



HOME HEALTH CARE AND NON-PHYSICIAN MEDICAL STAFFING

Professional and General Liability Insurance Application

This is an application (the "Application") for a **Claims Made** Insurance Policy. Please answer all questions. If the answer to any question is none, state "None". If space is insufficient to answer any question fully, attach a separate sheet with applicable information.

Desired Effective Date: _____

PART I - PROFESSIONAL LIABILITY

1. APPLICANT INFORMATION

- a. Full name of applicant: _____
- b. Principal business premise address: _____
 _____ (Street) _____ (County)
 _____ (City) _____ (State) _____ (Zip) _____ (Risk Management Contact Person)
 Phone No. _____ Email Address: _____
- c. Individual Partnership Corporation Governmental For Profit Not for Profit
- d. Date business established: _____ Website: _____
- e. Number of Employees: Full time _____ Part time _____ Total _____
- f. Do you own or operate any business other than that shown above? Yes No
 If Yes, please provide details: _____

2. OPERATIONS

- a. Please indicate your professional specialty: _____ Home Health Care Agency _____ Medical Personnel Pool
 _____ Nurse Registry _____ Visiting Nurse Association _____ Other (specify): _____
- b. Are you:
- (i) Certified for Medicare? Yes No
- (ii) Certified for Medicaid? Yes No
- (iii) Licensed and certified as required by state and/or federal law? Yes No
- (iv) Accredited by JCAHO, ACHC or CHAP? Yes No
- (v) A member of a state or national association? Yes No
 If Yes, please identify: _____
- (vi) Affiliated or contracted with any HMO/PPO or Managed Care System? Yes No
 If Yes, please describe: _____
- c. Please list all states and any foreign countries where you provide service: _____
- d. Have you entered into any written indemnification agreements holding any other party harmless? Yes No
- e. Are you under contract to any government entity? Yes No
 If Yes, please provide details: _____

- f. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory)? Yes No
 If Yes, attach a copy of ALL of your advertisements.
- g. Annual Gross Revenues: Last 12 months Estimated next 12 months
 (include all sources) _____
- h. Annual Number of Client Visits: Last 12 months Estimated next 12 months

- i. Do you provide any internet services? Yes No
 If Yes, please explain: _____
- j. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
 If Yes,
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 (ii) Provide the name and title of the Applicant's Privacy Officer: _____

3. SERVICES

- a. Please give the approximate percentage of total service time spent in the following locations:
- | | | |
|----------------------------------|-------------------------------------|-----------------------------------|
| _____ % Patient's Home | _____ % Outpatient Clinic | _____ % Hospital Ward (specify): |
| _____ % Assisted Living Facility | _____ % Surgery Center | _____ |
| _____ % Nursing Home | _____ % Operating Room | _____ % Physician Office (specify |
| _____ % Laboratory | _____ % Emergency Dept. of Hospital | _____ |
| _____ % Other (specify): _____ | | |
- b. Please indicate the approximate division of your patients or clients among:
- | | | |
|--------------------------------|----------------------------|----------------------------------|
| _____ % Intensive Care | _____ % Surgical | _____ % Physical Rehabilitation |
| _____ % Skilled Care | _____ % Obstetrical | _____ % Addiction Rehabilitation |
| _____ % Intermediate Care | _____ % Hemodialysis | _____ % Psychiatric |
| _____ % Personal Assistance | _____ % Diagnostic Imaging | _____ % Other (specify): |
| _____ % Other (specify): _____ | | _____ |
- c. Please indicate the approximate percentage of your patients or clients by age group:
 _____ Under 18 _____ 18 - 35 _____ 36 - 50 _____ 51 - 65 _____ Over 65
- d. Do you perform radiation therapy? Yes No
- e. Do you perform psychiatric shock therapy? Yes No

4. PROCEDURES

- a. Is there a written, formalized Risk Management/Quality Assurance Program? Yes No
- b. Do you have a standard system to handle patients'/clients' complaints or suggestions? Yes No
- c. In case of emergency, is management available 24 hours a day, 7 days a week? Yes No
- d. Do you have policies and procedures in place regarding medications? Yes No
- e. Are nursing charts maintained regularly? Yes No
- f. Do you have a supervision plan in place that monitors staff in daily relationships with clients? Yes No

5. STAFF

- a. (i) Are criminal record checks a part of pre-employment screening? Yes No
 (ii) Are state nurses aide registries checked for new hires? Yes No
 (iii) Are employment history checks a part of pre-employment screening?..... Yes No
 (iv) Are licensure/certification checks a part of pre-employment screening? Yes No
- b. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

	Full Time		Part Time		Annual Hours Worked	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Registered Nurses						
Licensed Practical Nurses						
Certified Nurse Assistants						
Nurse Aides						
Home Health Aides/ Caregivers						
Nurse Practitioners						
Physician Assistants						
Nurse Anesthetists						
Pharmacists						
Psychologists						
Counselors						
Social/Case Workers						
Physical Therapists						
Respiratory Therapists						
Laboratory Technicians						
Dieticians						
Administrative Personnel						
Other (describe):						
Total Number of Employees/ Independent Contractors						

- c. Do all of the above professionals have CPR/First Aid Training?..... Yes No
 d. Are all of the professionals licensed in accordance with applicable state and federal regulations? Yes No
 If No, please provide details: _____
 e. Is continuing education/staff development required of all professional personnel? Yes No
 f. Do all contracted professionals carry their own malpractice coverage? Yes No
 At what limits of liability? _____

6. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

- a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? Yes No
 b. Have you been the subject of any license suspension or revocation or been placed under probation? Yes No

- c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? Yes No
- d. Are written procedures in effect for incident reporting? Yes No
- e. Provide name and title of individual responsible for reviewing incident reports and determining whether corrective action is necessary: _____
- f. Has any professional liability claim or suit been brought against you and/or any of your employees? Yes No
If Yes, please attach all dates and details of any incidents or payments.
- g. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? Yes No
If Yes, attach an explanation.
- h. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
						Yes	No	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

- i. Does current policy cover sexual misconduct?..... Yes No
If Yes, please state sub-limits, if applicable: _____

PART II - GENERAL LIABILITY

1. PREMISES INFO

Complete the following for any owned or leased premises:

Location Address	Occupancy	Square Footage
_____	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	_____
_____	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	_____
_____	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	_____

2. PRODUCTS

- a. Do you sell, lease or supply any medical supplies or equipment to patients or clients?..... Yes No
If Yes, please complete the following:

Category	Description	Annual Sales/Receipts	Amount
Category I	Expendable Items - intended for one time use and then disposed	Annual Sales:	\$ _____
Category II	Non-Expendable Items - including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory aids (excludes diagnostic or treatment devices)	Annual Sales and/or Rental Receipts:	\$ _____
Category III	Diagnostic or Treatment Devices - including oxygen and other medical gasses used in conjunction with respiratory therapy (excluding ventilators)	Annual Sales and/or Rental Receipts:	\$ _____
Category IV	Life Sustaining or Critical Monitoring Equipment or Devices - including dialysis or heart/lung machines, all monitors	Annual Sales/ Rental Receipts:	\$ _____

- b. Do you install, service or demonstrate products or equipment? Yes No

3. CLAIMS/HISTORY

a. Has any general liability claim or suit been brought against you?..... Yes No
If Yes, please provide all dates and details of any incidents or payments:_____

b. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? Yes No
If Yes, attach an explanation.

c. Please list general liability insurance carried for each of the past five years. IF NONE, STATE NONE.

<u>Insurance Company</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Mo/Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
						<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

PART III - NON-OWNED AUTO OPTION

a. Does your business own any vehicles? Yes No

b. What types of non-owned autos are used in your business? _____

c. How are they used? _____

d. Are non-owned autos used for transporting clients or patients?..... Yes No
If Yes, please explain: _____

e. What is the maximum distance which a non-owned auto may be driven from your premises? _____ miles

f. How often are non-owned autos used in your business? _____ Daily _____ Weekly _____ Monthly

g. How many employees/contractors regularly drive their own vehicles on your behalf? _____

h. Are employees/contractors required to carry their own auto liability insurance?..... Yes No
If Yes, what are the minimum limits required? _____

Do you require evidence of insurance?..... Yes No

i. What is your practice for reviewing driver MVR records? _____

PART IV - ADDITIONAL ATTACHMENTS

1. Currently-valued Professional and General Liability loss experience for past five years.
2. Copies of contracts utilized for your services.
3. Current financial statements or proforma, if applicable.
4. Resume(s) of key management personnel.
5. List of additional insureds, description of their operations and relationship to you.

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

It is also agreed that notice of a claim or incident in a Claim Information Supplement or other form attached to this Application for renewal is not notice of claim as noted within an insurer's policy. Any such notice of claim must be made separately from and in addition to this Application for renewal. It is agreed that claims made, incidents reported, or incidents which I/we are aware of, prior to the inception of the proposed coverage, are excluded from this proposed coverage.

I/We also hereby authorize Tennant Risk Services Insurance Agency, LLC, by signing this Application, to contact third parties and obtain any details of prior losses or any other information which may be deemed important.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

Name of Applicant

Title (Officer, Partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Insurance Market Solutions, who may modify or withdraw any outstanding quotation or agreement to bind coverage.