GenStar

SUPPLEMENTAL APPLICATION

PROFESSIONAL LIABILITY

TELERADIOLOGY
Claims-Made and Reported Coverage

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

Applicant Name:

II. EDUCATION AND TRAINING

1	Are you currently certified by the American Board of Radiology (ABR)? If yes, which certification(s) do you hold?	☐ Yes ☐ No
2	Are you in compliance with ACR guidelines with respect to the following key teleradiology recommendations:	
	a Do you hold a valid medical license or a state-issued special purpose medical license in all jurisdictions from which images are transmitted to you for radiologic interpretation?	☐ Yes ☐ No
	b Are you credentialed by every institution from which you receive images for radiologic interpretation?	☐ Yes ☐ No
	c Do you make yourself immediately available for consultation in emergent cases?	☐ Yes ☐ No
3	How long have you been practicing teleradiology? years months	
4	Please list all subspecialties and any training certificates you hold for interpreting certain types of scans:	
5	What percentage of your teleradiology practice is dedicated to each subspecialty(ies)?	

III. PROCEDURES/ PRACTICE LOCATION(S)

1	What percentage of your practice is dedicated to the provision of teleradiology services outside of the state of your Primary Practice Location?	%
2	Please indicate, by state, the percentage of teleradiology services you provide outside of your Primary Practice Location:	

State(s)	Percentage of Practice in this State
	%
	%
	%
	%
	%
	%

3	Please identify the type(s) of teleradiology reads you perform: (check all that apply):			
	Type of Read	Read Type(s) by Percentage	# of Reads Last 12 Months	# of Reads Next 12 Months
	☐ Plain radiography			
	☐ Fluoroscopy			
	☐ Angiograph			
	☐ Ultrasound			
	☐ Computed tomography			
	☐ Mammography			
	☐ Nuclear Medicine			
	☐ MRI			
	☐ Other(s)			
		100%		

4	Of the total number of reads noted immediately above, please indicate the percentage of those that are final reads: %

IV. RISK MANAGEMENT PROTOCOLS

1	How do you determine the extent to which the equipment on which you rely for interpreting images is compatible with that of transmitting institutions?
2	Please indicate the Internet back-up procedures you have in place to ensure for timely interpretation:

V. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.
By signing this Application, you represent and agree to the following:

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Applicant:	**Date:**
Print or Type Name and Title:	

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date: