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

HOSPICE APPLICATION

Return completed application to submissions@glatfelterhealthcare.com

This application includes questions pertaining to your hospice 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.

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

☐ State Hospice Association: Number of member organizations represented: _____

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. _____

II. PROFESSIONAL SERVICES

HOSPICE SERVICES

1. How many hospice Patient Days on Service (total number of service days for all hospice patients) during the last 12 months? _____ Next 12 months? _____
2. Number of hospice patients during the last 12 months: _____
3. How many licensed inpatient/residential beds (Include both owned and contracted hospice beds)? _____
4. Do you provide hospice or palliative care for children? ☐ Yes ☐ No If "yes," what percentage of your total services includes pediatric care? _____%
5. Do you provide palliative care for non-hospice patients? ☐ Yes ☐ No If "yes," how many palliative care patient visits will you complete during the next 12 months? _____
6. Do you participate in any clinical trials, pharmaceutical testing, or research? ☐ Yes ☐ No If "yes," please describe: _____
7. Do you provide pet therapy? ☐ Yes ☐ No If "yes," have the pets been specially trained or certified for use in the therapy program by Therapy Dogs International or the American Kennel Club? ☐ Yes ☐ No
8. Do you sponsor any special events or fund-raisers? ☐ Yes ☐ No If "yes," **please complete Supplement No. 1.**
9. Do you sponsor any bereavement camps? ☐ Yes ☐ No If "yes," **please complete Supplement No. 3.**

HOME HEALTH CARE SERVICES

If your organization only provides hospice care and you do not provide home health services, please skip this section and proceed to Section III, Operations.

1. Do you provide **skilled** home health care services? ☐ Yes ☐ No If "yes," how many total patient visits during the past 12 months? _____ Next 12 months? _____
2. Number of skilled home health care patients treated during the past 12 months? _____
3. Please indicate which of the following skilled home health services are provided by your organization:

☐ Adult Day Care ***(Complete Supplement No. 6)***	☐ Pharmacy ***(Complete Supplement No. 2)***
☐ Cardiac Care	☐ Rehab Services (PT,OT, Speech Therapy)
☐ Case Management	☐ Respiratory Therapy
☐ Child Day Care ***(Complete Supplement No. 5)***	☐ Trach/ventilator
☐ Gastrostomy Tube (GT) Care	☐ Respite Care
☐ Infusion Therapy	☐ Special Care (Alzheimer's/Dementia, etc.)
☐ Medical Equipment Supplier ***(Complete Supplement No. 4)***	☐ Supplemental Staffing ***(Complete Supplement No.9)***
☐ Medical Social Services	☐ Telehealth
☐ Obstetrical Services	☐ Thrift Shops: Annual Gross Sales $ _____
☐ Palliative Care. Number of annual visits: _____	☐ Other: _____

4. Please indicate the location where services are provided: ☐ Private Homes ☐ Hospitals ☐ Clinics ☐ Nursing Homes/ALF's ☐ Schools ☐ Outpatient Facilities ☐ Other _____
5. Do you participate in community wellness programs, including immunizations or vaccination programs? ☐ Yes ☐ No If "yes," please provide the number of immunizations. _____
6. Do you provide **non-skilled** services? (Do not include ADL services provided by skilled personnel) ☐ Yes ☐ No If "yes," what is the number of annual clients? _____ How many of these clients are provided 24-hour "live-in" care? _____
7. Do you provide any home health services for children? ☐ Yes ☐ No If "yes," what percentage of your total services includes pediatric care? _____%

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? ☐ JCAHO ☐ CHAP ☐ ACHC ☐ NCQA ☐ COA
3. Are you Medicare-certified? ☐ Yes ☐ No
4. Licensure:
   Are you required to be licensed in any states in which you operate? ☐ Yes ☐ No
   If "yes," in what state(s) are you currently licensed? _____
   Are any license applications currently pending? ☐ Yes ☐ No
   If "yes," what state(s)? _____
   Please attach a copy of your most recent state agency's inspection report, together with corrective actions completed, if any.
5. Does your organization participate in the State Patient Compensation Fund? ☐ Yes ☐ No ☐ Not Applicable
6. 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.

   _____

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

   _____

   _____
8. 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 _____ Volunteers
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. Which of the following background check methods do you use?

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

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

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. CREDENTIALING

Information to be supplied by the Medical Director (or Individual responsible for professional staff credentialing)

1. Do you have a formalized credentialing process? ☐ Yes ☐ No
2. Does your physician credentialing process include primary source verification of:
   ☐ Physician/Nurse Practitioner licensure ☐ Training and Experience
   ☐ Certifications ☐ DEA registration
   ☐ Education
3. Do your physician files include:
   ☐ Completed application ☐ Criminal background check ☐ Query of NPDB (malpractice history)
   ☐ Copy of current license ☐ Copy of current DEA registration ☐ Evidence of continuing education
   ☐ Copy of current Certificate of Insurance, if primary liability insurance is maintained
   ☐ Authorization and information relating to any past/pending claims, suits, or settlements

4. Has there even been a review by a state medical board or other oversight organization of any physician or nurse practitioner? ☐ Yes ☐ No
   If "yes," please provide details: _____

5. Has there ever been a license suspension, revocation, restriction, or voluntary surrender of license of any physician or nurse practitioner? ☐ Yes ☐ No
   If "yes,"please provide details: _____

6. Is there a recredentialing process? ☐ Yes ☐ No
   If "yes," how often do you recredential? _____
7. Does your organization require that contracted physicians/nurse practitioners maintain primary professional liability insurance? ☐ Yes ☐ No ☐ Not Applicable
   If "yes," what are the minimum professional liability limits required? _____
   Is proof of coverage (Certificate of Insurance) required? ☐ Yes ☐ No
8. What is the total number of physicians/nurse practitioners in your organization? (Please include volunteers and independent contractors.) _____

Please provide the following information for each physician/nurse practitioner:

Name / Title	State of Licensure	Employed, Volunteer, or Independent Contractor	Average Hours per Month	Primary Insurance Elsewhere (Yes/No)*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

*Answer "yes" if the physician or nurse practitioner maintains primary liability insurance elsewhere which would respond to an incident or claim while performing duties on your behalf.

Do any of the above-named physicians participate in a state's Patient Compensation Fund (PCF)? ☐ Yes ☐ No
If "yes," please include a copy of the PCF Certificate of Insurance.

VII. 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.**

MANAGEMENT LIABILITY

If your organization is a nonprofit organization and you desire a proposal, please contact us for an application.

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 complete Supplement No. 7.**

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

FUNDRAISING AND SPECIAL EVENT SUPPLEMENT (No. 1)

(Complete only if you sponsor fundraising or Special Events)

1. **Name of Applicant:** _____

2.

Name of Event	Date	Number Attending	Alcoholic Beverages Served?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

3. Do any of the above events involve dance, casino nights, carnivals, races, sports, animals, water or vehicles?
☐ Yes ☐ No If "yes," please identify:

_____

_____

_____

_____

4. Does your organization require the facility to maintain liability insurance? ☐ Yes ☐ No
If "yes," do you obtain copies of Certificates of Insurance and require that you are named as an Additional Named Insured?
☐ Yes ☐ No

5. Do you require a mutual hold harmless agreement in the contract? ☐ Yes ☐ No

6. Are any Certificates of Insurance required? If so, list name and address of each organization below:

_____

_____

_____

_____

_____

Glatfelter[SM] HEALTHCARE

PHARMACY SUPPLEMENT (No. 2)

(Complete only if you operate an in-house pharmacy.)

1. **Name of Applicant:** _____

2. Annual Gross Revenue from Pharmacy: _____

3. Are drugs dispensed to anyone other than the insured's hospice or home health patients? ☐ Yes ☐ No

4. How many pharmacists are on-staff? _____

5. Are all licensed pharmacists credentialed by your organization prior to hire? ☐ Yes ☐ No

6. Who has access to stock? _____

7. Where/how is stock stored? _____

8. Does your pharmacy operate in compliance with the Controlled Substances Act (CSA)? ☐ Yes ☐ No

9. Does your pharmacy store, dispense and dispose of all drugs as required by state & federal regulation?
☐ Yes ☐ No

10. Describe disposal process for unused, spoiled or radioactive drugs:

_____

_____

_____

11. Describe security measures, security systems or alarms that have been installed to protect the pharmacy unit:

_____

_____

_____

12. Describe the policies that have been instituted to ensure that prescription drugs are stored under appropriate conditions and properly dispensed:

_____

_____

_____

13. Are drugs delivered to the patient's home? ☐ Yes ☐ No If "yes," do you have a policy to ensure proper security and safe home delivery? ☐ Yes ☐ No

14. Does your organization have an "in-home" policy for disposal of unused prescription drugs? ☐ Yes ☐ No

Glatfelter HEALTHCARE

HOSPICE BEREAVEMENT CAMP SUPPLEMENT (No. 3)

(If more than one camp is scheduled, please provide information for each camp.)

1. **Name of Applicant:** _____
2. Dates of Camp: _____ Overnight? ☐ Yes ☐ No
3. Location of Camp: _____
4. Does the campground maintain its own liability insurance? ☐ Yes ☐ No
   If "yes," please request a Certificate of Insurance for your records.
5. How many children are enrolled? _____ What is the age of campers? _____ to _____ years of age.
   What is your ratio of staff to children? _____
   Does the ratio of staff to children meet state requirements? ☐ Yes ☐ No
6. Are you securing a signed release form from guardians? ☐ Yes ☐ No
7. How are the children being transported to and from camp? _____
   (If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.)
8. Are comprehensive background checks completed on all staff members, including adult, young adult, and student volunteers? ☐ Yes ☐ No
9. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following?
   - ☐ Isolated settings
   - ☐ Individual meetings
   - ☐ Sleeping arrangements (if applicable)
   - ☐ Changing clothes/showering
10. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No
11. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No
    If "yes," please provide complete details:
    _____
    _____
12. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse? ☐ Yes ☐ No
    If "yes," please provide complete details:
    _____
    _____
13. Will there be a licensed RN or LPN on premises at all times? ☐ Yes ☐ No
14. Recreational activities:
    Are recreational swimming or boating activities included? ☐ Yes ☐ No
    If "yes," is there a certified lifeguard on duty? ☐ Yes ☐ No
    If boating activities are planned, are all participants required to wear life safety jackets at all times?
    ☐ Yes ☐ No ☐ N /A
15. Describe any other athletic or recreational activities that are planned and indicate any precautions that will be taken to ensure camper safety:
    _____
    _____

Glatfelter HEALTHCARE

DURABLE MEDICAL EQUIPMENT SUPPLEMENT (No. 4)

If this service is subcontracted, please confirm that Certificates of Insurance are required of the DME provider, and leave the remainder of the form blank:

☐ **Certificates Required** ☐ **Certificates Not Required**

1. **Name of Applicant:** _____
2. Do you supply medical equipment to only your patients? ☐ Yes ☐ No
   If "no," what percentage of annual revenue is derived from the general public? _____%
3. What services do you provide for this equipment? ☐ Sell ☐ Lease ☐ Repair medical equipment
4. Annual revenue from sales/leases/repairs: $ _____
5. Types of Durable Medical Equipment:
   Category III – Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines or sending devices.

   Number of inventory items in this category: _____

   Category IV – Life Sustaining or Critical Life Monitoring Equipment or Devices – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/fail or improperly function which could result in death or serious deterioration in health condition.

   Number of inventory items in this category: _____
6. Do you accept donated equipment? ☐ Yes ☐ No
   If "yes," is there an equipment maintenance policy in place for repairs and general maintenance? ☐ Yes ☐ No
7. Who trains your clients/families regarding proper operation of the equipment? _____
8. Do you provide written instructions to your customers? ☐ Yes ☐ No
9. Do your employees deliver equipment? ☐ Yes ☐ No
   If "yes," do you provide driver safety training to drivers? ☐ Yes ☐ No
10. Do you repackage, re-label, modify or manufacture any medical equipment or products? ☐ Yes ☐ No
11. Is all equipment checked and its condition documented prior to release? ☐ Yes ☐ No
12. Do you distribute oxygen cylinders? ☐ Yes ☐ No
    If "yes," are the cylinders pre-filled? ☐ Yes ☐ No
13. Do you subcontract labor for any maintenance, installation services or repair of medical equipment or supplies? ☐ Yes ☐ No

    If "yes," do you require Certificates of Insurance? ☐ Yes ☐ No

Note: If Property insurance is desired for durable medical equipment, please include these items under Business Personal Property on the Property Supplement No. 8.

Glatfelter HEALTHCARE

CHILD DAY CARE CENTER SUPPLEMENT (No. 5)

1. **Name of Applicant:** _____

2. Address of day care center: _____
(Street) (City) (State) (Zip Code)

3. Hours of operation: _____ Average daily attendance: _____

4. Is this a licensed day care facility? ☐ Yes ☐ No If "yes," what is the licensed capacity? (# of children): _____

5. Does the day care center comply with Board of Health regulations and building code requirements? ☐ Yes ☐ No

6. Ages of children: from _____ to _____

7. Are the director and staff members certified and trained? ☐ Yes ☐ No

8. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following:
   - ☐ Isolated settings
   - ☐ Individual meetings
   - ☐ Sleeping arrangements
   - ☐ Changing clothes/showering

9. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No

10. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No
If "yes,"please provide complete details:

_____

_____

11. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse?
☐ Yes ☐ No If "yes," please provide complete details:

_____

_____

12. Do you or your employees provide transportation to or from the facility? ☐ Yes ☐ No

13. Are children taken off-site for any activities? ☐ Yes ☐ No If "yes," who provides transportation?

_____

(If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.)

Glatfelter HEALTHCARE

ADULT DAY CARE SUPPLEMENT (No. 6)

1. **Name of Applicant:** _____

2. Address of adult day care center: _____
(Street) (City) (State) (Zip Code)

3. Hours of operation: _____ Average daily enrollment: _____

4. Is this a licensed adult day care facility? ☐ Yes ☐ No
If "yes," what is the licensed capacity? (# of clients): _____

5. Does the day care center comply with Board of Health regulations and building code requirements? ☐ Yes ☐ No

6. Are policies and procedures in place regarding one-on-one contact between staff and clients addressing isolated settings?
☐ Yes ☐ No

7. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No
If "yes," please provide complete details.

_____

_____

8. Have you ever had to administer any disciplinary action against any current or previous staff members because of improper care or treatment of clients? ☐ Yes ☐ No If "yes," please provide complete details.

_____

_____

9. Is there a Registered Nurse on-site? ☐ Yes ☐ No

10. Is fall prevention training provided? ☐ Yes ☐ No

11. Clients served: (Please check all that apply)
☐ Dementia ☐ Frail Elderly ☐ Mental Retardation/Developmentally Disabled ☐ Physically Disabled
☐ Chronic Mental Illness ☐ HIV/AIDS ☐ Brain Injury ☐ Other: _____

12. Services provided: (Please check all that apply)
☐ Therapeutic Activities
☐ Health-related services (medication administration, blood sugar testing, and weight monitoring, etc.)
☐ Activities of Daily Living ☐ Meals ☐ Medical Escort
☐ Nursing services (wound care, injections colostomy care, etc.)
☐ Respite ☐ Rehabilitation Therapy ☐ Hospice ☐ Emergency respite ☐ Overnight care

13. Do you or your employees/volunteers pick up or transport clients to or from your day care facility? ☐ Yes ☐ No

14. Describe security measures or precautions taken to protect adult day care clients and to prevent them from leaving your facility unattended. _____

_____

15. Have you ever had any prior incidents arising out of your day care facility that required notification to your insurance carrier, state or local authorities? ☐ Yes ☐ No If "yes," provide complete details.

_____

_____

Glatfelter HEALTHCARE

ERISA BOND APPLICATION SUPPLEMENT (No. 7)

1. **Name of Applicant:** _____

2. Plan Name: _____
(As filed with the Department of Labor)

3. Address: _____

4. Plan Assets: _____

Do any of the plans contain non-qualifying assets? ☐ Yes ☐ No

Do any of the plans contain employer securities? ☐ Yes ☐ No

5. Bond Amount:

☐ $25,000	☐ $125,000	☐ $350,000
☐ $50,000	☐ $200,000	☐ $400,000
☐ $75,000	☐ $250,000	☐ $450,000
☐ $100,000	☐ $300,000	☐ $500,000

Limit Other than Above: $_____

6. Effective Date: _____ No. of Trustees: _____
(3-year policy term)

7. Nature of Sponsor Business: _____

Agency (if applicable): _____

Prior Carrier: _____

Prior Losses (Past Three Years): _____

Completed by: _____

This Bond is a requirement of the Employee Retirement Income Security Act of 1974. The Act requires the assets of any Employee Benefit Plan to be insured against loss due to employee dishonesty in the amount of 10% of the plan assets. The Bond must be at least $1,000 and need not be greater than $500,000. Please keep this in mind when determining the bond amount.

An Inflation Guard endorsement is added to each ERISA bond. This endorsement automatically provides a limit of liability equal to that required by ERISA for your benefit plans (provided the amount required by ERISA is purchased at the policy's inception). As long as the bond is in force, the bond amount will be in compliance with the ERISA limit requirement and you will not have to monitor the amount, or request periodic increases, saving you time and money.

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.

Glatfelter HEALTHCARE

MEDICAL STAFFING SUPPLEMENT (No. 9)

1. **Name of Applicant:** _____

2. **Address:** _____
(Street) (City) (State) (Zip Code) (County)

I. STAFFING OPERATIONS

Please attach a copy of your Agency Staffing Agreement.

1. Do you staff any non-medical positions? ☐ Yes ☐ No
2. What type of staffing services do you offer? ☐ Per diem ☐ Temporary Staffing (less than one month) ☐ Long-term Staffing ☐ Temporary-to-Direct Hire Placement
3. Do you employ 100% of the individuals that you place for your clients? ☐ Yes ☐ No
4. Please estimate which of the following are your typical staffing clients: (Total must equal 100%)

☐ Hospitals / Health Systems	____%	☐ Non-skilled personal care agencies	____%
☐ Nursing Homes / Assisted Living Facilities	____%	☐ Hospices	____%
☐ Private Physician Practices	____%	☐ Social Services Agencies	____%
☐ Home Healthcare Agencies	____%	☐ Surgical Centers	____%
☐ Pharmacies	____%	☐ Other _____	____%

5. Please indicate the location(s) where staffing services are provided: ☐ Private Homes ☐ Hospitals ☐ Clinics ☐ Nursing Homes/ALF's ☐ Schools ☐ Outpatient Facilities ☐ Other _____
6. Do you also offer human resources consulting services on a fee-for-service basis? ☐ Yes ☐ No
   If "yes," what is your estimated annual revenue from these services? $ _____
7. What is your total estimated annual revenue from staffing for your current fiscal year? $ _____
   Last year? $ _____ **(If your revenue exceeds $5,000,000 please attach a copy of your latest audited financial statement)**

II. EMPLOYEE SELECTION

1. Do you perform employee background checks on staffed workers based on the requirements of the state or the healthcare facility? ☐ Yes ☐ No
2. Which of the following background check methods do you use?

	Staffed Workers
Current Licensure, certification, and registration	☐ Yes ☐ No
Criminal background checks	☐ Yes ☐ No
Present employment and two previous employers' verification	☐ Yes ☐ No
Pre-employment verification of convictions for abuse/neglect	☐ Yes ☐ No
Social Security number verification and search	☐ Yes ☐ No
Education	☐ Yes ☐ No
Home telephone/residency verification	☐ Yes ☐ No
Driver's license information (MVR) *if placement requires driving responsibilities*	☐ Yes ☐ No
Drug screening	☐ Yes ☐ No

3. Do your staffing contracts stipulate that you are responsible for performing criminal background checks? ☐ Yes ☐ No
4. Do you conduct face-to-face interviews with all prospective staffed workers? ☐ Yes ☐ No
5. Do you have a process in place to assure that the staffed worker's qualifications and competencies are consistent with job placement responsibilities? ☐ Yes ☐ No
6. Do you require that your clients orient the staffed workers to the facility setting, the unit, and policies and procedures on each staffing assignment? ☐ Yes ☐ No
7. Do you seek regular feedback from your clients on employee performance on all staffed workers? ☐ Yes ☐ No
8. Do you have a written description of your complaint process that is supplied to each of your clients? ☐ Yes ☐ No

9. Do you have a process in place for temporary staffed workers to contact you if they question the appropriateness of their assignment? ☐ Yes ☐ No
10. Do you provide ongoing education, including in-services and other activities? ☐ Yes ☐ No

III. RISK MANAGEMENT AND LOSS CONTROL

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

1. Do you carry Workers Compensation insurance? ☐ Yes ☐ No
2. Do you have processes in place for reporting and investigating allegations of hostile work environments? ☐ Yes ☐ No
3. Do you have a process in place to evaluate prospective clients before offering staffing services? ☐ Yes ☐ No
   If "yes," does this process include an on-site visit as well as a review of the facility's orientation program for staffed workers? ☐ Yes ☐ No
4. Do your staffing agreements include defined roles and responsibilities of both parties? ☐ Yes ☐ No
5. Do your staffing agreements include mutual hold harmless agreements? ☐ Yes ☐ No
6. Is the use of personal vehicles by staffed workers addressed in your agency staffing agreement? ☐ Yes ☐ No
7. Are staffing agreements reviewed by legal counsel? ☐ Yes ☐ No

IV. EMPLOYEE INFORMATION – ANNUAL STAFFING

1. Please provide the estimated number annual billable hours and annual payrolls for each type of staffed employee for the next twelve months. Do NOT include your own internal agency staff.

Employee Type (staffed workers)	Estimated Annual Billable Hours	Estimated Annual Payroll
Nurse (RN)		$
LPN		
Nurse Aide/ Nursing Assistant		
Home Health Aide		
Homemaker		
Social Worker		
Physical Therapist		
Speech Pathologist		
Occupational Therapist		
Pharmacy Assistant		
Lab Technician		
EKG Technician		
X-ray Technician		
Radiology Technician		
Medical Technician		
Certified Medical Assistant		
Dietician/Nutritionist		
Dialysis Technician		
Enterostomal Therapist		
Respiratory Therapist		
Phlebotomist		
Radiation Therapist		
Clerical/Administrative		
Other:_____ _____		
Total		$

Note: Staffing agencies which staff physicians, medical directors, physician assistants, surgeons, dentists, psychiatrists, residents, interns, externs, chiropractors, acupuncturists, nurse practitioners, nurse midwives, certified registered nurse anesthetists and pharmacists are not eligible for coverage

2. What percentage of these total staff workers are assigned to Critical Care, Emergency, Obstetrics, Radiology or Pediatric Departments? _____%
3. What percentage of your business includes staffing travel nurses? ☐ None ☐ _____%
4. Do you employ international healthcare workers on work visas? ☐ Yes ☐ No
5. Do you place staffed workers in prisons or correctional facilities? ☐ Yes ☐ No