

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application For Home Health Care & Nurse Registries Liability

1. Name of Applicant _____
2. Individual Corporation Partnership Other (Explain) _____
Date Established _____
3. Street Address _____
City _____ State _____ Zip _____
Applicant's Web Site Address _____
4. Provide full name(s) of individual and partners. _____
5. How long has applicant been licensed/certified? _____
6. Has applicant's license ever been suspended or revoked? Yes No
Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? Yes No
If yes to either question above, provide full details on Attachment to A62.
7. Is applicant's operation Medicare approved? Yes No Medicare sales? \$ _____
8. Is applicant accredited by any of the following?
National Homecare Council Yes Joint Commission on Accreditation of Healthcare Organizations Yes
National Association of Home Care Yes Community Health Accreditation Program Yes
9. Sales from employees: \$ _____ Sales from independent contractors: \$ _____
Sales from non-nursing operations: \$ _____ Total Sales: \$ _____
10. Do employed nurses have their own Professional Liability coverage? Yes No
Limits Required? \$ _____
Does the applicant require Certificates of Insurance from all nursing independent contractors? Yes No
Limits Required? \$ _____
11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
 - If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number. _____
 - If this information is kept by the applicant, please provide the telephone number and address where the records are kept. _____
 - If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: _____
 - Applicant's telephone number if not previously given: _____
12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made	Any Claims (Circle One)	Description
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	Y / N	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	Y / N	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	Y / N	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	Y / N	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	Y / N	_____
13. Is the applicant aware of any circumstances which may result in a claim? Yes No
If yes, provide full details on Attachment to A62.
14. Does the applicant want the policy to cover employees? *There is a premium charge.* Yes No
(Note: The policy already protects the applicant for the acts of his/her employees.)
15. Are applicant's employees or independent contractors responsible for monitoring any equipment? Yes No
If yes, please provide full description. _____

Check if continued on Attachment to A62.

16. Are employees required to complete daily work reports? Yes No
 If patient is receiving skilled care, does patient have a current and regularly updated physician treatment plan on file with your agency? Yes No
 Does applicant utilize a formal Quality Assurance/Risk Management program? Yes No
 Does applicant conduct patient/client surveys? Yes No
 Is there an informed consent process in place? Yes No
 Are there written policies in place for:
- | | | | |
|---------------------------------|--|---|--|
| Drug administration procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient acceptance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergencies in the field? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient rights? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employee training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physician orders? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food preparation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Proper lifting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handling of complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reporting of suspected physical/sexual abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical equipment training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Termination of Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

** If the answer to any question is no, refer risk to Company.

17. Please provide details of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in:		
				Hospital	Nursing Home*	Home
Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____	_____	_____
Dialysis Technicians	_____	_____	_____	_____	_____	_____
Medical Social Workers	_____	_____	_____	_____	_____	_____
Mental Health Professionals	_____	_____	_____	_____	_____	_____
Phlebotomists	_____	_____	_____	_____	_____	_____
Physician Assistants	_____	_____	_____	_____	_____	_____
Physicians/Medical Director	_____	_____	_____	_____	_____	_____
Therapists (Physical, Speech Occupational or Respiratory)	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%

* If yes, is contract with client for private duty work? Yes No If no, please explain on Attachment to A62.

18. Are the following background checks performed?
- | | | | |
|---|--|--------------------------------------|--|
| All prior employers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Home telephone verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All educational institutions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Professional licensing verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Residency information? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug screening required? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex offender registry search? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Federal, State (if possible) and County criminal record search? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security No. verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

** If the answer to any question is no, refer risk to Company.

19. Are any of the following services performed or offered? Show percentage of receipts. If the answer to any question is yes, provide full details on Attachment to A62.
- | | | | |
|---|---|--|---|
| AIDS case management? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Medical lab services? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Ambulatory dialysis? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Operating room? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Cardiac recovery programs/cardiac monitoring? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Pain management? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Chemotherapy? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Parenteral and enteral feeding through gastrostomy tube or central line? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Chronic/terminal illness management? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Pediatric home care? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Complex wound management? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Rehabilitative services? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Crisis intervention of psychiatric patients? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Short-stay surgery home recovery? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Infusion (IV therapy)? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Telemedicine? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Description of IV therapy performed: _____ | | Tracheostomy/ventilator care? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Labor/delivery room? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | Twenty-four hour service / live-in service? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No |
| Maternal/newborn assessment or neonatal monitoring? | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | | |

** If the answer to any question is yes, refer risk to Company.

20. Please describe services performed by any other professionals. _____

Check if continued on Attachment to A62.

21. Please list any medical equipment applicant supplies to clients. _____

22. Does the applicant sell or rent equipment to clients? Yes No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____

Check if continued on Attachment to A62.

24. Limits of Insurance Requested

General Aggregate Limit (Other than Products-Completed Operations)	\$	_____	
Products-Completed Operations Aggregate Limit	\$	_____	
Personal and Advertising Injury Limit	\$	_____	
Each Occurrence Limit	\$	_____	
Damage to Premises Rented to You (Up to \$50,000 limit available)	\$	_____	Any One (1) Premises
Medical Expense Limit (Up to \$5,000 limit available)	\$	_____	Any One (1) Person
Each Professional Incident Limit (if applicable)	\$	_____	

25. Effective Dates Desired – From: _____ To: _____

26. Does the applicant want sexual molestation coverage for protection against alleged or actual acts of his/her employees? Yes No
IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS # 27. THROUGH 33.

Applicant's Signature _____ Date _____

Title _____ Producing Agent _____

COMPLETE THIS SECTION IF REQUESTING SEXUAL MOLESTATION COVERAGE.

27. Has the facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? *If yes, please provide full details.* Yes No

28. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? *If yes, please provide full details.* Yes No

29. Describe all background checks performed (prior employer, police, references, etc.) _____

30. Are there written guidelines regarding sexual misconduct? Yes No

31. What steps have been taken to prevent or avoid a sexual misconduct incident? (e.g. same gender caregiver/client)

32. Has any facility that applicant has been associated with in the past ever had any incidents occur or claims brought against it while applicant was there? *If yes, please provide full details.* Yes No

33. Please indicate the liability limits requested.
 \$25,000/\$50,000 \$50,000/\$100,000 \$100,000/\$300,000



