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Sleep Clinic Program Application

Requested Policy Effective Date: __________

I. ACCOUNT INFORMATION

1. Business Name: ____________________
2. Mailing Address: ____________________
3. City: __________ State: __________ Zip: __________ Phone: __________
4. Contact Name, Title, and Phone Number: ____________________ Fax: __________
5. Coastal State: Yes ☐ No ☐ If yes, distance to body of water: __________ 6. Number of locations: __________
7. Do you have a website? Yes ☐ No ☐ *If yes, URL:* ____________________
8. **E-mail address(s):** ____________________

II. COMPANY INFORMATION

1. Corporation: Yes ☐ No ☐ Individual: Yes ☐ No ☐ **FEDERAL TAX ID#:** __________
2. Current Insurance Carrier: __________ Premium: __________ Years with Carrier: __________
3. Prior Insurance Carrier and Policy Date: ____________________
4. Professional Liability: Occurrence ☐ Claims Made/ if Claims Made Please mark prior acts date: ☐ __________
5. General Liability: Occurrence ☐ Claims Made/ if Claims Made Please mark prior acts date: ☐ __________

III. CLAIMS HISTORY

1. Have you had any losses in the past 3 years? Yes ☐ No ☐ *If yes, please describe below:*

Description of Loss	Date of Loss	Amount Paid

IV. GENERAL QUESTIONS

1. Have you or anyone ever been convicted of fraud, arson or other crimes related to a property loss in the last 5 years? Yes ☐ No ☐
2. Have there been any bankruptcies in the past 3 years? Yes ☐ No ☐

   2a. If yes, what type and what is the status? ____________________

V. SLEEP CLINIC OPERATIONS

1. Please provide a brief description of operations including years in business: ____________________
2. If new venture, please provide years of experience in sleep field: ____________________
3. Any business conducted other than Sleep Center? Yes ☐ No ☐

   3a. If yes, please describe: ____________________
4. Within the past 5 years, has applicant acquired, sold or discontinued any operations? Yes ☐ No ☐

   4a. If yes, please describe: ____________________
5. Number of Sleep Studies performed in current year? ____________________
6. Total Annual Gross Receipts for the past 12 months: $ __________
7. Total Annual Projected Gross Receipts for the next 12 months: $ __________
8. Do you rent/ sell any medical equipment? Yes ☐ No ☐

   8a. If yes, of the annual gross receipts, how much of it is from the sale or renting of this equipment? __________

9. Please name any sleep related associations you belong to: ______

10. Is applicant a member of the American Academy of Sleep Medicine (AASM)? Yes ☐ No ☐

10a. If no, please provide an explanation as to why not: ______

10b. Does the applicant meet the standards for the accreditation? Yes ☐ No ☐

10c. If no, please provide an explanation as to why not: ______

11. Is the facility accredited? Yes ☐ No ☐

11a. If yes, by whom and what year? ______

12. Is applicant licensed to do business in the State(s), where required? ______

13. Does the applicant provide any overnight bed facilities? Yes ☐ No ☐

13a. If yes, how many beds are provided? ______

14. Number of sleep tests performed: Current Year: ______ Last Year: ______

15. Who is interpreting or analyzing the results of the sleep test? ______

15a. Who employs this individual? ______

16. Are tests administered by a certified Registered Polysomnographic Technologist (RPSGT)? Yes ☐ No ☐

16a. If not, then who administers? ______

17. Does the RPSGT score the tests? Yes ☐ No ☐

17a. If not, then who is scoring? ______

18. Where is the test performed? (Check all that apply): Patient Home ☐ Sleep Clinic ☐ Hospital ☐

19. How many patients can stay over at one time? ______

20. What is the ratio of staff to patients? ______

21. Are any drugs or medications provided or prescribed in Sleep Clinics Name? ______

21a. If yes, please describe what kind of prescriptions: ______

21b. If yes, who prescribes the medication: ______

Employee/ Independent Contractors:

1. Total number of employees (W-2): ______ Total number of independent contractors: ______

2. Types of employees and employment status:

1. Physician: Full Time/ Part-time Employee: ______ Independent Contractors: ______
2. Registered Polysomonographic Techs: Full Time/ Part-time Employee: ______ Independent Contractors: ______
3. Nurses: Full Time/ Part-time Employee: ______ Independent Contractors: ______
4. Respiratory Therapists: Full Time/ Part-time Employee: ______ Independent Contractors: ______
5. All Others: Full Time/ Part-time Employee: ______ Independent Contractors: ______

Please provide information requested for each licensed individual providing services at the applicant's facility.

(Attach Copy of Medical Malpractice Policy Declarations)

Please list each licensed individual separately (including their specialty) below and fully complete the following:	Insurance Carrier & Effective Date	Policy Limits	State & License #	Specialty / Board Certified	Employee or Contractor	Hours Per Month

3. Are employees required to actively participate in continuing education? Yes ☐ No ☐

4. Does applicant verify any pending license suspensions, revocations or pending disciplinary actions? Yes ☐ No ☐

5. What management body oversees the quality of patient care? (i.e. Medical Director, Advisory Board, etc) ______

6. Do you have a formal written quality assurance and risk management program? Yes ☐ No ☐

6a. If yes, please provide name and title of the person(s): ______

7. Is there a written supervision plan that monitors staff in day to day interaction with clients, both on and off premises? Yes ☐ No ☐

8. What procedures are in place to make sure no inappropriate interaction occurs between staff and clients? ______________________

____

9. Are Professional Employees and/or Independent Contractors required to carry their own Insurance? Yes ☐ No ☐

9a. Do you keep Certificates of Insurance on file? Yes ☐ No ☐

9b. Do you request to be added on as an additional insured on their policy? Yes ☐ No ☐

10. If applicable, please indicate if the following policies and procedures are established and adhered to by all staff, including independent contractors:

1. Therapy or any treatment procedures: Yes ☐ No ☐
2. Medical Testing: Yes ☐ No ☐
3. Any drug research: Yes ☐ No ☐
4. Any type of Sleep Environmental Analysis Yes ☐ No ☐
5. Solely mobile in nature: Yes ☐ No ☐

11. Do you require all vendors, manufacturers, distributors, contractors and independent contractors you do business with to provide proof of insurance? Yes ☐ No ☐

11a. If NO, will you implement the practice of requesting proof of insurance? Yes ☐ No ☐

VI. PROPERTY DESCRIPTION/ LOCATIONS

FULL Location Address	# of stories	Construction	Protection Class	Year Built	Sprinklered	Square feet
1.						
2.						
3.						
4.						
5.						

1. NOTE: If requesting building coverage and building is over 30 years old, please provide information when the roof, plumbing, electrical & heating systems have been updated: ______________________

____

2. **If a coastal state, please indicate locations' roof type and roof update information:** ______________________

3. Do you/ business own the building? Yes ☐ No ☐

3a. If yes, is there any outdoor property, I.E. a fence, that needs to be added to the property schedule?

Please list: ______________________

4. Are the buildings on a historical registry or in a historical district? Yes ☐ No ☐

5. Do you lease any part of the premises to another business or are there any other business activities, other than Sleep, conducted on the premises that are not directly related to the coverage being requested on this application? Yes ☐ No ☐

If so, please explain, and specify which locations: ______________________

____

6. Is there aluminum wiring? Yes ☐ No ☐

6a. If yes, is it pigtailed? Yes ☐ No ☐

7. Is there knob and tube wiring? Yes ☐ No ☐

VII. PROPERTY DESCRIPTION (Please fill out if requesting Property Quote)

Property Coverage:	Location #1	Location #2	Location #3	Location #4	Location #5
Building Value					
Contents Value					
Out Buildings (Garage, Sheds, etc)					

Note: Values should be 100% Replacement Cost.

VIII. FACILITY SAFETY

1. Central station alarm for (check all that apply): Fire ☐ Smoke ☐ Break In ☐ Monitored 24 hours a day?(check all that apply): Fire ☐ Smoke ☐ Break In ☐

2. Please specify locations: ______________________

3. Who is responsible for the maintenance of the building, sidewalks and parking areas? ______________________

IX. GENERAL LIABILITY

General Liability	Limit	General Liability	Limit
General Aggregate:	$3,000,000	Professional Liability:	Included
Each Occurence:	$1,000,000	Employee Benefit Liability:	$________
Damage to premises you rent:	$300,000	Hired & Non-Owned Auto Liability:	$1,000,000
Medical Payments:	$5,000	Stop Gap Liability (for OH, ND, WA & WY):	$________

1. If you are requesting limits other than what is listed above, please specify the limits you are requesting:________________________

X. ADDITIONAL INSUREDS- Please list name and address below and their interest in your operations

Name/Address of Additional Insured	Interest of Additional Insured and Form #
1.	
2.	

XI. WOULD YOU LIKE A QUOTE FOR:

1. Flood Insurance Yes ☐ No ☐ (Please complete separate Flood Application)
2. Wind Insurance Yes ☐ No ☐
3. Directors & Officers Yes ☐ No ☐
4. Employment Practice Liability coverage Yes ☐ No ☐ (Please complete separate EPLI Application)

XII. Would you like a quote for an Excess Policy, to go over the existing policy limits? Yes ☐ No ☐

(Please Note: Most information for the Auto & Workers Comp Policies can be found on the Declarations Pages of those policies)

1. If yes, what limit is desired?: $________________ (Limits start at $1 million and up.)

2. If yes for Excess, please include the following: **(Note: Underwriter cannot quote without this information.)**

Commercial Auto Insurance

1. Name of Auto Insurance Carrier:________________________
2. Effective Date:________________________
3. Policy Number:________________________
4. Auto Liability Insurance Limit: $________________________
5. Premium for Auto Liability Only: $________________________
6. Does the policy provide Hired Auto? Yes ☐ No ☐ and/or Non-Owned Auto? Yes ☐ No ☐
7. Vehicle list: Number of:________ PPT's, ________ Light, ________ Medium, ________ Heavy
8. Vehicle use:________ Service, ________ Commercial, ________ Retail
9. Radius of Operation: Is the majority of driving less than 100 miles? Yes ☐ No ☐
   *9a. If more than 100 miles, how often and under what circumstances?*________________________
10. Are all drivers at least 23 years of age with a minumum of 5 years driving experience? Yes ☐ No ☐
    10a. If a driver is over the age of 75, a completed physician's statement is needed.
11. Have you had any at fault auto liability losses greater than $100,000? Yes ☐ No ☐
    *11a. If yes, please provide date of loss, description of loss:*________________________
    *11b. Is loss open or closed?*________________________
    *11c. What is that amount reserved or paid?*________________________
12. Are there any "public vehicles" defined as contract business, taxi cabs or livery for hire - fee paid for using or transporting passengers? Yes ☐ No ☐

Employers Liability Insurance:

1. Name of WC Insurance Carrier: ______________________
2. Effective Date: ______________________
3. Policy Number: ______________________
4. Employers Liability Insurance Limits: $ ______________________
5. Premium for Workers Comp: $ ______________________
6. Any losses in the past 5 years? Yes ☐ No ☐

   6a. If yes, please list and describe loss including reserve amounts or paid amounts and whether the loss is open or closed:

____

____

FRAUD STATEMENTS

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD Only.

Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an 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 policyholder 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.

Applicable in FL and OK

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)*. *Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

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* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA

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. *Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

______________________ ______________________

Applicant's Signature (if you don't have a digital signature, use pencil tool to sign) Date

Title ______________________