

HOME HEALTH/MEDICAL STAFFING SUPPLEMENTAL APPLICATION

I. INSTRUCTIONS

1. Completion of this application neither binds coverage nor guarantees that a quote or policy will be issued.
2. Requested coverage is not automatically provided. Read your quote carefully. The policy, if issued, will determine actual coverage.
3. All questions must be answered. If a question does not apply, write "N/A." If more space is needed, continue a separate sheet, and indicate the question number.
4. Some questions require supporting documentation. Provide all requested documentation with the fully completed application, signed and dated by the owner, partner, or legal officer.
5. Include with your application copies of 5-year carrier loss runs (valued within 45 days), state or county inspection reports, licensing information, and any complaint reports/investigations. *All applicable documentation must be received and reviewed prior to binding.*

II. APPLICANT INFORMATION

1. Name of entity to be listed as first Named Insured: _____

2. Are any other entities or DBAs to be listed as Named Insured? Yes No
 - a. If yes, list: _____

 - b. Do all entities have common ownership with the first Named Insured in whole or majority? Yes No
 - c. Do you have other entities or operations for which you are not seeking insurance under this application? Yes No
 - If yes, list: _____

 - Are they insured separately? Yes No
 - d. Within the next 12 months, do you expect or intend to merge, acquire, or consolidate with another entity? Yes No
 - If yes, please clarify: _____

3. Years in operation under current ownership/management: _____
4. Mailing Address: _____
City: _____ State: _____ Zip: _____
5. Premise Address: _____
City: _____ State: _____ Zip: _____
(If you have multiple premise locations, please attach a complete address list or Excel sheet of locations)
6. Website: _____
Please attach complete, detailed marketing materials or operations brochures if a website is not available.
7. What is your corporate structure? Please check one:
 Corporation Joint Venture LLC Sole Proprietorship Other: _____
8. What is the nature of your enterprise? Please check one:
 Non-profit For-profit Governmental

9. Do you currently have Professional Liability insurance for your operations? Yes No
- a. Do you currently have General Liability insurance for your operations? Yes No
- b. If yes and your policy is with Richmond National, what is the policy number? _____
(if your policy is with Richmond National, skip c. through f. below)
- c. What is the policy expiry date? _____
- c. If your current policy is on a Claims Made form, what is the Retroactive Date? _____
Please attach a copy of your current policy Declarations Page for Date and Limits confirmation if you want to retain this Retroactive Date.
- d. Who is the current insurance carrier? _____
- e. Are they offering renewal? Yes No
- f. Expiring premium: _____
10. Name of your Insurance Agent/Agency: _____
11. Name of your Insurance Broker/Brokerage: _____

III. UNDERWRITING INFORMATION

1. Please briefly describe your operations: _____

2. What accreditations and/or state licenses to you currently hold? _____
- a. Has the facility or any of your employees ever faced any limitations, suspensions, revocations, denials, or investigations by a licensing board or regulatory agency regarding their professional license or accreditations? *(If yes, provide copies of all documents and additional details)* Yes No
3. Please complete the following table regarding your projected and historic revenues:

	Next Year (projected):	Last Year:	1 Year Prior:	2 Years Prior:
Medicare				
Medicaid				
Charitable				
Private Pay				
Total Gross Revenues				

4. Please complete the following table regarding the percentage of time spent at the following work locations:

Location	Percent	Location	Percent
Private Home – Senior Care		Hospital – OR	
Private Home – Adults		Hospital – ER	
Private Home – Pediatric		Hospital – Labor & Delivery	
Assisted Living Facility		Hospital – Neonatal/NICU	
Independent/Senior Living Facility		Hospital – Adult ICU	
Institutional Hospice		Hospital – Pediatric ICU	
Ambulatory Surgery Center		Other: _____	
Adult Day Care		Other: _____	
Clinic		Other: _____	
Physician's Office		Other: _____	
Jail, Prison, Correctional Facility, etc.		TOTAL	100%

5. Please complete the following table regarding the percentage of your services:

Service	Percent	Service	Percent
Personal Care Companion (<i>non-medical</i>)		Skilled Nursing	
Rehabilitation – Physical, OT, Speech		Chemotherapy	
Infusion Therapy		Radiation Therapy	
In-Home Hospice		Behavioral Therapy – Adult	
Supplemental Staffing		Behavioral Therapy – Pediatric	
Obstetrical, Midwifery, etc.		Pediatric Care	
In-Home Dialysis		Medical Equipment Supply/Consulting	
Cardiac Care		Other: _____	
Traumatic Wound Care/Burn Care		Other: _____	
Skin Care/Decubitus Wound Care		Other: _____	
Respiratory Therapy		TOTAL	100%

6. Do you provide any overnight/24-hour care services? Yes No

7. What is the age range of your patients? _____

8. Do you perform any treatment or services at your premise location? Yes No

9. Do you provide care or treatment for patients receiving enteral nutrition or patients with a tracheostomy or on a ventilator? Yes No

a. If yes, about what percentage of your services are for this care? _____ %

10. If you are providing any placements of staff, what percentage is permanent: _____ % and temporary: _____ %?

11. Please complete the following table regarding your staff:

Type of Health Care Provider	Employees		Independent Contractors	
	# Employees	Annual Hours	# Contractors	Annual Hours
Personal Companion (<i>non-medical</i>)				
Live-In Companion				
Certified Nurse Aid (CNA)				
Licensed Practical Nurse (LPN)				
Registered Nurse (RN)				
Medical Technician				
Nurse Practitioner				
Speech Therapist				
Occupational Therapist				
Physical Therapist				
Behavioral Therapist/Counselor				
Social Worker				
Physician Assistant				
CRNA				
Nurse Midwife/Doula				
Physicians (all)				
Other: _____				

12. What is the name and specialty/title of your current Medical Director? _____
 a. How long have they been employed with you? _____
 b. How many lifetime years of experience do they have in this position? _____
 c. Do they have any direct patient care responsibilities? Yes No
13. Are all employees and contractors licensed in accordance with applicable state and federal regulations? Yes No
14. Do ALL employees carry their own professional liability/medical malpractice insurance? Yes No
 a. If yes, what limits do they carry? \$ _____ per claim/\$ _____ aggregate
15. Do ALL contractors carry their own professional liability/medical malpractice insurance? Yes No
 a. what limits do they carry? \$ _____ per claim/\$ _____ aggregate
16. Do you conduct pre-employment screening and investigation/background checks? Yes No
17. Do you conduct pre-employment drug/alcohol abuse screening? Yes No
18. Do you have written incident/occurrence reporting policies and procedures? Yes No

IV. LOSS EXPERIENCE

1. Please provide Loss Runs with a valuation date no greater than 45 days old for the last five years of your liability coverage. Attach additional details for all open claims and any closed claims with \$20,000 or more incurred.
2. Have you or any of your employees ever faced any limitations, suspensions, revocations, denials, or investigations by a licensing board or regulatory agency regarding the authority to prescribe and dispense narcotics? *If yes, attach an explanation.* Yes No
3. Have you or any of your employees ever faced charges or been found guilty of any offense, excluding minor traffic violations? *If yes, attach an explanation.* Yes No
4. Have you or any of your employees ever received a diagnosis or undergone treatment for alcoholism, drug addiction, chemical dependency, mental illness, or chronic physical illness? *If yes, attach an explanation.* Yes No
5. Do you have any liability losses or suits against you which occurred outside of coverage, or were otherwise not included in your provided Loss Runs? If yes, please complete the below table for these suits:

Date and Description of Incident	Date Suit Filed	Suit in litigation?	Amount Demanded	Amount Awarded
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

6. In the last five years, has any insurance carrier canceled or non-renewed your liability coverage? *(This question is not applicable for applicants in the state of Missouri.)* Yes No
 a. If yes, why? _____
7. Are you or any individual affiliated with your organization aware of any actual or alleged accident, incident, altercation, occurrence, offense, or other circumstance which may reasonably be assumed to possibly result in a suit or demand for damages being filed against you or filed against another party and involving your premises or operations? Yes No
8. Are you or any individual affiliated with your organization aware of any actual or alleged incident, altercation, occurrence, offense, or other circumstance which may reasonably be assumed to possibly result in an allegation of physical or sexual abuse or molestation? Yes No

V. ACKNOWLEDGEMENTS AND SIGNATURE

FRAUD WARNING

General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in the following states, districts, and territories, the below notice supersedes the previous paragraph:

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California	For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia:	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	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.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota	A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey	Claim: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal 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 such violation.
Ohio	Any person who, with intent to defraud or knowing that he 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.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
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 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 such person to criminal and civil penalties.
Rhode Island	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee	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.
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 purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
West Virginia	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant:

By signing below, I declare that to the best of my knowledge all answers provided herein and any attached or appended documents are true, that no material facts have been withheld or misstated, and that my answers are based on a reasonable inquiry or investigation.

I understand that I have a continuing obligation to notify Richmond National of any material changes in the answers to the questions on this application which may arise prior to the effective date of any policy issued pursuant to this application, and I understand that any outstanding quotations may be modified or withdrawn based upon such changes at Richmond National's sole discretion. I understand that all written statements and materials furnished to Richmond National in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

I understand that completion of this form does not bind coverage, and that I will need to accept Richmond National's quotation prior to binding coverage and policy issuance.

Applicant Signature: _____

Applicant Written Name and Title: _____

Date: _____

Agent/Broker:

1. If coverage is currently in place, does your office currently control this risk? Yes No
2. If this application is completed on behalf of an insured, are you personally familiar with the applicant's operations? *(Application will need to be verified and signed by the applicant prior to binding if a quote is offered.)* Yes No

Agent or Broker Signature: _____

Agent or Broker Written Name and Agency/Brokerage: _____

Date: _____