Sabal INSURANCE GROUP

HEALTHCARE LIABILITY APPLICATION
Completed applications should be faxed to 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: _____ How did you hear about us? _____

Additional Locations: _____
(Attach extra sheet, if necessary)

Additional Entities/Named Insureds: _____
(Attach 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 attach a copy of the license along with your latest inspection report, and a copy of the documented 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)						

_____ _____

Submitter's Name / Signature Date

Please attach: ***1- Resume/CV on primary clinical staffer, if available or on Company Principal(s)/Administrator; (Resume is only required for start up or new operations.)***
2- Declarations Page of Existing Policy showing retro date (if applicable)