o DEERFIELD INSURANCE COMPANY
o ESSEX INSURANCE COMPANY
o EVANSTON INSURANCE COMPANY
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# SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency _____ Nurse Registry _____ Other Medical Staffing (specify) _____

3. Date Established: _____

4. Location(s) where services are provided (total must equal 100%):
_____%Home _____%Hospice _____%Nursing Home _____%Assisted Living Facility _____%Hospital
_____%Clinic/Doctor's Office _____%Adult Day Care _____% Other Facility (specify)_____

5. Employees/Independent Contractors – Annual Staffing:

| Type of Employee/Independent Contractor | No. Full-Time | No. Part-Time | Billable Hours Per Year |
|---|---|---|---|
| Employed Registered Nurse | | | |
| Contracted Registered Nurse | | | |
| Employed Licensed Practical Nurse | | | |
| Contracted Licensed Practical Nurse | | | |
| Employed Certified Nurse Assistant | | | |
| Contracted Certified Nurse Assistant | | | |
| Employed Nurse Practitioner/Physician Assistant | | | |
| Contracted Nurse Practitioner/Physician Assistant | | | |
| Employed Companion/Home Health Aide | | | |
| Contracted Companion/Home Health Aide | | | |
| Employed Social Worker | | | |
| Contracted Social Worker | | | |
| Employed Physical Therapist | | | |
| Contracted Physical Therapist | | | |
| Employed Other Medical (specify) _____ | | | |
| Contracted Other Medical (specify) _____ | | | |

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____
Name of Applicant Title

_____ _____
Signature of Applicant Date