SPG SPECIALTY PROGRAM GROUP

REHABILITATION THERAPY APPLICATION

SECTION 1: APPLICANT INFORMATION

Firm's Full Legal Name, Include Any DBA: _____

Primary Practice Address: _____ City/State/Zip: _____

Address for Additional Locations: ☐ No Other Locations _____

Primary Telephone Number: _____ Email Address: _____

Web Address: _____

Date Established:_____ Risk Manager Contact: _____

SECTION 2: INSURANCE HISTORY

Professional liability insurance history: ☐ Check here if you are buying coverage for the first time.

Policy Year	Professional Liability Carrier	Limits of Insurance	Deductible	Retro Date*	Premium
Expiring Policy					
One Year Prior					
Two Years Prior					

*If retroactive coverage is requested, we will need a copy of currently valued loss runs and the expiring declaration page for proof of expiring limits and retroactive coverage, prior to binding.

Coverage Requested:

☐ Professional Liability
☐ Physical & Sexual Abuse: Limit Requested:_____
☐ General Liability (Occurrence)
☐ Employee Benefits Liability: Retroactive Date:_____
☐ General Liability (Claims-Made): Retroactive Date:_____
☐ Hired & Non-Owned Auto
☐ Business Personal Property (BPP): Limit Requested:_____
☐ Stop Gap
☐ Employee Theft (3rd Party Liability): Limit Requested:_____

SECTION 3: SERVICES PROFILE

1. Type of Services provided (check all that apply):

☐ Physical Therapy Services____% ☐ Occupational Services_____% ☐ Speech Therapy Services _____%
☐ Cognitive Therapy Services____% ☐ Music/Art Therapy Services____% ☐ Recreational Therapy Services____%
☐ Vocational Rehab Services____% ☐ Respiratory Therapy Services____% ☐ Other Services_____%

2. Total annual gross revenues (projected):

☐ $0 to $500,000
☐ $500,001 to $1,000,000
☐ $1,000,001 to $2,000,000
☐ $2,000,001 to $3,000,000
☐ $3,000,001 to $4,000,000
☐ $4,000,001 to $5,000,000
☐ $5,000,001 to $6,000,000
☐ $6,000,001 to $7,000,000
☐ $7,000,001 to $8,000,000
☐ $8,000,001 to $9,000,000
☐ $9,000,001 to $10,000,000
☐ (Greater than $10m):_____

3. Total annual gross revenues (past 12 months):_____

4. Annual number of patient visits (projected):

☐ 0 to 10,000
☐ 10,001 to 20,000
☐ 20,001 to 30,000
☐ 30,001 to 40,000
☐ 40,001 to 50,000
☐ 50,001 to 60,000
☐ 60,001 to 70,000
☐ 70,001 to 80,000
☐ (Greater than 80,000):_____

5. Patient Care Plan (if applicable):

Confirmation the patient's care plan was established by a physician who has no financial relationship with the insured: ☐ Yes ☐ No

How often is the patient's care plan recertified? ☐ Never ☐ Every 60 days ☐ > 60 days

6. Incident Reporting and Patient Safety:

Does the insured have an incident reporting process? ☐ Yes ☐ No

Does the incident reporting process allow for tracking and monitoring of outcomes? ☐ Yes ☐ No

7. Location where services are provided:

☐ Private Homes _____% ☐ Owned Facilities _____% ☐ Adult Day Care Facilities_____%

☐ Nursing Homes _____% ☐ Independent Living Facilities __% ☐ Assisted Living Facilities _____%

☐ Other:_____ Percentage _____%

8. Does the insured provide: (for all yes answers, please elaborate in the comments/explanations section)

Any clients under the age of 18? _____% ☐ Yes ☐ No

Any services to clients with a tracheostomy? ☐ Yes ☐ No

Any services to clients on a ventilator? ☐ Yes ☐ No

Any swallow testing services? ☐ Yes ☐ No

Any correctional services? ☐ Yes ☐ No

Any services to clients that are medically fragile? (feeding tubes, breathing tubes, etc.) ☐ Yes ☐ No

Does the insured own, lease, or rent any medical equipment? ☐ Yes ☐ No

Residential Care Services (residential care facilities, inpatient services)? ☐ Yes ☐ No

SECTION 4: STAFFING AND TRAINING

1. Staffing Profile (Including Employed, Contracted, and Volunteers):

Staff Type	**Number of Staff Full Time / Part Time**		**Annual Hours**	**Payroll**	**Carries own insurance?**
Chiropractor					☐ Yes ☐ No
Licensed Vocational Nurses (LVNs)					☐ Yes ☐ No
Licensed Practical Nurses (LPN's)					☐ Yes ☐ No
Massage Therapist					☐ Yes ☐ No
Nurse Practitioners (NPs)					☐ Yes ☐ No
Occupational Therapists (OTs)					☐ Yes ☐ No
Occupational Therapy Assistants (OTAs)					☐ Yes ☐ No
Physical Therapists (PTs)					☐ Yes ☐ No
Physical Therapy Assistants (PTAs)					☐ Yes ☐ No
Registered Nurses (RNs)					☐ Yes ☐ No
Respiratory Therapists					☐ Yes ☐ No

Speech Language Pathologists (STs)					☐ Yes ☐ No
Social Workers (SWs)					☐ Yes ☐ No
Physician Assistants (PAs):					☐ Yes ☐ No

2. What is the insured annual staff turnover rate?_____

3. What is the average training time provided for new hires prior to clinical work?

☐ No Training ☐ 1 – 10 Hours ☐ > 10 Hours

4. What is the average training time provided for employees and contractors annually?

☐ No Training ☐ 1 – 10 Hours ☐ > 10 Hours

5. Risk Management:

How often is a performance review of staff completed? ☐ Never ☐ Every 6 months ☐ Annually

How frequently does the insured run their employee and contractor list through the Medicare exclusion list?

☐ On Hire Only ☐ Every Month ☐ Annually ☐ Never

6. Policies and Procedures:

How frequently are the insured's policies and procedures updated? ☐ Annually ☐ As Necessary ☐ Never

SECTION 5: EMPLOYEE BENEFITS LIABILITY ☐ Not Requested

1. How frequently does the insured offer open enrollment periods?

☐ On Hire Only ☐ Semi Annually ☐ Annually

2. Benefits enrollment:

Does open enrollment require the insured to actively elect coverage enrollment? ☐ Yes ☐ No

Is a signed acceptance or rejection of benefit programs required each open enrollment? ☐ Yes ☐ No

Is a physical exam required prior to enrollment in a Group Health/Life Insurance Program? ☐ Yes ☐ No

Does the insured allow for enrollment changes due to life changing events? ☐ Yes ☐ No

Does the insured use an outsourced provider to manage their benefit plans? ☐ Yes ☐ No

SECTION 6: HIRED AND NON-OWNED AUTOMOBILES ☐ Not Requested

1. Does the insured:

Annually check MVRs (motor vehicle records)? ☐ Yes ☐ No

Require all drivers to carry the state mandated personal auto liability limits? ☐ Yes ☐ No

Restrict or exclude any driver with either moving violations or accidents totaling more than two in the past 3 years, or more than three in the past 5 years? ☐ Yes ☐ No

Require all drivers to carry a 'business use endorsement' on their auto liability policies? ☐ Yes ☐ No

Transport any clients? *if yes, what is the percentage? ☐ Yes ☐ No _____%

Annual number of clients transports?..... _____

Make any deliveries? ☐ Yes ☐ No

Confirm all drivers are at least 21 years of age? ☐ Yes ☐ No

Annual reimbursable miles driven for all personal vehicles on behalf of the company? _____miles

SECTION 7: BUSINESS PERSONAL PROPERTY, EMPLOYEE THEFT, EQUIPMENT ☐ Not Requested

Coverage	**Maximum per item value**	**Description of item**	**Maximum value of transported items**	**Total combined values**
*Equipment**				
Business Personal Property				
*Resident & Client Property***				

1. (Equipment*) – provide further details in the comments section at the end of this application including the make, model, age, and location description of where the covered scheduled equipment is to be stored.
2. Resident & Client Property**:

Are all health care professional rendering services on your behalf bonded? ☐ Yes ☐ No

SECTION 8: ABUSE AND MOLESTATION Not Requested

1. Does the insured:

Have a zero tolerance policy for sexual and physical abuse? ☐ Yes ☐ No

Require all staff to undergo an abuse registry check? ☐ Yes ☐ No

Require all staff to undergo a criminal background check? ☐ Yes ☐ No

Percentage of the patients served that are disabled, handicapped or at risk? _____%

SECTION 9: GENERAL LIABILITY Not Requested

1. Are any services provided on the insured's premises? ☐ Yes ☐ No
2. Does the insured own or operate any bed/board facilities? ☐ Yes ☐ No
3. Has the applicant sold, acquired, or discontinued any operations in the past five years? ☐ Yes ☐ No
4. Are any services provided on the insured's premises? ☐ Yes ☐ No

SECTION 10: UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, complete the Supplemental Claim Information Form or provide further explanation in the comments section at the end of this application.

1. Has any insurance carrier ever declined, cancelled, refused to renew, restricted, or surcharged any professional liability insurance policy issued to your organization or any owner/officer? ☐ Yes ☐ No
2. Have you, your organization or any health care professional rendering services on your behalf ever been notified of an involvement in a malpractice claim, suit, or incident, either directly or indirectly? If **Yes**, how many claims, suits or incidents have been brought to your attention? (Complete a Supplemental Claim Information Form for each) _____ ☐ Yes ☐ No
3. Have you, your organization or any health care professional rendering services on your behalf ever been investigated or audited by a governmental or regulatory agency? ☐ Yes ☐ No
4. Have you, your organization or any health care professional rendering services on your behalf aware of or ever been notified of a hired or non-owned auto claim, suit, circumstance, occurrence, incident or accident, regardless of fault? ☐ Yes ☐ No

5. Has any healthcare practitioner, patient, or insurance plan ever filed a complaint of any kind against you or your organization with a medical society, foundation or state/federal agency? ☐ Yes ☐ No
6. Has any healthcare professional working for your organization ever had their admitting privileges to any hospital or other healthcare facility restricted, revoked or placed on probation? ☐ Yes ☐ No
7. Are you or any health care professional rendering services on your organization's behalf aware of any conduct, circumstance, occurrence, incident or accident that is likely to or reasonably could be expected to give rise to a claim? ☐ Yes ☐ No
8. Have you, your organization or any health care professional rendering services on your behalf ever been notified of an involvement in an advertising injury (defamation, libel, or slander) claim, suit, or incident, either directly or indirectly? ☐ Yes ☐ No
9. Does any healthcare professional working in your organization currently have or in the past had a probationary, restricted or suspended license? ☐ Yes ☐ No
10. Do the principal owners of your organization, operate, or control any specialized, medically related business, such as a long term care facility, independent living facility, residential care facility for the elderly, adult day care center, medical transportation risk, etc. that has not been previously named and described in this application? ☐ Yes ☐ No
11. Have you, your organization or any health care professional rendering services on your behalf ever been notified of a revocation or suspension in Medicare or Medicaid reimbursement ability? ☐ Yes ☐ No

COMMENTS / EXPLANATIONS

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Notice to California Applicants: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Maine, Tennessee, Virginia and Washington Applications: 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/or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 New Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

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 purposes 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 Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

This application is for insurance to be placed on a surplus lines basis with Hudson Excess Insurance Company.

_____ _____

Signature **Date**

_____

Print Name/Title

Supplemental Claim Information Form

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: ☐ Claim ☐ Suit ☐ Incident Report

4. Date of incident: _____ 5. Date claim was reported to Carrier: _____

6. Additional defendants: _____

7. If closed:
   Total loss paid including deductible: $ _____ Defense costs: $ _____

   Check One: ☐ Court judgment ☐ Out of court settlement
   Date closed: _____

8. If pending:
   Claimant's settlement demand: $ _____

   Defendant's offer for settlement: $ _____

   Insurer's loss reserve: $ _____

   Deductible amount: $ _____

   Is claim in suit? ☐ Yes ☐ No
   If **Yes**, amount asked in summons: $ _____

9. Insurance carrier:_____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged act, error or omission upon which Claimant bases claim:

B. Description of case and events:

C. Description of the type and extent of injury or damage allegedly sustained:

_____ _____
Signature of applicant Date