UNDERWRITERS DIRECT ACCESS

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HOME HEALTH CARE

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

Is this a new business? ☐ Yes ☐ No If no, how many years have you been in business? _____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture

☐ Other (please describe): _____

Annual Payroll: $ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?

☐ Yes ☐ No

If the standard markets are declining placement, please explain why: _____

2. Desired Insurance

Note: If Business Auto coverage is requested, a separate application must be completed.

Limit of Liability - Professional Liability Coverage:

	Per Act/Aggregate	OR	Per Person/Per Act/Aggregate
☐	$50,000/$100,000	☐	$25,000/$50,000/$100,000
☐	$150,000/$300,000	☐	$75,000/$150,000/$300,000
☐	$250,000/$1,000,000	☐	$100,000/$250,000/$1,000,000
☐	$500,000/$1,000,000	☐	$250,000/$500,000/$1,000,000
☐	Other: _____	☐	Other: _____

Self Insured Retention (SIR) – both coverages: ☐ $2,500 ☐ $5,000 ☐ $7500 ☐ $10,000 ☐ $25,000 ☐ Other _____

3. Business Activities

1. Employer Federal Tax ID #: _____
2. Applicant's total annual gross revenues: $ _____
3. Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (please describe): _____
4. Applicant is: ☐ Operated for Profit ☐ Operated as Non-Profit ☐ Medicare Certified
5. Additional Insureds to be added to the insurance coverage contract. List all entities to be named as Insureds with names and addresses as they would appear on the coverage contract issued. Attach additional sheets if necessary. Include an explanation of the interest. Indicate which policy (professional or commercial liability) the insured is required to be named on.

Name:_____

Address:_____

Explanation of Interest:_____

_____

Which coverage is required: _____

6. Complete the following table. Please also complete a list of individual named insureds, employees, contractors and/or volunteers who must be named under the coverage contract issued by the Insurer. Persons not specifically submitted, approved and named will not be provided coverage.

	EMPLOYEES				**CONTRACTORS**			**VOLUNTEERS**	
	# of Full Time	# of Part Time	Annual Payroll	Annual Hours of Service	#	Annual Billings	Annual Hours of Service	#	Annual Hours of Service
Reg. Nurses (RN) Lic. Practical Nurses (LPN), Lic. Visiting Nurses (LVN)									
Occupational Therapists, Speech Therapists									
Physical Therapists, Respiratory Therapists									
Therapists Aides, Lab Asst., X-Ray Technicians									
Dieticians, Nutritionists, Dental Hygienists									
Pharmacists									
Psychologists									
Social Workers									
Home Health Aides									
Dialysis Technicians									
Nurse Practitioners									
Other - describe:									

7. Please check those services/operations that apply and give percentages of annual revenues:
   - ☐ Skilled nursing services: _____%
   - ☐ Home health aide services (personal care, chore or companion): _____ %
   - ☐ Infusion Therapy/ Chemotherapy/ Kidney Dialysis / Blood Transfusion / Pediatric Nursing / Respiratory Therapy: _____%
   - ☐ Rehabilitation Therapy / Physical Therapy / Occupational Therapy / Speech Therapy: _____%
   - ☐ Supplemental Staffing / Medical Registry: _____%
   - ☐ Sales / Rentals of Medical Equipment and Supplies: _____%
   - ☐ Pharmacy: _____%

☐ Others: _____ _____%

8. If you sell or rent medical equipment and supplies, please provide:
   a. Annual revenues from sales: $_____
   b. Annual revenues from rentals: $_____

   (If you have noted sales or revenue from a or b above, please complete attached supplement).
9. Do you operate a pharmacy? ☐ Yes ☐ No

   If yes, provide annual revenues from pharmacy operations: $_____
10. Does the Applicant contact references for employee's, contractor's and volunteer's before hiring? ☐ Yes ☐ No
11. Do you verify the educational background of employees/contractors/volunteers? ☐ Yes ☐ No
12. Do you require information on any professional liability or work-related claims that the employee/contractor/volunteer might have previously been involved in? ☐ Yes ☐ No

    Reminder: A separate named person form must be completed for every person to be insured and submitted for approval.
13. Does the Applicant's policies and procedures include the following:
    a. Guidelines on how to handle complaints from customers, patients or referral services? ☐ Yes ☐ No
    b. Guidelines on the proper handling and disposal of hazardous or infectious wastes? ☐ Yes ☐ No
    c. Guidelines on how to ensure continuity of care and service to patients in the event of an emergency or disaster? ☐ Yes ☐ No
14. Is the Applicant aware of any incident, occurrences or circumstances, which may result in any claim or suit being made? ☐ Yes ☐ No

    If yes, please explain: _____

    _____
15. During the past three years, has any insurance company declined, cancelled or refused similar insurance to the Insured? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name