Sabal INSURANCE GROUP

HEALTHCARE LIABILITY/CRIME/WORKERS' COMPENSATION APPLICATION

Completed applications should be faxed to 1-800-915-3922

Name of Organization: _____ Requested effective date:____/____/____

Mailing Address:_____

(street) (county) (city) (state) (zip code)

Phone:_____ Fax:_____ FEIN No:_____

Email address:_____ Web site address: _____

Administrator or CEO/Insurance Contact Person:_____

Years in Business:_____ Annual Revenue:_____

Additional Locations:_____

(Attached extra sheet, if necessary)

Additional Entities/Named Insureds:_____

(Attached extra sheet, if necessary)

- Home health care; # of annual patient visits _____ ; Annual # of patients treated_____
- 24-hour "live-in" nurses or aides; # of assigned personnel _____; Annual # of patients_____
- Aides (nonskilled companion care domestic services): Annual # of clients _____; # of aides providing services_____
- % of pediatric care provided (compared to your overall operations) _____ % Annual # of pediatric patients:_____
- % of patients receiving infusion therapy (compared to your overall operations) _____%.
- Are you Medicare Certified? ☐ Yes ☐ No
- Are you licensed by the state, local or county agencies? ☐ Yes ☐ No **(If "yes", please attached a copy of the license along with your latest inspection report, and a copy of the documents remedial actions taken to correct any deficiencies cited in the report.)**
- 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
- Where are employees/independent contractors placed (by percentage)?

  Private Homes _____% Hospitals _____% Nursing Homes _____% Assisted Living _____%

  Medical Clinics _____% Doctor's Offices _____% Other (describe) _____%

Employees / Contracted Services	# of Emp	# Ind Contractors	Est. Hours Employees	Est. Hours Contractors	Est. Ann Payroll Employees	Est. Ann Payroll Ind. Contractors
Physical & Respiratory Therapist						
Nurses – Temporary Staffing						
Nurses – Other than Temporary						
Aides/Homemakers						
Medical Technicians						
Pharmacists						
Occ/Speech/Hearing Therapists						
Social Workers						
Physician						
PA/NP Clinic Nurse Specialist						
Live-in Companions						
All Others (Describe)						

Workers' Compensation Information:

Employee Classification	Number of Employees	Estimated Annual Payroll
Clerical		
Outside Sales/Marketing		
Supervisory/Intake Only RN		
Home Health/Field RN		
Nursing - ALF		
Domestic Aides		
Hospital Staffing		
Physicians Offices		

Names of Partners/Officers to be Included or Excluded from Workers' Compensation Coverage:

Name	Date of Birth	Title	Ownership %	Inc/Exc

Do You?

- Have employees who regularly travel out of the state (as part of their job)? ☐ Yes ☐ No
- Sponsor any athletic teams? ☐ Yes ☐ No
- Have any labor interchange with any other subsidiary or affiliated company? ☐ Yes ☐ No
- Have any leased employees or volunteers? ☐ Yes ☐ No
- Have any 1099 or independent contractor labor relationships (PT's / OT's / MSW's)? ☐ Yes ☐ No

Crime Bond Information:

Have you sustained any employee dishonesty losses in the last 6 years? ☐ Yes ☐ No

If "Yes", please give date(s), amount(s), employee's name(s), and action(s) taken on a separate sheet.

I am interested in the following limits of coverage:

☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

_____ _____

Name / Signature Date

Please attach:

- Estimated Annual Revenues
- A list of Employees
- Three Years Loss History, if applicable
- Resume/CV on primary clinical staffer, if available or on Company Principal(s)/Administrator; (Resume is only required for start up or new operations.)
- Declarations Page of Existing Policy showing retro date (if applicable)