183 Leader Heights Road
P.O. Box 2726
York, PA 17405
800.233.1957 or 717.741.0911
Fax: 717.747.7021
glatfelterhealthcare.com

Return completed application to
submissions@glatfelterhealthcare.com

HOME HEALTH CARE Aide (Non-Medical) APPLICATION

This application includes questions pertaining to your home health care aide (non-medical) organization. As a response is required for all questions, please indicate "NA" if any question does not apply to your organization. Supplemental Applications are also included which may apply to your organization.

Please Note: If your services consist of other than providing unskilled domestic services, do not complete this application.

I. GENERAL INFORMATION

Policy Effective Date: _____ Current Professional Liability Retro Date: _____ OR ☐ N/A (Occurrence)

Current General Liability Retro Date: _____ OR ☐ N/A (Occurrence)

(Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.)

Name of applicant (legal name): _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

Mailing address: _____
(Street) (City) (State) (Zip Code) (County)

Phone: (____) _____ Fax: (____) _____ FEIN (Federal Tax ID) #: _____

E-mail address: _____ Web site address: _____

Inspection and Insurance Contact Name: _____

Phone: (____) _____ E-mail: _____

How many years have you been in operation? _____

Is your organization? ☐ Non-Profit ☐ For-profit ☐ Governmental

What is your organizational structure? (Choose one): ☐ Corporation ☐ Partnership ☐ Privately/Individually-owned
☐ Joint Venture ☐ Limited Liability Company ☐ Other (describe): _____

Are there additional entities that are to be included as Additional Named Insureds? ☐ Yes ☐ No
If "yes," please list the name of each entity and a brief description of their operations. Please include a copy of your organizational chart. _____

_____

Do you engage in any business other than non-medical home health care services? ☐ Yes ☐ No If "yes," please describe:

_____

II. PROFESSIONAL SERVICES

1. How many clients did you provide services to in the last 12 months? _____ Next 12 months? _____
2. How many clients receive 24-hour "live-in" care? _____
3. How many clients are children (18 years of age or under)? _____
4. Please indicate the services provided by your organization:
   - ☐ Activities of Daily Living (ADL)
   - ☐ Bathing/Dressing
   - ☐ Doctor Visits
   - ☐ Errands
   - ☐ Bill paying
   - ☐ Hospice Support
   - ☐ Medication Reminders
   - ☐ Respite for Family Caregivers
   - ☐ Supplemental Staffing
   - ☐ Other: _____
5. Do you provide medical equipment to your patients other than Class I and II items (e.g. crutches, wheel chairs, walkers, etc.)? ☐ Yes ☐ No If "yes," please contact us for a Durable Medical Equipment Supplement.

6. Please indicate the locations where services are provided: ☐ Private Homes ☐ Hospitals ☐ Clinics ☐ Nursing Homes/ALF's ☐ Other: _____
7. Are you a franchise owner? ☐ Yes ☐ No If "yes," what is the franchise? _____

III. OPERATIONS

1. What is your total annual operating budget? $ _____ **(If budget exceeds $5,000,000 please attach a copy of your latest audited financial statement.)**
2. Are you accredited by? ☐ CHAP ☐ ACHC ☐ NCQA ☐ COA
3. Are you Medicare-certified? ☐ Yes ☐ No
4. Has your organization merged, acquired, or consolidated with any other organization within the last ten years? ☐ Yes ☐ No If "yes," please provide the name(s) of the organization(s) and the date of acquisition.

   _____

   _____
5. Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions.

   _____

   _____
6. Within the last three years has your organization or any of its senior managers, officers or other "insureds" been a part of any civil or criminal litigation or arbitration proceedings related to the applicant's activities? ☐ Yes ☐ No
   If "yes," please provide details on a separate attachment.

IV. EMPLOYEE INFORMATION

1. Total number of employees: _____ Full Time _____ Part Time/Per Diem
2. Is Employer's Stop Gap Liability desired? (Only applicable in ND, OH, WA, WY) ☐ Yes ☐ No
   If "yes," provide current annual payroll $_____
3. Do you engage the use of Independent Contractors to provide any services? ☐ Yes ☐ No
   If "yes," what percentage of services is provided by Independent Contractors? _____%
   What services do they provide? _____

   _____
   Do you require that all Independent Contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year? ☐ Yes ☐ No
4. What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies? _____%
5. Do you employ or contract with any licensed physicians or nurse practitioners? ☐ Yes ☐ No
6. Which of the following background check methods do you use?

Social Security number verification	☐ Yes ☐ No
Criminal background checks	☐ Yes ☐ No
Residency verification	☐ Yes ☐ No
Professional licensing verification	☐ Yes ☐ No
Prior employment	☐ Yes ☐ No
Driver's license information (MVR)	☐ Yes ☐ No

   Note: Only required if the employee/volunteer operates a company vehicle or their personal vehicle on the organization's behalf.
7. Who is responsible for human resources in your organization?
   Name and title: _____
8. Is training provided and attendance documented for all employees? ☐ Yes ☐ No If "yes," briefly describe your in-service training program for new hires and existing staff:

   _____

   _____

V. RISK MANAGEMENT AND LOSS CONTROL

Please attach a copy of your currently valued three-year loss experience from your insurance carrier.

1. Within the last three years has your organization been a part of any civil or criminal litigation or arbitration proceeding? ☐ Yes ☐ No If "yes," please provide details on a separate attachment.
2. Does your organization have knowledge of any incidents which have not been reported to your current insurance carrier that may result in a claim or suit? ☐ Yes ☐ No If "yes," please provide details on a separate attachment.
3. Does your organization have a formal Quality Assurance or Risk Management program? ☐ Yes ☐ No

If "yes," name and title of who is responsible for the program: _____

4. Do you have an active Safety Committee? ☐ Yes ☐ No
5. Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? ☐ Yes ☐ No
6. Has any insurer ever refused to renew or cancelled any insurance coverage during the past five years? ☐ Yes ☐ No If "yes," please provide the reason for cancellation: (Missouri Applicants are not required to reply.)

_____

VI. OPTIONAL COVERAGES

HIRED AND NON-OWNED AUTOMOBILE LIABILITY - Please indicate if this coverage is desired: ☐ Yes ☐ No

If "yes," please answer the following questions:

NOTE: If you have owned or leased vehicles titled or contracted under your organization's name, please contact us for an automobile application. If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned automobile policy.

1. Does your organization have positions where driving personal vehicles is a job function essential to the position? ☐ Yes ☐ No
2. Do you have a policy in place which addresses driving requirements for employees and volunteers? ☐ Yes ☐ No
3. Does this policy include specific hiring criteria applicable to new drivers who operate their personal vehicles on your behalf? ☐ Yes ☐ No
4. Does your pre-employment hiring process include driver screening? ☐ Yes ☐ No
5. Does this process include ordering Motor Vehicle Reports prior to hire? ☐ Yes ☐ No
6. Does this process include review of a driver's license, accident, and violation history? ☐ Yes ☐ No
7. Does this process include verification of the state's minimum financial responsibility limits? ☐ Yes ☐ No
8. Does your policy permit patient/client transport in personal vehicles? ☐ Yes ☐ No
   If "yes," what personal auto liability limits do you require?
   $_____ / _____ OR $_____ Combined Single Limit
9. Does your policy permit use of the patient or client's vehicles? ☐ Yes ☐ No
   If "yes," is the caregiver required to verify that the client maintains automobile liability insurance? ☐ Yes ☐ No
10. Does your policy include a process for removing drivers with unsatisfactory driving records from their driving duties? ☐ Yes ☐ No
11. Does your organization offer training on safe driving practices? ☐ Yes ☐ No

SEXUAL ABUSE LIABILITY - Please indicate if this coverage is desired: ☐ Yes ☐ No

If "yes," please answer the following questions:

1. Do you order Criminal Background Checks on all employees and volunteers who work directly with patients prior to hire? ☐ Yes ☐ No
2. Does your organization have a written "zero tolerance" sexual abuse and molestation policy? ☐ Yes ☐ No
   Does your written policy include the following?
   - A zero tolerance statement ☐ Yes ☐ No
   - Definition of sexual abuse/molestation ☐ Yes ☐ No
   - Reporting procedures with at least two persons to report to internally ☐ Yes ☐ No
   - Investigation and follow-up procedures ☐ Yes ☐ No
   - Anti-Retaliation warning ☐ Yes ☐ No
3. Are all employees/volunteers required to acknowledge having read and comprehended the policy? ☐ Yes ☐ No
4. Have you ever had any prior incidents, allegations or claims involving sexual abuse? ☐ Yes ☐ No
   If "yes," please provide details.

_____

_____

_____

If you are requesting sexual abuse coverage under your Excess Liability policy, please attach a copy of your current sexual abuse and molestation prevention policy. (If you would like to view a copy of a standardized version of an acceptable sexual abuse and molestation prevention policy for reference in developing your own, visit our web site, glatfelterhealthcare.com)

EMPLOYEE BENEFITS LIABILITY

$25,000 each employee/$50,000 aggregate is automatically provided, but additional limits may be available. Please indicate desired coverage limit if different from automatic coverage:

☐ $50,000/$50,000 ☐ $100,000/$100,000 ☐ $250,000/$250,000 ☐ $500,000/$500,000
☐ $750,000/$750,000 ☐ $1,000,000/$1,000,000

CYBER LIABILITY AND PRIVACY CRISIS MANAGEMENT EXPENSE

Please indicate if this coverage is desired: ☐ Yes ☐ No If "yes," please answer the following questions:

Cyber Liability protects you when claims are made against you for monetary damages arising out of an electronic information security event:

$1,000,000 Each Electronic Information Security Event, subject to
$3,000,000 Annual Aggregate

Privacy Crisis Management Expense reimburses for expenses you incur as a result of a privacy crisis management event first discovered during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements.

☐ $50,000 each privacy event / $50,000 aggregate automatically included
☐ $100,000 each privacy event / $100,000 aggregate
☐ $250,000 each privacy event / $250,000 aggregate
☐ $500,000 each privacy event / $500,000 aggregate

1. ☐ Yes ☐ No Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks?
2. ☐ Yes ☐ No Do you use antivirus software on all desktops, portable computers and mission critical servers?
3. ☐ Yes ☐ No Are antivirus applications updated in accordance with the software provider's requirements? How often? _____
4. ☐ Yes ☐ No Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access?
5. ☐ Yes ☐ No Has your organization suffered a computer attack, such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack, in the last 12 months? If Yes, please explain: _____
6. ☐ Yes ☐ No Do you have a written information security and privacy policy?
7. ☐ Yes ☐ No Do you backup your computer data and store it off site?

Cyber Liability and Privacy Crisis Management Expense Comments: _____

_____

_____

EXCESS LIABILITY - Please indicate if this coverage is desired: ☐ Yes ☐ No

If "yes," please indicate the limit of liability desired:

☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000 Other:_____

COMMERCIAL PROPERTY

If you have any owned or leased property and desire a quote, please indicate ☐ Yes ☐ No **If "yes," please complete Supplement No. 8.**

EMPLOYEE RETIREMENT INCOME SECURITY ACT INSURANCE (ERISA)

We can offer you a proposal for a bond to insure your organization's liability in the proper administration of employer-administered employee benefit plans. The act is designed to protect the rights of employees and beneficiaries covered under the benefit plans your organization administers.

If a quote is desired, please indicate ☐ Yes ☐ No **If "yes," please request a Supplement.**

OCCUPATIONAL ACCIDENT/BUSINESS TRAVEL ACCIDENT

Are you interested in Occupational Accident/Business Travel Accident coverage for your volunteers and/or independent contractors? ☐ Yes ☐ No **If "yes," please complete the Supplement on our website.**

ANY SIGNIFICANT CHANGES TO YOUR ORGANIZATION DURING THE POLICY YEAR MUST BE REPORTED TO GLATFELTER UNDERWRITING SERVICES, INC. TO ENSURE COVERAGE.

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

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 act, which is a crime, and may subject such person to criminal and civil penalties.

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.
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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
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 or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kansas	Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 Jersey	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.
Oregon	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, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
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.
Vermont	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
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.

Your signature below acknowledges that you have read the Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Applicant's signature: **Title**: _____ **Date**: _____

Agent's signature: **Date:** _____

INSURANCE AGENT INFORMATION:

Agency name: _____

Contact person: _____

Agency address: _____

Telephone number: _____ Fax number: _____

E-mail address: _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

Contact's name: _____

Contact's email: _____

Contact's direct phone number: _____

Glatfelter[SM] HEALTHCARE

PROPERTY SCHEDULE SUPPLEMENT (No. 8)

(If more than two locations exist, please make copies of the supplements, as required, complete and attach.)

Name of Applicant: _____

General Property Information:

	Building:	**Building:**
1. Street address		
2. City, County, State, Zip Code		
3. Construction code of building*		
4. Your occupancy (office, residential inpatient, garage, etc.)		
5. If residential facility, number of beds		
6. List other occupants in building (office, retail, manufacturing, etc)		
7. Do you own or lease?		
8. Mortgagee name & address, if applicable		

*Construction Codes of Building: (select one only) (1) Frame, (2) Joisted Masonry, (3) Non-combustible, (4) Masonry Non-combustible, (5) Modified Fire Resistive, (6) Fire Resistive, (7) Heavy Timber Joisted Masonry, (8) Superior Non-Combustible, (9) Superior Masonry Non-Combustible

9. Year building built		
10. Square footage of TOTAL building		
11. Square footage YOU occupy		
12. % of TOTAL building sprinklered		
13. # of floors in building		
14. Basement (Y/N)	☐ Yes ☐ No	☐ Yes ☐ No
15 If building is over 25 years, provide date of updates to:		
Wiring		
Heating/Ventilation		
Roof		
16. Type of fire alarms (heat/smoke detectors, remote alarms, central station, none)		
17. Other alarms (hourly watchman, security guard, surveillance cameras, intrusion alarms, none)		

Property Coverage:

1. Deductible ($250, $500, $1,000, $5,000)	$	$
2. Building Limit – includes signs if insuring the building	$	$

PROPERTY SCHEDULE SUPPLEMENT (No. 8)
PAGE 2 OF 2

3. Business Personal Property Limit – includes but not limited to contents, furniture, fixtures, laptops, computer hardware and software, communication systems, durable medical equipment, phone systems, fax machines, signs (if not insuring the building), and tenants glass	$	$
4. Thrift Store merchandise (actual cash value)	$	$
5. Loss Payee's Name and Address for Business Personal Property, if applicable. Identify items.		

PROPERTY COVERAGE ENHANCEMENT OPTIONS

1. **Building Ordinance Coverage**

   A **$500,000** limit is automatically included at no additional cost for coverages B & C. For an additional premium, increased limits are available. Please indicate requested limits below.

   Coverage A extends the replacement cost coverage for damage to your building to include loss to the undamaged portion of the building and:

   Coverage B provides an additional limit to cover the cost to demolish and clear the site of undamaged parts of the property.

   Coverage C provides an additional limit to pay for increased costs to repair or reconstruct damaged and undamaged portions of the building.

	Building:	**Building:**
Building Ordinance (Coverage B)	$	$
Building Ordinance (Coverage C)	$	$

2. **Business Income and Extra Expense**

   A **$250,000** BI/EE limit is automatically included and applies on a blanket basis to all locations on your policy. For an additional premium, increased limits are available. A Business Income Worksheet may be required to bind coverage. Please indicate requested limits below.

   Increased BI/EE Blanket Limit: $_____ ☐ Other (Non-Blanket): $_____

3. **Equipment Breakdown Coverage**

   Automatically included up to the applicable combined Building and Business Personal Property limits. A Sublimit of **$100,000** applies to each of the following: Expediting Expenses, Hazardous Substances, Spoilage, and Electronic Data Restoration. Additional limits are available for an additional premium.

   Increased Limit: $_____

PROPERTY PACKAGE COVERAGE OPTIONS

Commercial Crime:

Crime coverage is offered if property insurance is provided. Please indicate the coverage limit requested.

☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $400,000

Do checks require at least two signatures? ☐ Yes ☐ No

Are bank accounts reconciled by someone not authorized to deposit or withdraw? ☐ Yes ☐ No

Are financial records audited by outside parties? ☐ Yes ☐ No

Please be certain that the limits of coverage you select for insuring your buildings or business personal property are sufficient to meet your obligation to insure your property to at least 90% of the estimated replacement cost values.