TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES – TELEMEDICINE SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1. Applicant Name (as identified in the Liability Insurance Application for proposed insurance): _____

2. Indicate your best estimate of percentage of time dedicated to the delivery of Telemedicine services:
Telemedicine _____ Total Hours (all other) :_____

3. Please briefly describe the scope of telemedicine services provided and list any companies you contract with to provide telemedicine services:

4. Please confirm all media through which Telemedicine services are provided:
_____ Audio _____ Video _____Virtual Network _____Other:_____

5. Please indicate the (%) percent of exposure by state:

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

6. Please indicate the number of visits by specialty:

Service	Annual visits	Service	Annual visits/Reads
Primary Care		Family Planning	
Urgent Care		Counseling	
Psychiatry		Teleradiology:	
Dental		Other: _____	

7. Do you provide services in a Correctional environment (i.e. Jails, Prisons)? ☐Yes ☐No
If "Yes," what percent and what services do you provide?

8. Revenue for the last 12 months: _____ / Projected revenue for the next 12 months: _____

TDC Specialty Underwriters, Inc., in California: dba Insurance City Solutions, License #0L85833

9.	Have you undergone an accredited Telemedicine training program? If "Yes," what program? _____	☐Yes ☐No
10.	Are you licensed in all states where Telemedicine servies will be provided? If "No," please explain:	☐Yes ☐No
11.	Do you provide Telemedicine to patients without a previously established patient relationship? If "Yes," please explain:	☐Yes ☐No
12.	Is the delivery of Telemedicine limited exclusively to encrypted communication? If "No," please explain:	☐Yes ☐No
13.	Are all Telemedicine communication platforms updated on a routine basis? If "No," please explain:	☐Yes ☐No
14.	Are protocols in place to determine when an in-person visit is necessary? If "No," please explain:	☐Yes ☐No
15.	Are advanced practice providers utilized during the delivery of Telemedicine services? If "Yes," are all advanced practice providers employed by you and covered under this policy? If "No," please describe the relationship to these providers and include proof of coverage :	☐Yes ☐No ☐Yes ☐No
16.	Do you obtain informed consent prior to the delivery of Telemedicine services? If "No," please explain:	☐Yes ☐No
17.	Are written protocols in place regarding medical record documentation and necessary patient follow-up after the delivery of Telemedicine services? If "No," please explain:	☐Yes ☐No
18.	Do you provide any of the following: a. Intraoperative surgical monitoring? ☐Yes ☐No Weekly Hours _____ b. Remote prescription of controlled narcotics? ☐Yes ☐No Number of Scripts Weekly _____ c. Medical services not currently recognized or accepted by the American Telemedicine Association ☐Yes ☐No Weekly Hours/Visits/Scripts/Other _____	
19.	Do you credential remote providers?	☐Yes ☐No

20 Please provide a list of all providers who deliver Telemedicine services on your behalf:

Name	Specialty	Employed	Contracted

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20. **Continued...**

Name	Specialty	Employed	Contracted

21. Do you obtain certificates of insurance from all contacted providers? ☐Yes ☐No

What are the minimum limits of liability required? _____

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	