

# Cailor Fleming & Associates

P.O. Box 3989

Youngstown, Ohio 44513

Phone: 800-796-8495

Fax: 330-782-0874

## 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 : \_\_\_\_\_  
\_\_\_\_\_

3. Tax Identification Number : \_\_\_\_\_  
Street City State County  
Years in Business : \_\_\_\_\_

4. Phone Number : (\_\_\_\_) \_\_\_\_\_  
Fax Number : (\_\_\_\_) \_\_\_\_\_

5. Mailing Address (if different from above) \_\_\_\_\_  
\_\_\_\_\_

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.

<u>Name</u>	<u>Description</u>	<u>% Owned</u>	<u>Date Acquired</u>	<u>Prior Acts Date</u>

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**

	<u>Last Year</u>	<u>Prior Year</u>
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)

	<u>Ins. Carrier &amp; Eff. Date</u>	<u>Policy Limits</u>	<u>State &amp; License #</u>	<u>Specialty / Board Certified</u>	<u>Employee or Contractor</u>	<u>Hours Per Month</u>
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              | <input type="checkbox"/> | Multi-State Registry           | <input type="checkbox"/> |
| Drug / HIV / Hep. Testing | <input type="checkbox"/> | Criminal Background Checks     | <input type="checkbox"/> |
| Education / Competency    | <input type="checkbox"/> | Licenses / Annual Confirmation | <input type="checkbox"/> |
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 :                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Consultation in lab's name :  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Therapy or any treatment procedures :                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Medical , genetic or drug research :                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Any type of environmental analysis :                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Solely mobile in nature :   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Any services to the public (health fairs, shopping mall exhibits, etc.) : | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 :**

<u>FULL Location Address</u>	<u># of Stories</u>	<u>Construction / PC</u>	<u>Year Built</u>	<u>Sprinkler System</u>	<u>Sq. Feet</u>
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 :**

	<u>Location #1</u>	<u>Location #2</u>	<u>Location #3</u>	<u>Location #4</u>	<u>Location #5</u>
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.

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## SUPPLEMENTAL APPLICATION

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

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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