Cailor Fleming & Associates
PO Box 3989
Youngstown, Ohio 44513
Phone: 800-796-8495
Fax: 330-782-0874
www.cailorfleming.com

LICENSED SLEEP PROFESSIONALS (Excluding Physicians)

Full Name of Applicant _____ Phone Number: _____

Polysomnographic License Number: _____ (Please include Copy of License)

Business Name if Self Employed / Employer Name if Employed _____
_____

Address _____

City _____ State _____ Zip _____

E-Mail Address (**Policy will be e-mailed to you**) _____

Requested Effective Date _____

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1) Has your licensed ever been suspended, revoked, cancelled, non-renewed, put on probation or voluntarily surrendered?
☐ yes ☐ no
2) Have you ever had a claim made, suit brought against you, or are you aware of any professional incident that might reasonably lead to a claim or suit? ☐ yes ☐ no
3) Has your professional liability insurance been suspended, revoked, cancelled or non-renewed? ☐ yes ☐ no

If the answer to any of the above questions is yes, please explain.
_____
_____

EMPLOYED ONLY – INDEPENDENT CONTRACTOR (Includes full time/part time employee working for others. Does not include a person that owns their own business.)
Name of Employer:
_____

Professional Liability Limit Available is:

$1,000,000 per Occurrence/ $3,000,000 Aggregate
(Terrorism Coverage is Included at No Charge)
Premium Charge: $100 per technician _____

- Abuse and Molestation sub-limit Add On:
  $ 25,000 sub- limit: Included Included
  $100,000 sub- limit: $100 _____
  $300,000 sub-limit: $200 _____

- Additional Insured: CG2026 (Designated Person or Organization) –
  $20 per AI at 1,000,000/3,000,000 _____
  (Please list the name and address of each additional insured)
  _____
  _____

Totals from Above Page:

Premium:	_____
Filing Fee:	$25.00
Surplus Lines Tax:	_____
Total Premium:	_____

We/I have not carried business insurance coverage during the past three years.
There have been no claims (insured or otherwise) during the past three years. We/I are not aware of any circumstances during the past three years which may give rise to a claim.

NOTICE TO 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 ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

IMPORTANT NOTICE: SIGNING THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. Coverage becomes effective only when accepted by the Insurance Company.

_____

APPLICANT SIGNATURE DATE