



**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:

<u>Exposure</u>	<u>Gross Receipts for the Past 12 Months</u>	<u>Estimated Gross Receipts for the Next 12 Months</u>
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:

	<u>Number</u>		<u>Number</u>
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/Optometrlist		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:

	<u>Number</u>		<u>Number</u>
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/Optomtrist		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.

	<u>% Exposure</u>
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 %:

	<u>% Exposure</u>
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 wound care services? Yes _____ No _____

If yes:

a) Is wound care only provided according to a written physician's order? Yes _____ No _____

If no, please give details: _____

b) What % of patients require wound care? _____

c) Is this exposure expected to change over the next 12 months? Yes _____ No _____

If yes, please give details: _____

18. 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: _____

19. 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.

20. 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: _____

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date</u> <u>(if applicable)</u>

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date</u> <u>(if applicable)</u>

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

	<u>Yes</u>	<u>No</u>
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?		

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

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

25. 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 PrintTitle

Signature: _____
NameDate

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