psychotherapists		
Social Workers		
Other Technicians		
Other:		

6. Does the organization specify minimum levels of professional liability to be carried by paramedical providers? $_____ per claim/aggregate

7. Is the organization managed or administered by any third party under contract or agreement? ☐Yes ☐No
If yes, attach a copy of the contract.

***Please provide samples of contracts used for health care professionals and other employed health care providers; organizations' peer review and credentialing procedures; physician staff rules and regulations and physician application.**

The undersigned authorized officer of the Organization declares that to the best of his knowledge, the statements set forth herein are true. Any misrepresentations, omissions or concealment of facts may potentially void coverage.

Signing of this application does not bind the undersigned to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and this form will be attached and become part of the policy.

The Company is hereby authorized to make any investigation and inquiry in connection with this application as they deem necessary.

Signed_____

Title:_____

Organization:_____

Date:_____

IMPORTANT NOTICE ABOUT THE POLICY
OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

I. READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.

2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.

3. The results of the arbitration are final and binding on you and the insurance company.

4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.

5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.

6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

Applicant/Insured	Date	Time
Applicant/Insured	Date	Time

ADDITIONAL COMMENTS

If an answer to a specific question, please identify the question by number.