1111 W. San Marnan Drive
P.O. BOX 1328
WATERLOO, IA 50704
PHONE: 800-362-3363
FAX: 319-235-6656

Allied Healthcare Programs and Facilities

VGM MEMBER No._____

Proposed Effective Date_____

Legal Named Insured (full name of all companies to be insured under this policy)

_____

DBA _____

Entity is: ☐ S Corp ☐ C Corp ☐ Individual ☐ Partnership ☐ Limited Partnership ☐ LLC ☐ Other

If other, please describe: _____

Please check all that apply: ☐ Home Healthcare Agency ☐ Temporary Staffing Agency ☐ Residential Hospice

☐ Nurse Registry ☐ Medical Testing and Imaging Lab ☐ Hospice – Home ☐ Dialysis Center

☐ Physical Therapy Clinic

Website _____

Mailing Address _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

Contact Person _____ Email _____

Phone No. _____ Fax No. _____

FEIN _____ Medicare Provider No. _____

NPI No. _____ Unemployment No. _____

List all locations and areas of operations (if more room is needed, please attach a separate piece of paper)

_____

Street City State Zip County

_____

Street City State Zip County

_____

Street City State Zip County

What percent of your services are provided to pediatric clients? _____

Entity – Years in Business? _____ Applicant – Years of Experience? _____

Exposure Information

Last 12 Months: Revenue $_____ Payroll $_____

Patient/Client Contacts _____ Telehealth Patient/Client Contacts _____

Next 12 Months: Revenue $_____ Payroll $_____

Patient/Client Contacts _____ Telehealth Patient/Client Contacts _____

Staffing Roster Employees/Contractors

Physical Therapists	No. of Full Time _____	No. of Part Time _____
Nurses Temporary Staffing	No. of Full Time _____	No. of Part Time _____
Nurses – Other than Temporary Staffing	No. of Full Time _____	No. of Part Time _____
Nurse Aides/Home Health Aides/Homemakers	No. of Full Time _____	No. of Part Time _____
Medical Technicians	No. of Full Time _____	No. of Part Time _____
Pharmacists	No. of Full Time _____	No. of Part Time _____
Speech & Hearing Therapists	No. of Full Time _____	No. of Part Time _____
Social Workers	No. of Full Time _____	No. of Part Time _____
Physician/Physician Assistant	No. of Full Time _____	No. of Part Time _____
Nurse Practitioner/Clinic Nurse Specialist	No. of Full Time _____	No. of Part Time _____
Live-In Companions	No. of Full Time _____	No. of Part Time _____
Occupational Therapists	No. of Full Time _____	No. of Part Time _____
Ultrasound/Sonography Technicians	No. of Full Time _____	No. of Part Time _____
Laboratory Technicians	No. of Full Time _____	No. of Part Time _____
X-Ray Technicians	No. of Full Time _____	No. of Part Time _____
Respiratory Therapist	No. of Full Time _____	No. of Part Time _____
All Others	No. of Full Time _____	No. of Part Time _____

If others, please describe: _____

Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured? ☐ Yes ☐ No If yes, please describe.

_____

Please attach a copy of loss runs.

Are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? ☐ Yes ☐ No If yes, please describe below or attach an explanation.

_____

Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process: ☐ Applications ☐ Drug/HIV/Hep Testing ☐ Education/Competency ☐ Written/Verbal References

☐ Multi-State Registry ☐ Criminal Background Checks ☐ Licenses/Annual Confirmation

Are employees required to actively participate in continuing education? ☐ Yes ☐ No

Is your facility accredited? ☐ Yes ☐ No If yes, with whom? _____

Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No

Do you keep files or medical records on all patients? ☐ Yes ☐ No If yes: ☐ Paper Records ☐ Digital Records

Do all employees/contractors maintain and provide daily reports on all patients for whom they provide services?

☐ Yes ☐ No If yes: ☐ Paper Records ☐ Digital Records

If Hired and Non-Owned Auto is requested, please answer the following:

Do you require any drivers using their own vehicle on behalf of your business carry minimum of personal auto limits of $100,000? ☐ Yes ☐ No

Does the applicant perform MVRs annually on all drivers using their own vehicles on behalf of your business?

☐ Yes ☐ No

Do you ever use a client's vehicle when providing services to clients on behalf of your business? ☐ Yes ☐ No

If yes, do you verify that the client has minimum personal auto limits of $100,000? ☐ Yes ☐ No

Do you verify that the client's personal auto policy extends to your use of the vehicle while providing the agreed upon services? ☐ Yes ☐ No If no, state minimum required. _____

Home Healthcare

Where are employees/independent contractors placed, (by percentage)?

Private Homes _____ % Hospitals _____ % Nursing Homes _____ % Assisted Living _____ %

Medical Clinics _____ % Doctor's Offices _____ % Other _____ %

If other, please describe. _____

What percentage of clients require?:

Wound Care _____ % Cardiac Care _____ % Respiratory Support _____ % Infusion Therapy _____ %

Temporary Staffing

Where are employees/independent contractors placed?

Hospitals _____ % Nursing Homes _____ % Assisted Living _____ % Medical Clinics _____ %

Doctor's Offices _____ % Other _____ % If other, please describe. _____

Are any of your employees/contractors staffed in the following departments?

Emergency Room ☐ Yes ☐ No If yes, number of staff? _____

Labor & Delivery Rooms ☐ Yes ☐ No If yes, number of staff? _____

Intensive Care Units ☐ Yes ☐ No If yes, number of staff? _____

Maternity Ward ☐ Yes ☐ No If yes, number of staff? _____

Medical Testing and Imaging Labs

Percentage of revenue from the following testing:

Xray _____ % MRI _____ % Ultrasound _____ % PET _____ % CT _____ % EKG _____ %

Mammogram _____ % Drug Testing _____ % Routine Blood Work _____ % Urinalysis _____ %

DNA _____ % Sleep Testing _____ % Other _____ %

If other, please describe. _____

Are results released directly to patient? ☐ Yes ☐ No

Are any treatments performed? ☐ Yes ☐ No

Are any reads/interpretations provided by an employee or contractor of the insured? ☐ Yes ☐ No

Are any overnight services provided? ☐ Yes ☐ No

Physical Therapy Clinics

What percent of your practice is associated with the following?

Sports Injuries _____ % Professional Athletes _____ % Collegiate Athletes _____ %

Aquatic Therapy _____ % Spinal Manipulations _____ %

Fitness Classes/Wellness Services _____ %

Fitness/Exercise Classes? ☐ Yes ☐ No

High Endurance/High Intensity Classes? ☐ Yes ☐ No

Provide Exercise Equipment for Client User? ☐ Yes ☐ No

Dry Needling/Acupuncture _____ %

No. of treatments? _____

Guarantee Results? ☐ Yes ☐ No

Complete assessment prior to treatment? ☐ Yes ☐ No

Fully disclose side affect or risk to client? ☐ Yes ☐ No

Needles are single use only? ☐ Yes ☐ No

Pediatric Clients _____ %

Percentage of services provided to ages 10 or under _____ %

Percentage of services provided to ages 11 – 18 _____ %

Is a parent/guardian present during the therapy session? ☐ Yes ☐ No

Length of session? _____ Minutes.

Maximum number of clients in a session? _____

Do you sell any products? ☐ Yes ☐ No

If yes, please explain. _____

Do you recommend any supplements for use by clients? ☐ Yes ☐ No

Do you recommend client consult with PCP prior to using any supplements? ☐ Yes ☐ No

Do you obtain signed and dated waiver of liability from client when recommending use of a supplement? ☐ Yes ☐ No

Do you have policies and procedures for the following?

Heat Therapy ☐ Yes ☐ No Electro Stimulation ☐ Yes ☐ No

Medical fragile or mobility challenged clients ☐ Yes ☐ No

Controlled substances/opioids – clients/employees ☐ Yes ☐ No Physical/Sexual Abuse ☐ Yes ☐ No

Protocol for injured clients ☐ Yes ☐ No Clients deemed to be unfit for a therapy session ☐ Yes ☐ No

Do you assess all clients prior to beginning a therapy session? ☐ Yes ☐ No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions, and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of their knowledge and belief that particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident, or event taking place prior to the effective data of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the application does not bind the undersigned to purchase the insurance, nor does the review of the application bind the Company to issue a policy. It is understood the Company is relying on the application in the event the policy is issued. It is agreed that the Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and may be attached to and become part of the policy.

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.

Name (Please Print)	Title (Must be President, Chairman, CEO, or Director)
Signature	Date

The above signed warrants that they are authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the Applicant and the Applicant's respective Directors, Officers, or other insured parties.