Application
For
Home Health Care & Nurse Registries

1. Name of applicant _____

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Explain) _____
   Date your company established: _____

3. Street address _____
   City _____ State _____ Zip _____
   Website Address _____

4. Provide full name(s) of individual and partners: _____

5. Receipts from employees $ _____ Receipts from Independent Contractors $ _____
   Receipts from non-nursing operations $ _____ Total Receipts $ _____

6. Do employed nurses have own Professional Liability coverage? ☐ Yes ☐ No Limits required? $ _____
   Do you require Certificates of Insurance for all independent contractors? ☐ Yes ☐ No Limits required? $ _____

7. Description of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits required	Percentage working in: Hospital	Nursing Home	Home
Aides						
LPN's						
RN's						
Nurse Practitioners						
Physicians						
Physician Assistant						
Others (Specify)						

8. Are background checks made with all prior employers and educational institutions? ☐ Yes ☐ No
   Does background check include Police record? ☐ Yes ☐ No
   If either answer is "No", refer risk to Company.

9. Is chemotherapy performed? ☐ Yes ☐ No
   Describe types of IV therapy performed: _____

10. Describe services performed by any other professionals: _____

11. Do you want your policy to cover your employees? There is a premium charge. ☐ Yes ☐ No

    (NOTE: The policy already protects *you* for the acts of your employees.)

12. Do you want sexual molestation coverage to protect you for alleged or actual acts of your employees? If yes, please complete sexual molestation section on back page. ☐ Yes ☐ No

13. Are your personnel responsible for monitoring any equipment? ☐ Yes ☐ No
If yes, describe _____

14. Please list any medical equipment you supply to clients. _____

15. Do you want coverage for the equipment sold or rented to clients? ☐ Yes ☐ No
Receipts-Sales: $ _____ Receipts-Rental: $ _____

16. Provide details of licensing or certification needed for this operation: _____

17. How long have you been licensed/certified? _____

18. Has your license ever been suspended or revoked? ☐ Yes ☐ No If yes, provide details on back.

19. Is your facility Medicare approved? ☐ Yes ☐ No Medicare receipts? $ _____

20. Your premium is adjustable based on your **total** receipts. Our auditor needs to be able to verify your total receipts.
- If this information is kept by your accountant, please provide your accountant's name, address and telephone number: _____
- If this information is kept by you, please provide the telephone number and address where the records are kept: _____
- If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: _____
- Your telephone number if not previously given: _____

21. Prior coverage:

Insurance Company	Year	Premium	Any Claims	Description

22. Is the applicant aware of any circumstances which may result in a claim? ☐ Yes ☐ No
If yes, please describe: _____

23. LIMITS OF INSURANCE WANTED

General Aggregate Limit (Other than Products-Completed Operations)	$ _____	
Products-Completed Operations Aggregate Limit	$ _____	
Personal and Advertising Injury Limit	$ _____	
Each Occurrence Limit	$ _____	
Fire Damage Limit	$ _____	any one (1) fire
Medical Expense Limit (up to $5,000 limit available)	$ _____	any one (1) person
Each Professional Incident Limit (if applicable)	$ _____	

24. Policy effective dates: From _____ To _____

25. If sexual molestation coverage is <u>not</u> desired, proceed to signature block at bottom of next page.

SUPPLEMENTAL APPLICATION
FOR SEXUAL MOLESTATION COVERAGE

26. Please indicate the liability limits you are requesting.
☐ $25,000/50,000 ☐ $50,000/100,000 ☐ $100,000/300,000

27. Please describe your hiring practices: _____

28. Describe all background checks performed (prior employer, schools, police, references, etc.) _____

29. Do you have written guidelines regarding sexual misconduct: ☐ Yes ☐ No

30. What steps have you taken to prevent or avoid a sexual misconduct incident?
(e.g., same gender caregiver/client) _____

31. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, give details _____

32. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, give details _____

33. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? ☐ Yes ☐ No
If yes, give details _____

34. **Notice to applicants: In most states any person who knowingly, and with intent to defraud, files an application for insurance containing any materially false information, or conceals, for the purposes of misleading, information concerning any fact material hereto, commits a fraudulent act, which is a crime.**

APPLICANT'S NAME (PLEASE PRINT): _____

TITLE: _____

APPLICANT'S SIGNATURE: _____

DATE: _____