Sleep Laboratories Program Application

Instructions

A. Please type or print clearly. Answer ALL questions completely.
B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
C. If more space is needed, continue on a separate sheet of your company's letterhead, indicating the question number.
D. With this application, please attach copies of :
   1. Marketing or advertising brochures
   2. Descriptive materials provided to clients
   3. Copy of all accreditation reports, or other similar, if applicable.
   4. Other attachments as required in response to application questions.
E. All materials submitted or required will be held in confidence.

General Information

1. Named Insured : ______________________________

2. Main Location Address :

____

____
Street City State County

3. Tax Identification Number : ____________ Years in Business : ____________
4. Phone Number : (___)____________ Fax Number : (___)____________
5. Mailing Address (if different from above)

____
Street City State County

6. Please list all Locations and Areas of Operation:

____
Street City State County

____
Street City State County

____
Street City State County

7. Please provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

8. Current Insurance Carrier: ____________ Premiums: ____________
   Prior Carrier (2 yrs.) ____________ Premiums: ____________

____

9. Within the past 5 years, has applicant acquired, sold or discontinued any operations? ☐ Yes ☐ No

10. Applicant is ☐ Individual ☐ Partnership ☐ Corporation Other ____________

11. Describe operations : ____

____

____

12. Does the applicant provide any overnight bed facilities? ☐ Yes ☐ No
If YES, how many beds? ____________

13. Does the applicant perform any treatment or services on the applicant's premises? ☐ Yes ☐ No
If, YES please describe:____

____

____

COVERAGE REQUESTED

14. Requested Effective Date : ______________________________
(If new venture, please provide owner's resume' and description of related industry experience.)

15. _______ *Professional Liability* ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date __________
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

16. _______ *General Liability* ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date __________
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)
Each Occurrence Limit (cannot be excess PL limit) $ ______________
Medical Expense Limit (Per Person) $ ______________
Damage to Premises Rented To You $ ______________
Products/Completed Operation Aggregate Limit $ ______________
General Aggregate Limit (Other than Products) $ ______________

For the next two coverage parts, please input the exposure information on the following pages.

17. _______ *Employee Benefits Liability / Claims Made* *(General Liability Coverage Must Be Selected)*
Each Person $ ______________
Total Limit $ ______________
Prior Acts Date ______________
(Attach Copy of Prior Claims Made Policy Declarations, if applicable.)

18. _______ *Stop Gap Liability* *(General Liability Coverage Must Be Selected)*
Each Person $ ______________
Each Disease $ ______________
Total Limit $ ______________

CLAIM HISTORY

19. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? ☐ Yes ☐ No

If YES, please attach information for each claim, suit or incident that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered

20. Has any company cancelled, declined or refused to issue similar insurance? ☐ Yes ☐ No
If YES, please explain :

____
____
____

GROSS RECEIPTS AND NUMBER OF TREATMENTS

21. Total Annual Gross Receipts (last 12 months) $ ____________
Total Annual Gross Receipts (next 12 months) $ ____________

22. Gross Receipts by Category :
Sleep Studies ____________ Rental / Sales of Equipment ____________
All Other ____________

23.

Number of Treatments / Procedures

	Last Year	Prior Year
Sleep Studies		
Rental Sales		
All Other		

EMPLOYEES / INDEPENDENT CONTRACTORS

24. Total Employees ____________ # Total Independent Contractors ____________ #

25. **Types / Number of Employees / Contractors**

Physicians Full-Time ________ # Part-Time ________ #
Ultrasound / Sonography Technicians Full-Time ________ # Part-Time ________ #
Polysomnographic Technologists Full-Time ________ # Part-Time ________ #
ALL OTHERS :
____________ Full-Time ________ # Part-Time ________ #
____________ Full-Time ________ # Part-Time ________ #

26. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach Copy of Medical Malpractice Policy Declarations)

	Ins. Carrier & Eff. Date	Policy Limits	State & License #	Specialty / Board Certified	Employee or Contractor	Hours Per Month
Name - Medical Director						
Name – Physician						
Name – Physician						

27. Are employees / contractors' references contacted before hiring or placement? ☐ Yes ☐ No
Check all that apply : ________ Written ________ Verbal

28. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process :

Applications	☐	Multi-State Registry	☐
Drug / HIV / Hep. Testing	☐	Criminal Background Checks	☐
Education / Competency	☐	Licenses / Annual Confirmation	☐

29. Does applicant question prospects about previous claims or suits? ☐ Yes ☐ No
30. Are employee required to actively participate in continuing education? ☐ Yes ☐ No
31. Does applicant verify any pending license suspensions, revocations, or pending disciplinary actions? ☐ Yes ☐ No

ACCREDITATION AND LICENSING

32. Is your facility accredited? ☐ Yes ☐ No
    If so, by whom? ______________________________
    (Please attach verification of accreditation.)
33. Is applicant licensed to do business in the states listed above where required? ☐ Yes ☐ No
34. Has applicant's license ever been suspended, revoked or restricted? ☐ Yes ☐ No
    (If YES, please provide details ______________________________
    ____
    ____
35. Is applicant certified for Medicare reimbursement? ☐ Yes ☐ No

RISK MANAGEMENT

36. What management body oversees the quality of patient care?
    (i.e. medical director, advisory board, etc.) ______________________________
37. Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No
    Person Responsible : ____________________ Title : ____________________
38. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "NO" answers.
    a. Test result interpretation in lab's name : ☐ Yes ☐ No
    b. Consultation in lab's name : ☐ Yes ☐ No
    c. Therapy or any treatment procedures : ☐ Yes ☐ No
    d. Medical , genetic or drug research : ☐ Yes ☐ No
    e. Any type of environmental analysis : ☐ Yes ☐ No
    f. Solely mobile in nature : ☐ Yes ☐ No
    g. Any services to the public (health fairs, shopping mall exhibits, etc.) : ☐ Yes ☐ No

    If YES, Annual Receipts expected In-House : $ ____________________
    Annual Receipts expected Reference Lab : $ ____________________

CONTRACTUAL AGREEMENTS

39. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)? ☐ Yes ☐ No
40. Do contractual agreements contain/hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No
41. Is applicant required to name any other entity as an additional insured? ☐ Yes ☐ No
    If so, please list name and address of each entity and the business relationship.
    ____
    ____
    ____

42. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? If so, please attach explanation (including name of physicians, details of financial relationship and type of referrals). ☐ Yes ☐ No

"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.

General Liability

43. Does applicant sponsor any sporting, fundraising or social events? ☐ Yes ☐ No
If YES, please explain ______________________________

44. Does applicant sell any medical supplies and/or equipment? ☐ Yes ☐ No
If YES, Annual Receipts $ ____________________

45. Does applicant rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No
If YES, Annual Receipts $ ____________________

46. Is the applicant named as an additional insured or vendor on the manufacturer's policy for any/all products? ☐ Yes ☐ No

Employee Benefits Liability

47. Limits Requested :
- ☐ $ 25,000 per incident / $ 50,000 aggregate
- ☐ $ 100,000 per incident / $ 300,000 aggregate
- ☐ $ 500,000 per incident / $ 500,000 aggregate
- ☐ $ 500,000 per incident / $ 1,000,000 aggregate
- ☐ $ 1,000,000 per incident / $ 1,000,000 aggregate
- ☐ $ 1,000,000 per incident / $ 2,000,000 aggregate

48. Average professional turnover ________ % Average non-professional turnover ________ %

49. Employee Benefits Provided :
- ☐ Health
- ☐ Life
- ☐ 401K
- ☐ Section 125

Stop Gap Liability

50. Total Annual Payroll by State :

____
____
____
____

Facility Safety

51. Central Station Alarm System for : Fire, Smoke, Break-in? ☐ Yes ☐ No
Monitored 24 hours a day? ☐ Yes ☐ No
Are all stairs covered with anti-slip treads? : ☐ Yes ☐ No
Are handrails provided on all stairways? : ☐ Yes ☐ No Hallways? : ☐ Yes ☐ No
Are parking lots free of debris and are surfaces smooth? : ☐ Yes ☐ No
Is exterior of building well lit? ☐ Yes ☐ No
Are the edges of curbs, sidewalks and steps color-coded to identify raised surfaces? : ☐ Yes ☐ No
Who is responsible for the maintenance of building, such as snow/ice removal? : ____________________

Please explain any "NO" responses : ______________________________

____

52.

Property Description / Locations :

FULL Location Address	# of Stories	Construction / PC	Year Built	Sprinkler System	Sq. Feet
1)					
2)					
3)					
4)					
5)					

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

____

____

If a coastal state, please indicate roof type of location: ____________________________________

53.

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. Unless otherwise requested or noted, all deductibles are $500.					

GENERAL QUESTIONS

54. Have you ever been convicted of fraud, arson or any other crimes related to a property loss in the last five years? ☐ Yes ☐ No

How close is the nearest fire department? ________ Miles

Are there any fire hydrants with-in 200 feet of the building? ☐ Yes ☐ No

Who has access to cash registers/safes? ____

Who has check writing authority? ____

Are pre-employment criminal background checks done? ☐ Yes ☐ No

Do you run MVR's? ☐ Yes ☐ No

Do you make daily deposits? ☐ Yes ☐ No Do you use an armed guard service? ☐ Yes ☐ No

How many individuals work with accounts payable? ________

Do you require those working with accounts to take at least a weeks' vacation? ☐ Yes ☐ No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance policy.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

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

Underwritten by United National Insurance Company, Diamond State Insurance Company or any members of Diamond State Group.

SIGNATURE OF APPLICANT X ______________________________ DATE X ______________

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer : ____

Telephone Number : (_____)______________________

Producer's Address :

____

Street City State / Zip

Surplus Lines Agent License #

____

(Applicable in AL, CO, FL, LA, MA, MS, NH, NJ, NM, NY, OK, RI, SD, TN, WV and HI)

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 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 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.

Supplemental Application

1. Who is interpreting or analyzing the results? Who employs this individual?

____

____

2. Is there a fee for the service? ☐ Yes ☐ No

3. Are tests administered by a certified Polysomnographic Technologist (PST)? ☐ Yes ☐ No
   Does the PST score the tests? ☐ Yes ☐ No

4. Where is the testing done? *(Please check ALL that apply)*
   ☐ Patients Home ☐ DME Facility
   ☐ Hospital ☐ Sleep Lab

   a. Please enclose a list of facility locations.
   b. How many patients stay overnight at one time? ______________________
   c. What is the ratio of staff to patients? ______________________

5. Are professional employees and/or independent contractors required to carry their own insurance? ☐ Yes ☐ No

   a. Do you keep Certificates of Insurance on file? ☐ Yes ☐ No
      (Please attach copies of certificates, if applicable.)
   b. Do you request to be added on as an additional insured on their policy? ☐ Yes ☐ No

6. Are any drugs or medications provided, used, sold or prescribed? ☐ Yes ☐ No
   a. If YES, please describe : ______________________
   b. If YES, prescribed by whom? ______________________

X______________________________ ______________________
Signed Date