ALLIED HEALTHCARE APPLICATION

INSTRUCTIONS

A. Please type or print clearly. Answer ALL questions completely.

B. If any question, or part thereof, does not apply, print "N/A" in the space provided.

C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.

D. To this application, please attach copies of:

- ☐ Marketing or advertising brochures
- ☐ Descriptive materials provided to clients
- ☐ Copy of JCAHO accreditation report, or other similar, if applicable
- ☐ Other attachments as required in response to application questions
- ☐ Most current annual financial statement prepared by a CPA

E. All materials submitted or required shall be held in confidence.

GENERAL INFORMATION

Proposed Effective Date:_____

1. Insured: _____

Mailing Address:_____

Street City State/Zip County

2. Tax Identification Number:_____ Telephone Number: (____)_____

3. Years in Business: _____ Are you currently enrolled in a Patient Compensation Fund? O Yes O No

4. Mailing Address (if different than above):

_____

Street City State/Zip County

5. List all locations and areas of operations (if more room is needed, please list on a separate piece of paper):

_____

Street City State/Zip County

_____

Street City State/Zip County

_____

Street City State/Zip County

6. **LICENSING/CERTIFICATION**

Is applicant licensed to do business in the states listed above where required? O Yes O No

Has license ever been revoked, suspended, placed on probation or restricted in any way? O Yes O No

If Yes, please explain: _____

Are you certified by Medicare/Medicaid? O Yes O No

Do you bill Medicare/Medicaid? O Yes O No

If Yes, would you like someone to contact you regarding a quote for a surety bond? O Yes O No

7. **PATIENT/TREATMENT INFORMATION**

Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

_____

_____

_____

_____

8. Provide names of all legal entities, including subsidiaries, desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

9. Within the past five years, has applicant acquired, sold or discontinued any operations? O Yes O No

10. Is the applicant owned or operated by a hospital? O Yes O No

11. Applicant is: ◯ Individual ◯ Partnership ◯ Corporation ◯ Other _____

REVENUE AND PAYROLL HISTORY

	Revenue	Payroll
Last 12 months		
Estimated next 12 months		

COVERAGE REQUESTED

12. Requested Effective Date _____

(If new venture, please provide owner's resumé and description of related industry experience.)

13. ____ **Professional Liability** ◯ Occurrence ◯ Claims Made ◯ Prior Acts Date _____

(Attach copy of prior claims made policy declarations if requesting prior acts.)

☐ $100,000 per incident / $300,000 aggregate

☐ $500,000 per incident / $500,000 aggregate

☐ $1,000,000 per incident / $1,000,000 aggregate

☐ $1,000,000 per incident / $3,000,000 aggregate

☐ $2,000,000 per incident / $4,000,000 aggregate

☐ $3,000,000 per incident / $3,000,000 aggregate

Other: _____

14. ____ **General Liability** ◯ Occurrence ◯ Claims Made ◯ Prior Acts Date _____

(Attach copy of prior claims made policy declarations if requesting prior acts.)

Each Occurrence (cannot exceed PL limit) $ _____

General Aggregate (other than products) $ _____

15. Deductible

(Same deductible must be selected for both Professional and General Liability.)

◯ none ◯ $1,000 ◯ $5,000

◯ $10,000 ◯ $25,000 ◯ Other _____

EMPLOYEE BENEFITS LIABILITY (General Liability Coverage must be selected)

16. Limits requested: $100,000 per incident / $300,000 aggregate

☐ $500,000 per incident / $500,000 aggregate

☐ $500,000 per incident / $1,000,000 aggregate

☐ $1,000,000 per incident / $1,000,000 aggregate

Other: _____

STOP GAP LIABILITY

17. Stop Gap Liability (General Liability Coverage must be selected):

Each Person $ _____

Each Disease $ _____

Total Limit $ _____

COVERAGE HISTORY

18. List Professional Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

19. List General Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

CLAIM HISTORY

20. 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, or 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? O Yes O No

If YES, please attach information for each claim, suit or incident that includes the following:

- ☐ Date of accident and date of notice
- ☐ Claimant name
- ☐ Amount paid or reserved
- ☐ Status – Open or Closed
- ☐ Insurance carrier
- ☐ Allegations
- ☐ Description of treatment rendered

21. Has any company cancelled, declined or refused to issue similar insurance? O Yes O No

If Yes, please explain:

_____

SUPPLEMENTAL CLAIMS INFO

Claimant: _____ Status: ◯ Open ◯ Closed

Date of Loss: _____ Date Reported: _____

Expenses: Paid _____ Reserved _____

Indemnity: Paid _____ Reserved _____

Description of Loss:

_____

Claimant: _____ Status: ◯ Open ◯ Closed

Date of Loss: _____ Date Reported: _____

Expenses: Paid _____ Reserved _____

Indemnity: Paid _____ Reserved _____

Description of Loss:

_____

STAFFING ROSTER

(Numbers below should reflect total annual hours and payroll for all employees/contractors.)

Employees/Contracted Services	Est. Hours Worked Employees/Contractors	Est. Annual Payroll Employees/Contractors
Physical therapists		
Nurses - Temporary Staffing		
Nurses - Other than Temporary Staffing		
Nurse aides/home health aides/ homemakers		
Medical technicians		
Pharmacists		

Employees/Contracted Services	Est. Hours Worked Employees/Contractors	Est. Annual Payroll Employees/Contractors
Speech & hearing therapists		
Social workers		
Physician/physician assistant		
Nurse practitioner/clinic nurse specialist		
Live-in companions		
Occupational therapists		
Ultrasound/sonography Technicians		
Laboratory technicians		
X-Ray technicians		
Respiratory therapist		
All others (Describe – A breakdown of each type of staff and applicable hours should be provided.)		

EMPLOYEES/INDEPENDENT CONTRACTORS

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

Private homes___% Hospitals___% Nursing homes___% Assisted living ___%

Medical clinics___% Doctor's offices___% Other (describe) _____%

23. Does the applicant provide overnight beds or residential services? O Yes O No

24. Does the applicant provide treatment or services on their own premises? O Yes O No

25. What percentage of clients require:

Pediatric care____% Cardiac care ____% Respiratory support_____% Infusion therapy ____%

26. Are any of your employees assigned to temporarily staff the:

		If Yes, number of staff:
Emergency room	O Yes O No	_____
Labor & delivery rooms	O Yes O No	_____
Intensive care units	O Yes O No	_____

27. Please provide information requested for each medical director and/or physician providing services at the applicant's facility. (Attach copy of medical malpractice policy declarations.)

	Ins. Carrier and Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Director						
Name - Physician						
Name - Physician						

HIRING/SCREENING AND EMPLOYMENT PROCEDURES

28. Are employees'/contractors' references contacted before hiring or placement? O Yes O No

Check all that apply: _____ Written _____ Verbal

29. Check all the following that apply if obtained, verified and filed as part of each employee screening and hiring process:

Applications	_____	Multi-state registry	_____
Drug/HIV/Hep. Testing	_____	Criminal background vhecks	_____
Education/Competency	_____	Licenses/annual confirmation	_____

30. Does applicant question prospects about previous claims or suits? O Yes O No

31. Are employees required to actively participate in continuing education? O Yes O No

32. Does applicant verify any pending license suspensions, revocations or pending disciplinary actions? O Yes O No

33. Are professional employees required to carry their own insurance? O Yes O No

If Yes, what minimum is required? $_____

Are certificates of insurance kept on file? O Yes O No

34. Do you subcontract work out to other agencies? O Yes O No

If Yes, please explain:_____

ACCREDITATION

35. Is applicant a member of?

JCAHO	_____	National Association of Home Care	_____
CHAP	_____	National League for Nursing	_____
Nat'l Homecaring Council	_____	Nat'l Assoc. For Home Care	_____
Nat'l Assoc. of Private Duty	_____	American League for Nursing	_____
Am. Public Health Assoc.	_____	Nat'l Hospice Organization	_____

Other: _____

36. Is applicant certified for Medicare/Medicaid reimbursement? O Yes O No

RISK MANAGEMENT

37. What management body oversees the quality of patient care?

(e.g., medical director, advisory board, etc.): _____

38. Do you have a formal written quality assurance and risk management program? O Yes O No

Person responsible: _____ Title: _____

39. Does applicant participate in any health fairs/health screening? O Yes O No

If Yes, what percentage of total revenue is from these services? _____

40. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers:

a. Physician notification in the event of changes in the patient's condition	O Yes O No
b. Communication to supervisors and team members	O Yes O No
c. Drug administration procedures	O Yes O No
d. Medical emergencies	O Yes O No

e. Daily work reports (nursing reports, hospital notes, etc.) O Yes O No

f. Patient selection/physician home care treatment plan O Yes O No

g. Service discontinuation O Yes O No

h. Safe lifting, transferring and ambulating O Yes O No

i. Incident reporting (medication errors, patient injury, etc.) O Yes O No

j. Sexual/physical abuse awareness training O Yes O No

k. Advance directives (living will) O Yes O No

l. Medical equipment training O Yes O No

m. Patient's rights O Yes O No

n. Keep medical records on all patients O Yes O No

41. How are medical emergencies handled?

a. On-call physicians? O Yes O No

b. Affiliated physicians on premises? O Yes O No

c. Hospital and/or emergency center? O Yes O No

If Yes, is hospital and/or emergency center located within a 15 minute drive under typical conditions?

O Yes O No

d. Other (explain): _____

42. Specify arrangements for storage and dispensing of drugs: _____

43. Does applicant sponsor any sporting, fundraising or social events? O Yes O No

Please explain: _____

44. Does the applicant provide any flu shots? O Yes O No

If Yes, what percentage of total revenue is from these services? _____

CONTRACTUAL AGREEMENTS

45. Does applicant enter into contractual agreements (e.g., hospitals, nursing homes)? O Yes O No

46. Do contractual agreements contain hold-harmless or indemnification clauses favorable to the applicant?

O Yes O No

47. Is applicant required to name any other entity as an additional insured? O Yes O No

Please list name and address of each entity and the business relationship.

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 his/her knowledge and belief the 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 date 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 this 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 containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

SIGNATURE OF APPLICANT: _____ DATE: _____

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: _____Telephone Number: (____) _____

Producer's Address: _____

Street City State/Zip

Surplus Lines Agent:_____License #:_____