The Hanover Insurance Group™

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Allied Healthcare Advantage

Commercial Lines

SLEEP STUDIES/THERAPY SUPPLEMENTAL

Hanover Agency Code:_____

A. APPLICANT INFORMATION

1. Desired effective date for coverage:_____ Do you currently have coverage? ☐ Yes ☐ No
2. Are you accredited by the American Academy of Sleep Medicine? ☐ Yes ☐ No ☐ Other _____
3. Company Name (Named Insured and other Named Insureds): _____
4. Mailing Address: _____
5. Contact Person:_____ Title: _____
6. Year Business Established: _____ Phone: _____ Fax: _____
7. Website Address: _____ Email Address: _____
8. Please briefly describe business operations:
9. Please identify the type of services that are provided at the center:
   ☐ Diagnostic testing AND treatment of sleep disorders ☐ Diagnostic testing ONLY of sleep disorders
   ☐ Other: _____
10. Do you engage in any business, or have a majority interest in any business other than sleep studies or do you sell or rent durable/home medical equipment to patients/customers? ☐ Yes ☐ No
    If Yes, please explain and indicate total annual gross receipts from these operations: _____
11. Coverage(s)/Limits Desired: ☐ General Liability ☐ Product Liability ☐ Professional Liability*
    *This coverage can be provided for applicants who employ any licensed medical professionals (i.e. respiratory therapists, nurses, etc.), Coverage does not include any physicians, doctors, surgeons, dentists, etc. ***NOTICE**: A copy of the license for each and every professional employee **MUST** be attached to this application in order for coverage to apply.
    ☐ $500,000 occurrence/$1 million aggregate ☐ $1 million occurrence/$1 million aggregate
    ☐ $1 million occurrence/$2 million aggregate ☐ $1 million occurrence/$3 million aggregate
    ☐ Other: $ _____

B. COVERAGE HISTORY

1. Has applicant had any policy or coverage declined, canceled, or non-renewed in the last three years? ☐ Yes ☐ No
   If Yes, briefly explain: _____
2. Prior Carrier:_____ Policy Number: _____
3. Policy Period:_____ Annual Premium: $_____
4. Policy Type: ☐ Claims Made ☐ Occurrence ☐ Limits of Coverage: $ _____

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C. CLAIMS HISTORY

1. Has any claim or suit for allegations against your company ever been brought against you in the past ten (10) years ☐ Yes ☐ No

   If Yes, please attach explanation and a copy of your loss runs.

D. RISK MANAGEMENT/EMPLOYMENT PROCEDURES

1. Where are Sleep Studies conducted? (i.e., clinic outpatient center, private home, etc.)

   _____

2. Who supervises Sleep Studies? (i.e. physician, sleep tech, etc.)

   _____

3. How many people are present during a Sleep Study (ratio)? _____ Technicians _____ Patient
4. Do patients share sleeping quarters? ☐ Yes ☐ No
5. How many sleep rooms does the center have?_____
6. Does a physician qualified in sleep medicine read and interpret the polysomnograms? ☐ Yes ☐ No
7. Are test results sent out for interpretation to a qualified physician? ☐ Yes ☐ No
8. Are test results read at the clinic by a qualified physician? ☐ Yes ☐ No
9. Do all technicians work under the direction of a licensed physician? ☐ Yes ☐ No
10. Are all patients referred by a physician? ☐ Yes ☐ No
11. Is at least one technician certified by the Board of Registered Polysomnographic Technologists? ☐ Yes ☐ No
12. Do you conduct online interpretations of scored sleep studies? ☐ Yes ☐ No

    If Yes, what is the percentage of business? _____%
13. Is there an employed physician on staff? ☐ Yes ☐ No

    If Yes, what are their duties?_____

    If Yes, do they carry their own malpractice policy? ☐ Yes ☐ No
14. Are you licensed in all states that you conduct operations in? ☐ Yes ☐ No

    If No, please explain (attach additional sheet(s) if necessary): _____

    _____
15. Has your state license or certification ever been revoked, suspended, canceled, voluntarily surrendered, or is any such action pending? ☐ Yes ☐ No

    If Yes, please explain (attach additional sheet(s) if necessary): _____

    _____
16. Are all professional employees and/or contractors of your company currently licensed in the state(s) of your operations? ☐ Yes ☐ No

    If No, please explain (attach additional sheet(s) if necessary): _____

    _____
17. Are background checks performed on all medical personnel and technicians? ☐ Yes ☐ No

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E. PROFESSIONAL LIABILITY

1. Please complete the following based on projections for the upcoming policy term. Indicate the number employed at a full-time and part-time basis

	Full Time	Part Time
Polysomnography Technologist		
Registered Nurses		
Sleep Technicians		
Respiratory Therapists		
Medical Directors		
Physicians		
Other		

Do you want Professional Liability to include Medical Director (for administrative duties only) ☐ Yes ☐ No

Name of Medical Director: _____

Do you utilize the services of any independent contractors? ☐ Yes ☐ No

Please list the types of professionals contracted: _____

Total estimated annual gross revenues (REQUIRED): $ _____

2. Services provided (please check all applicable services and indicate percentage of annual gross revenue)

☐ Sleep Studies _____ % ☐ Other_____ _____%

☐ Durable Medical Equipment _____ % ☐ Other_____ _____%

☐ Respiratory Therapy _____ % ☐ Other_____ _____%

By my signature below:

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.
2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.
3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.
4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

HANOVER FRAUD STATEMENT

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.

Please see the attached specific Fraud Warnings required by some states.

APPLICANT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

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FRAUD WARNINGS

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

Notice to Louisiana and West Virginia Applicants: Any person who knowing presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maryland Applicants: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

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

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 containing any materially false information or conceals, for the purpose of misleading, information or 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.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Pennsylvania 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 subjects such person to criminal and civil penalties.

Notice to Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.