Professional & General Liability Application for Home Health Agencies & Medical Personnel Staffing Agencies

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If multiple names and/or locations, please attach list of each along with annual gross receipts broken down by name and location)

4. Telephone Number: _____ Website Address: _____

5. Services Provided:

Exposure	Gross Receipts for the Past 12 Months	Estimated Gross Receipts for the Next 12 Months
Home Health Services (including medical services)		
Non-Medical Home Care (no medical services provided)		
Medical Personnel Staffing of Home Health/Care Services only		
Medical Personnel Staffing Services/Nurse Registry (other than home care)		

6. Are there any other exposures not shown in the above table? Yes ☐ No ☐

If yes, please give details:

_____

_____

7. Are any of the exposures listed in the above table expected to change over the next 12 months?

Yes ☐ No ☐

If yes, please give details: _____

_____

8. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

9. Does the applicant, any employees, independent contractors or volunteers provide any services to a relative?

Yes ☐ No ☐

If yes, please confirm % of patients who are related to their caregivers and give details: _____

_____

10. a) List the number and type of employees/owners including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational Therapist		Speech Therapist	
Respiratory Therapist		Massage Therapist	
Psychiatrist		Psychologist	
Social Worker/Counselor		Medical Assistant/Technician	
CRNA		Surgical Technician	
Chiropractor		Acupuncturist	
Optician/Optometrist		Pharmacist	
Dentist		Non-Medical Aide/Caregiver	
Admin/Clerical		Other (please describe)	

b) List the number and type of independent contractors including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational Therapist		Speech Therapist	
Respiratory Therapist		Massage Therapist	
Psychiatrist		Psychologist	
Social Worker/Counselor		Medical Assistant/Technician	
CRNA		Surgical Technician	
Chiropractor		Acupuncturist	
Optician/Optometrist		Pharmacist	
Dentist		Non-Medical Aide/Caregiver	
Admin/Clerical		Other (please describe)	

c) Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes ☐ No ☐ If no, attach explanation.

11. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

12. Do you require employed, contracted or volunteer physicians, nurse anesthetists, dentists, acupuncturists and/or chiropractors to carry their own Professional Liability Insurance at a minimum of $1M/$3M limits and secure Certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ **Please attach proof of coverage**

13. Location where services are currently provided:

NOTE: If this is a start-up business not yet in operation, please show estimated % exposures for the next 12 months in each of the areas listed.

	% Exposure
Private Homes	
Hospitals	
Nursing Homes	
Assisted Living Facilities	
Independent Living Facilities	
Medical Clinics / Private Doctor Offices	
Correctional Facilities, Prisons, Jails, Detention Centers, or other similar forms of facilities	
Other (please describe):	

If any hospital exposure listed above, please advise which departments are staffed by approximate %:

	% Exposure
Emergency Room	
Urgent Care	
Labor & Delivery	
Intensive Care Unit	
Operating Room	
Other (please describe):	

14. Are any of the exposures listed in both of the above tables expected to change over the next 12 months?

Yes ☐ No ☐

If yes, please give details: _____

_____

_____

15. Does the applicant provide services to anyone under the age of 18 years old? Yes ☐ No ☐

If yes:

a) What % of patients are under the age of 18 years old? _____

b) Is this exposure expected to change over the next 12 months? Yes ☐ No ☐

If yes, please give details: _____

_____

16. Does the applicant provide 24-hour care, live-in and/or overnight care? Yes ☐ No ☐

If yes:

a) What is the current % 24-hour care, live-in and/or overnight care? _____

b) Is this exposure expected to change over the next 12 months? Yes ☐ No ☐

If yes, please give details: _____

_____

17. Does the applicant provide any beds and/or overnight stays at a location that they own or lease?

Yes ☐ No ☐

If yes, please give details: _____

_____

18. Do you sell, rent or otherwise provide any equipment to products or others? Yes ☐ No ☐

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

19. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes ☐ No ☐

If yes, please give details: _____

_____

20. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

21. Please complete the table below showing the applicant's General Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

22. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

23. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

24. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)