

**HOME HEALTH CARE /  
TEMPORARY STAFFING  
APPLICATION**  
(Occurrence Coverage Only)

Return to:

**INSTRUCTIONS:**

- A. Please type or print clearly.
- B. Answer ALL questions completely. If any questions, or part thereof, does not apply, print "N/A" in the space provided. Leave no blanks. Failure to answer all questions may delay our ability to provide a quote which may result in a gap in coverage.
- C. If you need more space, continue on a separate sheet of your firm's letterhead and indicate question number.
- D. This form must be completed, signed and dated by a principal of the firm.

1. Insured \_\_\_\_\_

Address \_\_\_\_\_  
Street City State/Zip County

2. List all locations and areas of operations \_\_\_\_\_  
City State/Zip County

3. Type of Business \_\_\_\_\_  
Length of Time in Operation \_\_\_\_\_  
Is applicant licensed to do business in the states listed above where required?  Yes  No  
Has applicant's license ever been suspended, revoked or restricted?  Yes  No  
(If yes, please provide details). \_\_\_\_\_

4. Requested Effective Date \_\_\_\_\_

5. Applicant is:  Individual  Partnership  Corporation Other: \_\_\_\_\_

6. Does applicant employ a full time administrator?  Yes  No

7. Does the applicant provide any overnight bed facilities?  Yes  No

8. Does the applicant perform any treatment or services on the applicant's premises?  Yes  No

9. **COVERAGE DESIRED**

- \_\_\_\_\_ Professional Liability (including Personal Injury)  
 \_\_\_\_\_ General Liability (refer to Company if Claims-Made Professional Liability is selected).  
 \_\_\_\_\_ Non-owned Auto Liability (not available unless General Liability Coverage is selected).

10. **Limits Requested**

- \$200,000 per Incident/\$200,000 Aggregate  
 \$500,000 per Incident/\$500,000 Aggregate  
 \$1,000,000 per Incident/\$1,000,000 Aggregate  
 \$1,000,000 per Incident/\$3,000,000 Aggregate

11. Policy Form Desired:  Occurrence  Claims-Made

12. Are you requesting Claims-Made Prior Acts Coverage?  Yes  No

If yes, indicate prior acts date \_\_\_\_\_.

13. List Professional Liability Policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number:	Policy Period (Mo./Day/Yr.)	If Claims-Made List Retro-Active Date	Deductible Amount	Claims-Made (C) or Occurrence (O)	Annual Premium

14. **CLAIM HISTORY**

A. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured?  Yes  No

B. Are you aware of any claims or suits, or any incident which could become a claim or suit that has not been reported to your current insurance carrier?  Yes  No

If **YES**, to either A or B, provide the following for each claim, suit or incident: (Attach additional sheets if needed)

Date of Accident	Date of Notice:
Amount Paid or Reserved:	Claimant:
Insurance Carrier:	
Allegations: _____	
Description of Treatment Rendered:	

Date of Accident	Date of Notice:
Amount Paid or Reserved:	Claimant:
Insurance Carrier:	
Allegations: _____	
Description of Treatment Rendered:	

15. Has any company cancelled, declined or refused to issue similar insurance?  Yes  No

If **Yes**, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**NOTICE TO MISSOURI RESIDENTS: This question does not apply.**

16. Do you want independent contractors added to the policy as insureds?  Yes  No

17. Estimated annual receipts \_\_\_\_\_

18. Where are employees placed, (by percentage)?

Private Homes\_\_\_ Hospitals\_\_\_ Nursing Homes\_\_\_ Medical Clinics\_\_\_ Doctor's Offices\_\_\_ Other\_\_\_  
 (Describe)

19. Do you engage in any business other than Home Health Care / Temporary Staffing? If so, describe \_\_\_\_\_

\_\_\_\_\_

20. List exposures for both employees and independent contractors:

<u>Employees/ Contracted Services</u>	<u>Number of Employees</u>	<u>Number of Ind. Contractors</u>	<u>Est. Hours Worked Employees</u>	<u>Est. Hours Worked Contractors</u>	<u>Est. Annual Payroll Employees</u>	<u>Est. Annual Payroll Ind. Contractors</u>
Nurses-Hospitals & Clinics Temporary Staffing						
Nurses-Other Than Hospitals & Clinics Temporary Staffing						
Home Health Aides/ Homemakers						
Pharmacists						
Live-In Companions						
Volunteers						
Office Temporaries						
Applicant's Internal Staff						
Social Workers						
All Others (Describe)						

Therapists:

Physical						
Occupational						
Speech						
Other Therapists (Describe)						

21. Are you required to name any other entity as an additional insured?  Yes  No

If so, list name and address of each entity and the business relationship

\_\_\_\_\_

22. Does applicant rent or sell products to customers?  Yes  No

If yes, estimate the annual receipts \_\_\_\_\_

Briefly describe these products \_\_\_\_\_

23. Attach a copy of your employment application. Are references checked?  Yes  No

24. Complete job descriptions must accompany this application for those professionals indicated in Question 20 above.

25. Any descriptive or advertising brochures provided to clients must be attached to this application.

26. Describe hiring standards (screening methods) \_\_\_\_\_  
\_\_\_\_\_

27. Are employees completing Daily Work reports (Nursing notes, Hospital notes, etc.)?  Yes  No

28. Is there a continuing education program available to employees?  Yes  No

29. Are you a member of the National Association for Home Care (NAHC) or any other association?  
 Yes  No

If yes, please specify: \_\_\_\_\_

30. Are you accredited by CHAP, JCAHO or any other accrediting organization?  Yes  No

If yes, please specify: \_\_\_\_\_

31. Do you have a formal written quality assurance and risk management program?  Yes  No

32. Are all employees bonded?  Yes  No

33. Do you place any Nurse Practitioners?  Yes  No

34. Do any of your employees staff the:

Emergency Room  Yes  No

Labor & Delivery Rooms  Yes  No

Intensive Care Units  Yes  No

If yes, please specify the number of employees in each category: \_\_\_\_\_

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

This Professional Liability Program has been organized as a risk purchasing group, located and domiciled in Illinois, pursuant to the legislation enacted by Congress known as the Federal Liability Risk Retention Act of 1986. Coverage is provided to the purchasing group by the Chicago Insurance Company, a member of the Interstate National Corporation. Once the completed application has been approved and the premium received, you will automatically become a member of the Medical Related Professional Services Purchasing Group Association and obtain the insurance coverage afforded through the Group Policy on an annual term. This application is subject to the underwriter's approval. Your completion of this application and premium payment does not obligate the insurance company to issue you insurance coverage.

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.**

**This applicant declares** that the information contained in the application is true and that no material facts have been suppressed or misstated.

**The applicant understands** that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Underwritten by the Chicago Insurance Company, a member Company of Interstate National Corporation, one of the Fireman's Fund Insurance Companies.

**SIGNATURE OF APPLICANT X** \_\_\_\_\_ **DATE X** \_\_\_\_\_

(Must be signed by principal partner or officer of group or individual applying for insurance.)

Producer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Producer's Address: \_\_\_\_\_

Tax I.D. Number:  
\_\_\_\_\_

**Notice to New York Applicants:** 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.