APPLICATION FOR HOME HEALTH CARE AND NON-PHYSICIAN MEDICAL STAFFING ENTITIES
PROFESSIONAL AND GENERAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If more space needed, attach a separate sheet. If not applicable, please state "N/A".
2. Application must be signed and dated by owner, partner or senior officer.

(PLEASE TYPE OR PRINT IN INK)

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: _____

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. Are 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 specialty):
_____ % 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 provide 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? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

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
	☐Owned ☐Leased	
	☐Owned ☐Leased	
	☐Owned ☐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 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 Devises – 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.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

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.

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. **I/We authorize the release of claim information from any prior insurer to XS/Group, Inc.**

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 XS/Group, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.