



## Sleep Center / Diagnostic Lab / Blood Bank

### MISCELLANEOUS HEALTH CARE PROFESSIONAL AND GENERAL LIABILITY APPLICATION (CLAIMS MADE AND REPORTED BASIS)

Please email application to [rwilliams@virginiaroseinsurance.com](mailto:rwilliams@virginiaroseinsurance.com)

Effective date desired: \_\_\_\_\_

1. Complete name of facility : \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Contact name: \_\_\_\_\_ Title: \_\_\_\_\_ Email address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Web site Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
List all other locations (use an additional sheet of paper if necessary): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Applicant is: a.  Individual  Partnership  Corporation  Professional Association  Other: \_\_\_\_\_  
b.  Not-for-profit  For-profit  Both

3. Date established: \_\_\_\_ / \_\_\_\_

4. List all states where you are licensed to practice: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Current accreditations or associations:  NAHC  TAHC  JCAHO  CHAP  NHPCO  Other: \_\_\_\_\_

6. Is the firm engaged in, owned by or associated with or controlled by any other business?  Yes  No  
If yes, give details (use an additional sheet of paper if necessary): \_\_\_\_\_  
\_\_\_\_\_

7. Are any services provided outside of the United States?  Yes  No  
If yes, please explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services: \_\_\_\_\_

8. Do you provide any internet services?  Yes  No  
If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.  
\_\_\_\_\_

9. Does the applicant anticipate any facility expansions within the next year?  Yes  No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

10. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered?  Yes  No

If yes, give details: \_\_\_\_\_  
\_\_\_\_\_

11. Hold Harmless (Indemnification) Agreements: -

(a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: \_\_\_\_\_  
\_\_\_\_\_

(b) In favor of others: - has the applicant agreed to indemnify (hold harmless) others under written contract?  Yes  No  
If yes, please submit a copy of the agreement.

12. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule?  Yes  No

If yes,

(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule?  Yes  No

(ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_

13. Professional Activities and Specialty (check one)

- |   |  |
|---|--|
| <input type="checkbox"/> Adult Day Care **                                  | <input type="checkbox"/> Therapist: **                     |
| <input type="checkbox"/> Ambulatory Surgery Center **                       | Inhalation____, Occupational ____                          |
| <input type="checkbox"/> Chiropractor                                       | Physical _____, Speech _____                               |
| <input type="checkbox"/> Clinic **  | <input type="checkbox"/> Training School **                |
| <input type="checkbox"/> Counselor (Describe)                               | <input type="checkbox"/> Veterinarian                      |
| <input type="checkbox"/> Dental Hygienist                                   | <input type="checkbox"/> X-ray: Lab_____, Technician _____ |
| <input type="checkbox"/> Group Home **                                      | <input type="checkbox"/> Other (specify): _____            |
| <input type="checkbox"/> Hearing Aid Fitter                                 |  |
| <input type="checkbox"/> Home Health Care Agency **                         |  |
| <input type="checkbox"/> Hospice  |  |
| <input type="checkbox"/> Laboratory Technician                              |  |
| <input type="checkbox"/> Medical Staffing Agency **                         |  |
| <input type="checkbox"/> Mental Health Center **                            |  |
| <input type="checkbox"/> MRI Centers**                                      |  |
| <input type="checkbox"/> Pharmacist**                                       |  |
| <input type="checkbox"/> Nurse: Anesthetist _____, LPN** _____,<br>RN _____ |  |
| <input type="checkbox"/> Optician_____, Optometrist_____                    |  |
| <input type="checkbox"/> Paramedics_____, EMT** _____                       |  |
| <input type="checkbox"/> Perfusionist                                       |  |
| <input type="checkbox"/> Personal Care Home **                              |  |
| <input type="checkbox"/> Psychologist                                       |  |

14. Is there a swimming pool on premises you own or occupy?  Yes  No

15. State the number of patient encounters and/or patient tests carried out as follows (patient encounters refer to number of visits—not number of patients):

| Type of Encounters  | Number for Last 12 Months | Estimated Number for Next 12 Months |
|---|---------------------------|-------------------------------------|
| Patient Encounters  |                           |                                     |
| Patient Tests   |                           |                                     |
| Percentage of services provided involving minors (persons under age 18) _____ % |                           |                                     |

16. State sources and amounts of actual and projected gross revenue:

| Source                      | Amount this Fiscal Year | Amount Next Fiscal Year |
|-----------------------------|-------------------------|-------------------------|
| a. Charitable Contributions |                         |                         |
| b. Government Funding       |                         |                         |
| c. Fee for Service          |                         |                         |

17. Describe the type of procedures performed at or by this facility including imaging if applicable: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. Are all personnel performing these procedures certified?  Yes  No

19. Percentage of professional services performed: \_\_\_\_\_ % on premises \_\_\_\_\_ % off premises

20. List the number and type of applicant’s employees and volunteers (if none, state “none”):

| Number | Type of Profession       | Number | Type of Profession             |
|--------|--------------------------|--------|--------------------------------|
| (a)    | Acupuncturist            | (k)    | Pharmacist                     |
| (b)    | Inhalation Therapist     | (l)    | Physical Therapist             |
| (c)    | Laboratory Technician    | (m)    | Certified Physicians Assistant |
| (d)    | Licensed Midwife         | (n)    | Psychologist                   |
| (e)    | Nurse Anesthetist        | (o)    | Registered Nurse First Assist  |
| (f)    | Nurse, License Practical | (p)    | Social Worker                  |
| (g)    | Nurse Practitioner       | (q)    | Speech Therapist               |
| (h)    | Nurse, Registered        | (r)    | Home Health Care Aide          |
| (i)    | Optician                 | (s)    | Other (specify):               |
| (j)    | Optometrist              | (t)    | Other (specify):               |

- a. Are all the above individuals licensed in accordance with applicable state and federal regulations?  Yes  No  
 If no, attach an explanation.
- b. Does the applicant have any independent contractors?  Yes  No  
 If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant: \_\_\_\_\_
- c. Is continuing education or staff development required for your employees?  Yes  No

- d. Name of medical director, if any: \_\_\_\_\_  
 (i) Is coverage provided for the medical director under any other insurance policy?  Yes  No  
 (ii) If yes, please provide type of policy and name of carrier: \_\_\_\_\_

**HIRING PRACTICES**

21. a. Do you conduct a criminal background check?  Yes  No  
 b. Do you require signed applications on all prospective employees?  Yes  No  
 c. Do you verify all professional qualifications, licenses and certifications?  Yes  No  
 d. Do you require professional and personal references on each employee?  Yes  No  
 e. Do you provide training and orientation for new employees?  Yes  No  
 f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities?  Yes  No  
 g. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past?  Yes  No  
 h. Do you have written job descriptions?  Yes  No  
 i. Do you require drug/alcohol screening?  Yes  No

**RISK MANAGEMENT/LOSS CONTROL**

22. a. Is there a written, formalized Quality Assurance Program?  Yes  No  
 b. Is there a written, formalized Risk Management Program?  Yes  No  
 c. Do you have a standard system to handle a patient’s complaints or suggestions?  Yes  No  
 f. In case of an emergency, is management available 7 days a week, 24 hours a day?  Yes  No

**INSURANCE AND CLAIM INFORMATION**

23. Do you currently carry the following:  Yes  No  
 a. Professional Liability Insurance?  Yes  No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

| Policy Period  |              | Insurance Company | Limit of Liability | Deductible | Policy Form: Claims Made or Occurrence? | Premium |
|----------------|--------------|-------------------|--------------------|------------|---|---------|
| From: MM/DD/YY | To: MM/DD/YY |                   |                    |            |   |         |
| / /            | / /          |                   |                    |            |   |         |
| / /            | / /          |                   |                    |            |   |         |
| / /            | / /          |                   |                    |            |   |         |
| / /            | / /          |                   |                    |            |   |         |
| / /            | / /          |                   |                    |            |   |         |

If claims made, what is the **retroactive date/prior acts date** on your current policy? \_\_\_\_\_

- b. Commercial General Liability Insurance?  Yes  No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

| Policy Period | Carrier | Limit of Liability BI/PD | Deductible | Policy Form: Claims Made or Occurrence? | Premium |
|---------------|---------|--------------------------|------------|---|---------|
|               |         |                          |            |   |         |

If claims made, what is the **retroactive date/prior acts date** on your current policy? \_\_\_\_\_

**24. CLAIMS HISTORY:**

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance?  Yes  No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS  
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you?  Yes  No  
If yes, provide full details. \_\_\_\_\_
- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?  Yes  No  
If yes, fully describe the circumstances and follow up action taken: \_\_\_\_\_

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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.

\*Notice applicable in most states:

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

\_\_\_\_\_  
**Applicant's Signature** / **Title** \_\_\_\_\_ **Date**

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:**

1. COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS
2. COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY
3. IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN
4. COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS
5. COPY OF A SAMPLE CLIENT CONTRACT
6. RESUMES/CV'S FOR ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS

Limits of Liability desired for Professional Liability:

- \$100,000/\$100,000       \$250,000/\$250,000       \$500,000/\$500,000
- \$1,000,000/\$1,000,000       \$1,000,000/\$2,000,000       \$1,000,000/3,000,000
- Other: \$ \_\_\_\_\_ / \$ \_\_\_\_\_

Deductible desired:

- \$2,500       \$5,000       \$10,000       \$25,000       \$50,000       Other: \_\_\_\_\_

MINIMUM AND MAXIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

**YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS**