ADMIRAL INSURANCE COMPANY a W. R. Berkley Company

APPLICATION FOR HOME HEALTHCARE, HOSPICE AND STAFFING PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE)

Section I – General Information

1. Full Name of Applicant:

   (Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address:

   (If multiple addresses include an attachment with a complete schedule of all locations)

3. Website Address (if applicable): ______________________________

4. Date Established: _________________(mm/dd/yy)

5. Type of Entity: Corporation Partnership Individual Other (Specify): ___________________________

6. Is this entity owned by, associated with or controlled by any other entity? Yes No

   If Yes, please explain:

7. Type of Firm (check all that apply):

   Home Health Care Agency Visiting Nurse Agency Nurse Registry Hospice

   Staffing Company (not including physician staffing) Other (please explain):

8. Location of where services are provided (total must equal 100%)

   _____% Patient's Home _____% Stand Alone Hospice. _____% Nursing Home. _____% Assisted Living Facility

   _____% Clinic _____% Physicians Office _____% Hospital ER _____% Hospital OB

   _____% Hospital ICU _____% Hospital Other _____% Surgery _____% Schools

   _____% Other (please explain):

9. Are any of your services provided in, or under contract with a facility or entity that you own, operate or are somehow affiliated with? Yes No

   If Yes, please explain:

10. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No

    If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

Section II – Exposures

11. Gross Revenue:

Projected for Next 12 Months	Current Year to Date	1st Year Prior	2 Years Prior
$	$	$	$

12. Please provide the number of employees or independent contractors:

	Number of Employees	Number of Independent Contractors	Annual Billable Hours
Certified Nurse Assistant			
Companion/Home Health Aide			
Counselors (MFT & PhD)			
CRNA			
Dieticians/Nutritionists			
Licensed Practical Nurse			
Live-In Companions			
Nurse Practitioner			
Occupational Therapists			
Personal Care Attendants			
Pharmacists & Pharm Assistants			
Physical Therapists			
Physician Assistant			
Registered Nurse			
Respiratory Therapists			
Social Worker			
Speech Therapists			
Volunteers (Please explain)			
Others (Please Explain)			

13. Medical Equipment Suppliers Revenue:

	Annual Sales	**Annual Lease/Rental**
Category I Expendable Items (i.e. adhesive tape, bandages, hypodermic needles.)		
Category II Non-Expendable Items (i.e. hospitals beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)		
Category III Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, Transmitting devices).		
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)		

14. Please provide the Percentage of your patients/clients that are any of the following:

(Does not need to equal 100%)

Developmentally Disabled	
Hospice Care	
IV / Infusion Therapy	
Live In Care – Non Ambulatory	
Live In Care - Ambulatory	
OB Services	
Pediatric Care	
Personal Care	
Prenatal Care	
Respiratory Therapy	
Skilled Nursing Care	
Wound Care	

15. Do you have an Inpatient Hospice facility? Yes No

If Yes, please provide:

a. # of inpatient licensed beds _______

b. Are the inpatient beds located in a nursing home or assisted living facility? Yes No

If Yes, please explain:

Section III – Risk Management

16. Are you accredited by any accrediting organizations? Yes No

    If Yes, please explain:

17. Please list the association in which you are a member:

18. Please explain your Quality Assurance and Risk Management Program:

19. Are background checks performed for all employees, independent contractors and volunteers? Yes No

    If Yes, what level or type are the criminal background checks:

    County State Federal Sexual Offender Registry

    If No, please explain:

20. Are all employees, independent contractors and volunteers screened for drugs and alcohol? Yes No

    If yes, how often are screens performed? ______________________________

21. How are patients referred to your firm?

22. Does each patient have their own attending physician? Yes No

    If No, please explain.

23. Do you have a Medical Director? Yes No

    If Yes, please provide the following details:

    a. What is the name and specialty of your Medical Director?______________________________

    b. Does the Medical Director provide direct patient care? Yes No

       i. If Yes, does the Medical Director carry a medical malpractice policy? Yes No

       ii. What limits of liability are carried: ______________

    c. Does the Medical Director have supervisory duties over allied healthcare professionals? Yes No

       If Yes, please explain: ______________________________

24. Do you have back-up procedures if assigned staff is not able to make a scheduled visit? Yes No

25. Do you require any of your independent contractors to carry professional liability? Yes No

    If Yes, please provide details. ______________________________

26. Do you have a policy in place to prevent sexual abuse or allegations of sexual abuse? Yes No

    If Yes, please explain and advise how often it is reviewed.

Section IV Hired and Non-Owned Auto

27. Number of employees, volunteers or contractors driving their personal auto in connection with your business:
    a. ______ Regular use of Personal Auto
    b. ______ Occasional Use of Personal Auto
28. What percentage of the drivers are under 25 years old? __________
29. Are MVR's checked for all drivers? Yes No If Yes, how frequently? ____________________________
30. Are all drivers required to carry the state mandated minimum limits? Yes No
31. Do any drivers have either moving violations or accidents totaling more than two in the past 3 years or more than three in the past 5 years? Yes No

    If yes, please explain: ____
32. Do you prohibit driving if a driver is unlicensed, has a suspended/revoked license or has a major conviction such as a DUI/ DWI, reckless driving, leaving the scene or other similar driving conviction? Yes No
33. Do drivers transport patients:
    a. In the client's vehicle? Yes No

       If Yes, please explain: ____
    b. In the driver's vehicle? Yes No
    c. Please explain the frequency and circumstances of any transporting of clients:

       ____
34. Do you have any owned, leased or hired autos used in your business? Yes No

    If Yes, please advise:
    a. What is the estimated number of hired autos on an annual basis? __________________
    b. How will hired autos be used?

       _____% Regular Sales/Service Calls _____% Business Trips

       _____% Transportation of Clients/Patients _____% Others
35. Have any auto claims been made or occurrences reporting during the past five years? Yes No

    If Yes, please provide auto loss runs and a complete descriptions, open/close status, payments and reserves for each claim.

Section V Current Coverage

36. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

Carrier	Limit	Deductible	Premium	Policy Term

37. What is the retroactive date on your current policy? ___________

38. Is the applicant currently insured under a Commercial General Liability policy? Yes No

If Yes, please attach a copy of the declarations page.

Section VI Claims

39. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? Yes No

If Yes, please provide details including name of carrier and date:

40. Has any claim ever been made against the applicant or any of its employees? Yes No Form Link

If Yes, please provide a complete Supplemental Claim Information Form for each and every claim.

41. Is the applicant aware of any circumstances which may result in any claim against them or their employees?

Yes No

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident:

ADMIRAL INSURANCE COMPANY *a W. R. Berkley Company*

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Electronic Signature of Applicant of Authorized Representative:

Current Date:

Title

If you prefer not to return Application with an electronic signature, please print and sign below.

Signature of Applicant of Authorized Representative

Current Date:

Title

ADDITIONAL INFORMATION - Please provide the following information with this application:

a. Advertisements, brochures, descriptive literature
b. Sample contract between you and the clinical trial investigator, if the investigator is not your employee or employee of the test site facility.
c. Informed consent document

Please provide any additional details in the space provided: