

1. Name of Applicant: _____
2. Individual Corporation Partnership Other (Explain) _____
Date Established _____
3. Street Address: _____
City: _____ State: _____ Zip: _____
Applicant's Web Site Address: _____
4. Provide full name(s) of individual and partners. _____

5. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.

6. Has applicant's license ever been suspended or revoked? Yes No
Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? Yes No
If yes to either question above, provide full details on Attachment to A102.
7. Is applicant's operation Medicare approved? Yes No Medicare sales? \$ _____
8. Is applicant accredited by any of the following?
National Homecaring Council Yes Joint Commission on Accreditation of Healthcare Organizations Yes
National Association of Home Care Yes Community Health Accreditation Program Yes
9. Sales from employees: \$ _____ Sales from independent contractors: \$ _____
Sales from non-nursing operations: \$ _____ Total Sales: \$ _____
10. Do employed nurses have their own Professional Liability coverage? Yes No
Limits Required? \$ _____
Does the applicant require Certificates of Insurance from all nursing (RNs, LPNs) independent contractors? Yes No
Limits Required? \$ _____
11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.

If this information is kept by the applicant, 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: _____
Applicant's telephone number if not previously given: _____
12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made	Any Claims (Check One)	Description
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
13. Is the applicant aware of any circumstances which may result in a claim? Yes No
If yes, provide full details on Attachment to A102.
14. Does the applicant want the policy to cover employees? *There is a premium charge.* Yes No
(Note: The policy already protects the applicant for the acts of his/her employees.)
15. Are applicant's employees or independent contractors responsible for monitoring any equipment? Yes No
If yes, please provide full description. _____
 Check if continued on Attachment to A102.

16. Are employees required to complete daily work reports? Yes No
 Does applicant utilize a formal Quality Assurance/Risk Management program? Yes No
 Does applicant conduct patient/client surveys? Yes No
 Is there an informed consent process in place? Yes No
 Are there written policies in place for:
- | | | | |
|---------------------------------|--|---|--|
| Drug administration procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient acceptance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergencies in the field? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient rights? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employee training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physician orders? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food preparation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Proper lifting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handling of complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reporting of suspected physical/sexual abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical equipment training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Termination of Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to any question is no, refer risk to Company.

17. Please provide details of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in:		
				Hospital	Nursing Home*	Home
Aides/Homemaker Health Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Home Companions	_____	_____	_____	_____	_____	_____
Certified Nursing Assistants	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%

* If yes, is contract with client for private duty work? Yes No *If no, please explain on Attachment to A102.*

18. Are the following background checks performed?
- | | | | |
|---|--|--------------------------------------|--|
| All prior employers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Home telephone verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All educational institutions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Professional licensing verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Residency information? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug screening required? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex offender registry search? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Federal, State (if possible) and County criminal record search? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security No. verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to any question is no, refer risk to Company.

19. Is 24 Hour Service provided? Yes No If Yes, Percent of Operations _____ %
 If Yes, is this Live-in? Yes No Shift Work? Yes No

20. Please describe services performed by any other professionals. _____

 Check if continued on Attachment to A102.

21. Please list any medical equipment applicant supplies to clients. _____

22. Does the applicant sell or rent equipment to clients? Yes No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____

 Check if continued on Attachment to A102.

24. **Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations)	\$	_____	
Products-Completed Operations Aggregate Limit	\$	_____	
Personal and Advertising Injury Limit	\$	_____	
Each Occurrence Limit	\$	_____	
Damage to Premises Rented to You (Up to \$100,000 limit available)	\$	_____	Any One (1) Premises
Medical Expense Limit (Up to \$5,000 limit available)	\$	_____	Any One (1) Person
Each Professional Incident Limit (if applicable)	\$	_____	

25. Effective Dates Desired – From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE, PLEASE COMPLETE QUESTIONS 26. THROUGH 30.

\$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No
Please provide details: _____
27. 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
Describe: _____
28. Does your facility do background checks on all employees and volunteers? Yes No
Describe type of checks performed (prior employer, police, etc.): _____
29. Are there written guidelines in place regarding sexual misconduct? Yes No
If NO, please explain: _____
30. Please check the limits you are requesting: \$25,000/50,000 - included
 \$50,000/100,000 \$100,000/300,000 \$300,000/600,000 \$500,000/500,000 \$1MM/1MM

FOR HIRED AND NON-OWNED AUTO COVERAGE, PLEASE COMPLETE QUESTIONS 31. THROUGH 35.

31. What types of non-owned autos will be used in your business? _____
32. Total Number of Non-owned autos used in your business? _____
33. Do you require your employees to have their own insurance? Yes No
If YES, what are the minimum liability limits required? _____
34. Will you use Non-owned autos other than those owned by your employees? Yes No
If YES, describe relationship and use: _____
35. Please check the limits you are requesting:
 \$100,000 \$300,000 \$500,000 \$1MM

FRAUD WARNING STATEMENTS

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Arkansas Louisiana West Virginia	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.
Colorado	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 claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Maine	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, or denial of insurance benefits.
Maryland	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.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 CIVIL FINES AND CRIMINAL PENALTIES.
New York	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 five thousand dollars and the stated value of the claim for each such violation. Fire: 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.
Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Fire: This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.
Pennsylvania	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 subjects such person to criminal and civil penalties.
Rhode Island	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.
Tennessee Virginia Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
All Other States	Any person who knowingly and willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison.

Applicant's Signature: _____

Date: _____

Title: _____

Producing Agent: _____