Aces
COMMERCIAL • INSURANCE • SERVICES

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License # 0H23471

HOME HEALTH CARE LIABILITY APPLICATION

IMPORTANT: ALL OPERATIONS MUST BE DECLARED AND THE APPROPRIATE SECTION OF THE SUPPLEMENTAL APPLICATION COMPLETED WHERE APPLICABLE. THIS IS NOT A BINDER.

INSTRUCTIONS:

a. This form must be signed and dated by a Principal or Officer of the firm.

b. **PLEASE ATTACH ANY BROCHURES, LITERATURE OR DESCRIPTIVE MATERIAL PROVIDED TO CLIENTS.**

I. GENERAL INFORMATION

Effective Date Requested: **Date Quotation Desired:** **FEIN #**:

Check Coverage Desired: ☐ General Liability ☐ Professional Liability ☐ Employee Benefits Liability
☐ Claims Made ☐ Occurrence

Indicate Limit of Liability Desired:

Sexual Misconduct ☐ $100,000/$200,000 ☐ $300,000/$600,000
☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000

1. Applicant:
2. Business Address:
3. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation ☐ Non-Profit ☐ Other (describe)
4. a. Contact person for inspection, etc.:
   b. Website Address:
   c. Telephone: d. Fax: e. Email:
5. a. Total # of Employees: b. Total Annual Gross Receipts: $
   c. Date Business Established (Required: Attach current annual financial statement and principal's resumes if in business less than three years):
   d. Type of Firm (check all that apply):
      ☐ Home Health Care Provider ☐ Visiting Nurse Agency ☐ Supplemental Staffing
      ☐ Infusion Therapy Provider ☐ Nurse Registry ☐ Closed Pharmacy
      ☐ Hospice ☐ Other (specify)
   e. Description of operations:

II. HIRING/SCREENING AND EMPLOYMENT PROCEDURES (may not be applicable in all states):

1. Are employees/contractors references contacted before hired/placed? ☐ Yes ☐ No
2. How are references checked? ☐ Written ☐ Verbal ☐ Both
3. Do you question prospective employees/contractors as to any criminal record? ☐ Yes ☐ No
4. Does the applicant utilize criminal background checks? ☐ Yes ☐ No
   a. If yes, check those applicable: ☐ pre-hire search ☐ current employees
   b. If yes, at what level are criminal searches conducted? (check those applicable)
   ☐ county ☐ state ☐ federal ☐ felony ☐ misdemeanor convictions
5. Do you verify certification and/or professional licensure status of employees and independent contractors: ☐ Yes ☐ No
6. Are employees screened to rule out drug, alcohol and/or sexual abuse? ☐ Yes ☐ No
7. Are job descriptions provided for all professional and non-professional employees? ☐ Yes ☐ No
8. Are all employees bonded? ☐ Yes ☐ No

III. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS:

Is the applicant a member of, or accredited by, any organizations? ☐ Yes ☐ No

If Yes, please state which:

IV. RISK MANAGEMENT/QUALITY ASSURANCE:

1. Is the applicant licensed in all states in which it is operating? Please attach a copy of each license held. ☐ Yes ☐ No

   List states of operation:

2. Has the applicant's license ever been suspended, revoked, voluntarily surrendered, or subject to probate in any state: ☐ Yes ☐ No
   If yes, please explain:

3. Does the applicant utilize a formal written Quality Assurance and Risk Management Program? ☐ Yes ☐ No

   If no, please explain:
   If yes, attach copy.

4. Is the overall responsibility for Risk Management assigned to one individual in your firm:? ☐ Yes ☐ No

   If yes, please list name and title:
   If no, please describe how these functions are monitored: ☐ ☐

5. Is an "informed consent" document placed in the patient's medical record? ☐ Yes ☐ No
6. Does the applicant conduct patient/client surveys? (If yes, please attach sample) ☐ Yes ☐ No
7. Briefly describe educational training and certification programs utilized by your firm:

V. CLAIMS/COVERAGE HISTORY:

1. Have any claims/suits been made within the last five years against the applicant? If yes, please attach copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.) ☐ Yes ☐ No
2. Is the applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical records)? ☐ Yes ☐ No

   If yes, please explain:

VI. PREVIOUS PROFESSIONAL LIABLITY INSURANCE (PAST THREE YEARS):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

VII PREVIOUS GENERAL LIABILITY INSURANCE (PAST THREE YEARS):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

PROFESSIONAL LIABILITY SECTION
(All Applicants must complete this section)

I. EMPLOYEES – ANNUAL STAFFING:

EMPLOYEE TYPE	NUMBER FULL TIME	NUMBER PART TIME	ANNUAL HOURS	ANNUAL PAYROLL*
NURSE (RN)				
LPN/LVN				
NURSE PRACTIONER				
PHYSICAL THERAPIST				
RESPIRATORY THERAPIST				
SPEECH THERAPIST				
OCCUPATIONAL THERAPIST				
SOCIAL WORKER				
PHARMACIST				
HOME HEALTH AIDE				
HOMEMAKER				
SITTER/COMPANION				
CLERICAL PLACEMENTS				
OTHER (specify)				
TOTAL				

***If applicant has locations in more than one state, please provide total annual payroll by state.**

I./II EMPLOYEES/INDEPENDENT CONTRACTORS (Continued)

1. Are applicant's EMPLOYEES required to carry their own professional liability coverage? ☐ Yes ☐ No
2. Are applicant's INDEPENEDENT CONTRACTORS required to carry their own professional liability coverage? ☐ Yes ☐ No
   a. If yes, are minimum limits of liability required? ☐ Yes ☐ No
   b. Please specify limits required: $
3. Are certificates of insurance maintained on file for all employees and/or independent contractors? ☐ Yes ☐ No
4. Do you obtain updated certificates of insurance on an annual basis? ☐ Yes ☐ No

III. LOCATION WHERE SERVICES ARE PROVIDED % (Total must equal 100%):

☐ Private Homes	%	☐ Clinics	%
☐ Nursing Homes	%	☐ Doctor's Offices	%
☐ Hospitals	%	☐ Other Locations (please specify	%

IV. TYPES OF SERVICES PROVIDED % (Total must equal 100%):

☐ Personal Care Chore or Companion	%	☐ Respiratory Therapy (trach care?/ventilator care?) (please circle)	%
☐ Rehabilitation	%	☐ Radiation Therapy	%
☐ Infusion Therapy	%	☐ Skilled Nursing Care	%
☐ Hospice	%	☐ Social Services	%
☐ Supplemental Staffing (please complete section V. below)	%	☐ Infant Care	%
☐ Obstetrical Services	%	☐ Pediatric Care	%
☐ Adult Day Care*	%	☐ Closed Pharmacy	%
☐ Child Day Care*	%	☐ Clinics Owned/Operated	%
☐ Medical Equipment Supplier	%	☐ Other Services (please specify)	%
☐ Meals on Wheels	%		

***Firms providing day care may be required to complete a supplemental application.**

REQUIRED: Please attach any brochures, literature or descriptive materials provided to clients.

V. Supplemental Staffing % (Total must equal 100%): (*Supplying health care providers to other facilities for a fee)*

If no supplemental staffing provided, please check here:

☐ Nursing Homes	%	☐ Doctor's Offices	%
☐ Hospitals	%	☐ Other Facilities (please specify)	%
☐ Clinics	%	☐ Other Facilities (please specify	%

GENERAL UNDERWRITING SECTION
(Please complete for ALL lines of coverage)

I. OWNED OR LEASED PREMISES: (Please attach list of all other locations)

	ADDRESS	DO YOU OWN OR LEASE?	SQUARE FOOTAGE OCCUPIED
#1.			
#2.			

1. Are any professional services provided on your premises? ☐ Yes ☐ No
   If yes, please explain:

2. Are any bed or board or overnight services provided? ☐ Yes ☐ No
   If yes, please explain:

3. Do you provide any "high tech" services?
   (i.e. trach care, ventilator care, chemotherapy, etc.)? ☐ Yes ☐ No
   If yes, please explain:

4. Does the organization enter into any contractual agreements?
   (i.e., with hospitals, nursing homes or other health care facilities, etc.) ☐ Yes ☐ No
   a. If yes, please list and attach copies of all agreements

   b. If yes, do these agreements contain hold harmless or indemnification clauses favorable to the applicant?
   ☐ Yes ☐ No

5. Are certificates of insurance obtained from all subcontractors? ☐ Yes ☐ No

6.List all entities to be named as Additional Insureds with names and insurable interest:

(Please attach a copy of each contractual agreement, excluding landlords.)

1. NAME	2. NAME
ADDRESS	ADDRESS
INTEREST	INTEREST

7. Has applicant sold, acquired, or discontinued any operations in the past five years? ☐ Yes ☐ No
   If yes, please explain:

8. Is the applicant considering any changes in operations or products handled in the next 12 months?
   ☐ Yes ☐ No
   If yes, please explain:

INCOMPLETE AND UNSIGNED APPLICATIONS WILL BE RETURNED FOR COMPLETION

It is agreed by the applicant and us that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to us shall be the representations of the applicant and the insureds. It is further agreed by the applicant and insureds that this Policy, if issued, is issued in reliance upon the truth of such representations. The undersigned authorized officer of the applicant represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the applicant or us.

The undersigned further declares that any event taking place prior to the effective date of the insurance applied for which any render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to the insurer and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Arizona
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 a denial of insurance benefits.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement

of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Minnesota
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 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 violation.

Ohio
Any person who, with intent to defraud or knowing that he/she 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.

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 material 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.

Virginia
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.

Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All Other States
Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties.

IMPORTANT -- PLEASE READ BEFORE SIGNING

The undersigned certifies that he or she is the Executive Director or Chief Financial Officer of the organization applying for this insurance, that he or she is duly authorized by and acting on behalf of the organization in completing this application, and that all statements and answers set forth in this application are true, complete and correct. The undersigned acknowledges that this application, and the information set forth herein, is material to the Company, and shall form the basis for any coverage provided.

Date:

Executive Director's/Chief Financial Officer's Signature: _____

Print or Type Name:

Producing Agency:

Address:

Telephone: Email: