

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

Return completed application to
submissions@glatfelterhealthcare.com



Underwritten by: National Union Fire Insurance
Company of Pittsburgh, Pa. (for admitted business)

HOME HEALTH CARE AGENCY APPLICATION

In addition to this Application, please submit the following supplemental applications if applicable:

- 5 years of currently valued carrier loss run reports
- State Survey Report, Plan of Correction and Acknowledgement
- Resume of Administrator, CEO, COO, Owner or Other Key Employee (if in business less than three years)

New Business Application is required for first year only.

A pre-filled Renewal Questionnaire will be provided for subsequent renewals.

GENERAL INFORMATION

Date Proposal Needed By:

Policy Effective Date:

Professional Liability: Claims-made – Current Retroactive date:

Occurrence

General Liability: Claims-made – Current Retroactive date:

Occurrence

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

Deductible:

No Deductible

Current Carrier:

Number of years in operation:

Legal Name of Organization:

Additional Named Insureds and a brief description of their operations (attach additional schedule as needed):

Address:

Street or PO Box	City	County	State	Zip Code
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Mailing Address:

Street or PO Box	City	County	State	Zip Code
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FEIN:

Website:

Contact Information:

Primary:

Name	Phone	Email
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Inspection:

Name	Phone	Email
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Legal Status	Non-profit	For-profit	Governmental
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Organization Structure	Corporation Joint Venture	Partnership Limited Liability Company	Privately/Individually-owned Other:
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Home Health Care Services	Do you engage in any business other than home health care services? If yes, please explain:	Yes	No
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Operations	Total annual operating budget: \$ If revenue exceeds \$5,000,000 please attach a copy of your last audited financial statement.					
	Are you accredited by?	JCAHO	CHAP	ACHC	NCQA	COA
	Are you Medicare certified?				Yes	No
	<u>Licensure</u>					
	Are you required to be licensed in any states in which you operate? If yes, in what state(s) are you currently licensed?				Yes	No
	Are any license applications currently pending? If yes, what state(s) are pending?				Yes	No
	Does your organization participate in the State Patient Compensation Fund?				Yes	No
	Has there been any mergers, acquisitions or consolidations within the last 10 years? If yes, please provide the name(s) of the organization(s) and the date of acquisition:				Yes	No
	Has the applicant or any of its subsidiary organizations ever filed for bankruptcy?				Yes	No
	Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions:					

Employee Information	Number of Employees - Full-time:		Number of Employees - Part-time:			
	Number of Volunteers:					
	What percentage of staff is composed of temporarily assigned personnel acquired through staffing agencies?					%
	Which of the following background check methods do you use?		<u>Employees</u>		<u>Volunteers (if any)</u>	
	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): Only required if the employee/volunteer operates a company vehicle or their personal vehicle on the organization's behalf.		Yes	No	Yes	No
Is annual training provided and attendance documented for all employees and volunteers? If yes, briefly describe your in-service training program:				Yes	No	

Risk Management and Loss Control	Does your organization have a formal written Quality Assurance/Performance Improvement or Risk Management program? If yes, name and title of person responsible for program:				Yes	No
	Do you have an active Safety Committee? If yes, how often does the Safety Committee meet?				Yes	No

Loss History	In the past 5 years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? If yes, please explain:	Yes	No
	Are there any claims, suits, legal proceedings, or investigations against you or your subsidiaries that have <u>not</u> yet been reported to your former insurance carrier? If yes, please provide details on a separate document.	Yes	No
	Is the applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? If yes, please explain:	Yes	No
	In the past 5 years, has any insurance carrier cancelled or refused coverage? (Missouri applicants are not required to reply) If yes, please provide the reason for cancellation:	Yes	No
	Within the last 3 years has your organization been a part of any civil or criminal litigation or arbitration proceeding? If yes, please provide details on a separate document.	Yes	No
	If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date?	Yes	No

Contracted Services	Do you engage the use of independent contractors to provide any services? If yes, complete the following questions:	Yes	No			
	What percentage of revenue is provided by independent contractors? %					
	Do you require a written contract with hold harmless and indemnification language in your favor?	Yes	No			
	Do you require independent contractors list you as an additional insured on their liability policy?	Yes	No			
	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			
	Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements?	Yes	No			
	Service	Limit of Liability		Service	Limit of Liability	
	Dental:	Yes	No \$	Mental Health:	Yes	No \$
	Pharmaceutical:	Yes	No \$	Physical Therapy:	Yes	No \$
	Occupational Therapy:	Yes	No \$	Speech Therapy:	Yes	No \$
Dietary:	Yes	No \$	X-Ray:	Yes	No \$	
Medical Records:	Yes	No \$	Laboratory:	Yes	No \$	
Recreational Services:	Yes	No \$	Social Services:	Yes	No \$	
Barber/Beautician:	Yes	No \$	Transportation:	Yes	No \$	
Food:	Yes	No \$	Laundry:	Yes	No \$	
Other:		\$	Other:		\$	

Credentiaing	Do you have a formalized and written credentialing process?				Yes	No
	Is there a recredentiaing process?				Yes	No
	Does your physician credentialing process include primary source verification of:					
	Physician/Nurse Practitioner licensure		Training and Experience		Certifications	
	DEA registration		Education			
	Do your physician files include:					
	Completed application		Criminal background check		NPDB query (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					
	Has there ever 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:					
	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:					
Does your organization require that contracted physicians/nurse practitioners maintain primary professional liability insurance?				Yes	No	
If yes, what are the minimum professional liability limits required?				Not Applicable		
If yes, is proof of coverage (Certificate of Insurance) required?				Yes	No	
What is the total number of physicians/nurse practitioners in your organization? (Please include volunteers and independent contractors.)						
Do any physicians participate in a state Patient Compensation Fund (PCF)?				Yes	No	
If yes, please include a copy of the PCF Certificate of Insurance.						
Physician and Nurse Practitioner Schedule						
				<u>Primary Insurance Elsewhere</u>		
				Answer "yes" if Physician or Nurse Practitioner maintains primary liability insurance elsewhere which would respond to an incident or claim while performing duties on your behalf.		
<u>Name / Title</u>		<u>State of</u>	<u>Employed (E)</u>	<u>Average</u>		
<small>(Include each Physician and Nurse Practitioner)</small>		<u>Licensure</u>	<u>Volunteer (V) or Independent Contractor (IC)</u>	<u>Hours per Month</u>		
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	
				Yes	No	

Home Health Care Services (Please check all that apply.)		
Skilled Home Health Care Services	Number of total patient visits Last 12 months: _____ Next 12 months: _____	
	Number of skilled home health care patients to be treated Last 12 months: _____ Next 12 months: _____	
	Locations where services are provided: Private Homes Hospitals Clinics Nursing Homes /ALFs Schools Outpatient Facilities Other: _____	
Community Wellness Programs	Number of immunizations: _____	
Non-skilled Services Do not include ADL services provided by skilled personnel.	Annual number of clients: Number of clients provided with 24-hour "live in" care: _____	
Home Health Services for Children	Percentage of your total revenues that includes pediatric care: _____ %	
Additional Services	Adult Day Care Complete Adult Day Care Supplement	Case Management
	Child Day Care Complete Child Day Care Supplement	Gastrostomy Tube (GT) Care
	Infusion Therapy	Medical Equipment Supplier Complete Durable Medical Equip. Supplement
	Medical Social Services	Obstetrical Services
	Palliative Care Number of Annual Visits: _____	Pharmacy Complete Pharmacy Supplement
	Rehab Services (PT,OT, Speech Therapy)	Respiratory Therapy
	Respite Care	Special Care (Alzheimer's/Dementia, etc.)
	Supplemental Staffing Complete Medical Staffing Supplement	Telehealth
	Thrift Shop Annual Gross Sales: \$ _____	Consumer Directed Care Employee Family Member Independent Contractor
	Other: _____	

Hired and Non-owned Auto Liability	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	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 Auto policy.		
	Does your organization have positions where driving personal vehicles is a job function essential to the position?	Yes	No
	Do you have a policy in place which addresses driving requirements for employees and volunteers?	Yes	No
	Does this policy include specific hiring criteria applicable to new drivers who operate their personal vehicles on your behalf?	Yes	No
	Does your pre-employment hiring process include driver screening?	Yes	No
	Does this process include ordering Motor Vehicle Reports prior to hire?	Yes	No
	Does your policy include a process for removing drivers with unsatisfactory driving records from their driving duties?	Yes	No
	Does this process include verification of the state's minimum financial responsibility limits?	Yes	No
	Does your policy permit patient/client transport in personal vehicles? If yes, what personal auto liability limits do you require? \$ _____ / \$ _____ or \$ _____	Yes	No CSL
	Does your policy permit use of the patient or client's vehicles? If yes, is the caregiver required to verify the client maintains auto liability insurance?	Yes	No
	Does your organization offer training on safe driving practices?	Yes	No

Sexual Abuse Liability	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	Retroactive Date:	<i>Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.</i>	
	Do you order Criminal Background Checks including Sexual Abuse Registry on the following?		
	Employees:	Yes	No
	Volunteers:	Yes	No
	Agency personnel:	Yes	No
	Does your organization have a written "zero tolerance" sexual abuse and molestation policy?	Yes	No
	If yes, 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	
Are all employees/volunteers required to acknowledge having read and comprehended the policy?	Yes	No	
Is annual training on the policy completed and acknowledged?	Yes	No	
Have you ever had any prior incidents, allegations or claims involving sexual abuse?	Yes	No	
If yes, please provide details:			

Employee Benefits Liability	\$25,000 each employee/\$25,000 aggregate is automatically provided. If you are requesting higher limits, please indicate:		
	\$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

Employer's Liability Coverage	If your Workers Compensation coverage does <u>not</u> provide Employer's Liability (ND, OH, WA, WY), do you want Employer's Liability coverage?			Yes	No
	If yes, provide total annual payroll: \$				
	"Bodily Injury" by accident each accident	"Bodily injury" by disease policy limit	"Bodily injury" by disease each "employee" or volunteer		
Limits desired:					

Cyber Liability and Privacy Crisis Management Expense	Are you requesting this coverage? If yes, complete the questions in this section.	Yes	No
	Retroactive Date: <i>Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.</i>		
	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		
	Cyber Extortion Expense reimburses for expenses you incur as a result of a cyber extortion threat first made against you during the policy period. A \$20,000 limit applies to Each Cyber Extortion Threat, subject to the Privacy Crisis Management Expense Aggregate.		
	Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks?	Yes	No
	Do you use antivirus software on all desktops, portable computers and mission critical servers?	Yes	No
	Are antivirus applications updated in accordance with the software provide's requirements? How often?	Yes	No
	Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access?	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:	Yes	No
Do you have a written information security and privacy policy?	Yes	No	

REAL & PERSONAL PROPERTY

Yes

No

Complete this section or you may submit a Property ACORD application.

Coverage desired: Scheduled Property (Non-Blanket) Blanket Per Premises (Property and Contents) Policy Blanket
 Deductible desired: \$500 \$1,000 \$2,500 \$5,000 \$10,000 \$15,000 \$25,000 \$50,000 Other: \$

Loss of Income: \$250,000 is automatically included. If a higher limit is being requested, please indicate: \$	Extra Expense: \$250,000 is automatically included. If higher limit is being requested, please indicate: \$
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CONSTRUCTION CODES

1 Frame 2 Joisted Masonry	3 Non-combustible 4 Masonry Non-combustible	5 Modified Fire Resistive 6 Fire Resistive	7 Concrete 8 Steel	9 Reinforced Masonry
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ROOF CODES (0 = Unknown)

Covering	1 Metal sheathing with exposed fasteners 2 Metal sheathing with CONCEALED fasteners	3 Built-up roof or single-ply membrane WITH gutters 4 Built-up roof or single-ply membrane WITHOUT gutters	5 Concrete/clay tiles 6 Wood shakes	7 Shingle - 55 mph wind rating 8 Shingle - 55 mph wind rating/Secondary Water Resistance (SWR)	9 Shingle - 110 mph wind rating 10 Shingle - 110 mph wind rating/Secondary Water Resistance (SWR)
Geometry	1 Flat Roof WITH Parapets 2 Flat Roof WITHOUT Parapets	3 Hip Roof with Slope <= 6:12 (26.5°) 4 Hip Roof with Slope > 6:12 (26.5°)	5 Gable Roof with Slope <= 6:12 (26.5°) 6 Gable Roof with Slope > 6:12 (26.5°)	7 Braced Gable Roof with Slope <= 6:12 (26.5°) 8 Braced Gable Roof with Slope > 6:12 (26.5°)	
Anchors	1 Toe Nailing/No Anchorage	2 Clips	3 Single Wraps	4 Double Wraps	5 Structural

Premises #	Item #	Street Address City / State / Zip / County	Building Occupied as:	Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations.		Year Built	# Sq Feet	Building Area You Occupy	# of Stories	Protection Class	Construction Code	Sprinkler System Y/N	Vacant Y/N	Date of Last Inspection	Year of Mech System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors	Type of Fire or Other Alarms
				Building	Contents															
		/																		
		/																		
		/																		
		/																		

Premises #	Item #	Street Address City / State / Zip / County	Building Occupied as:	Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations.		Year Built	# Sq Feet	Building Area You Occupy	# of Stories	Protection Class	Construction Code	Sprinkler System Y/N	Vacant Y/N	Date of Last Inspection	Year of Mech System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors	Type of Fire or Other Alarms
				Building	Contents															
		/																		
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		/																		
		/																		

Other occupants?	Are there any other occupants in the buildings you occupy?			Yes	No
	Premises #	Item #	List of Other Occupants		

Mortgagee	Name: Street: City:							State:	Zip:
Applies to Premises/Item #s:	/	/	/	/	/	/	/	/	

Mortgagee	Name: Street: City:							State:	Zip:
Applies to Premises/Item #s:	/	/	/	/	/	/	/	/	

What Coverages and Limits do you require?	Accounts Receivable:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Debris Removal:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Outdoor Property	\$150,000 (automatically included)	Increase Limit \$
	Property in Transit or Off Premises:	\$100,000 (automatically included)	\$250,000
	Software:	\$500,000 (automatically included)	Increase Limit \$
Trees, Shrubs, Plants and Lawns:	\$25,000 (automatically included)	Increase Limit \$	
Valuable Papers and Records:	\$100,000 (automatically included)	\$250,000	
	\$500,000	\$1,000,000	

What Coverage Options do you want to purchase?	Scheduled Fine Arts:	Yes (attach schedule)	No
	Special Property Floater:	Yes (attach schedule)	No
	Equipment Breakdown including:		
	Spoilage:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Hazardous Substance:	\$250,000 (automatically included)	\$500,000
		\$1,000,000	
	Expediting Expense:	\$100,000 (automatically included)	\$250,000
		\$500,000	\$1,000,000
	Flood Coverage:	Yes Limit \$ Include Real Property/BPP/LOI/EE Include BPP/LOI/EE	No
Earthquake Coverage:	Yes Limit \$ Include Real Property/BPP/LOI/EE Include BPP/LOI/EE	No	

CRIME Yes No

Limits Option requested? (Select one of the following)

Limits Option	Employee Theft	Forgery or Alteration	Temporary Increased Limits for Special Events			Computer & Funds Transfer Fraud	Money Orders	Fraudulent Impersonation
			Inside the Premises		Outside the Premises			
			Theft of Money & Securities	Robbery/Safe Burglary				
1	\$10,000	\$10,000	\$10,000	\$5,000	\$10,000	\$20,000	\$10,000	\$10,000
2	\$25,000	\$25,000	\$25,000	\$5,000	\$25,000	\$20,000	\$10,000	\$10,000
3	\$50,000	\$50,000	\$50,000	\$5,000	\$50,000	\$50,000	\$25,000	\$25,000
4	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$100,000
5	\$250,000	\$250,000	\$250,000	\$100,000	\$250,000	\$250,000	\$250,000	\$250,000
6	\$400,000	\$400,000	\$400,000	\$100,000	\$400,000	\$400,000	\$250,000	\$250,000
7	\$500,000	\$500,000	\$500,000	\$100,000	\$500,000	\$500,000	\$250,000	\$250,000
8	\$1,000,000	\$1,000,000	\$1,000,000	\$100,000	\$1,000,000	\$500,000	\$250,000	\$250,000
9	\$2,000,000	\$1,000,000	\$1,000,000	\$100,000	\$1,000,000	\$500,000	\$250,000	\$250,000

Deductible requested? (Deductibles above \$1,000 are only available with Limits Options 5, 6, 7, 8 and 9.)

\$250	\$1,000	\$5,000	\$15,000
\$500	\$2,500	\$10,000	\$25,000

Indicate what security provisions apply and identify how often:

Audit	Reconciliations
Bank statements	Other
Countersignature	

Temporary Increased Limit for Special Events	Is temporary increased limit requested for inside and outside premises for special events?		Yes	No
	Limit Requested	Description of Event	# of days	

AUTO Yes No

Complete this section or you may submit an Auto ACORD application.

What Coverages and Limits do you desire?	Liability Limit (Combined Single Limit):	\$300,000	\$500,000	\$1,000,000	Deductibles:	
	Uninsured/Underinsured Motorists Limit:					Comprehensive: \$500 \$1,000 \$2,000 \$3,000 \$5,000
	PIP Limit:	Med Pay Limit:				Collision: \$500 \$1,000 \$2,000 \$3,000 \$5,000
	Hired and Non-owned Liability coverage desired? Yes No					

VEHICLE CLASSIFICATION				
Private Passenger	Truck – Service	Truck – Retail	Truck – Commercial	Van
Bus	Service/Utility Trailer	Mobile Equipment	Golf Cart	Other

Veh #	Year	Make	Description (Model / Type)	Vehicle Classification	Vans and Buses		Serial Number (VIN)	Cost New ACV	Garaged at Premises #
					Seating Capacity	Radius in Miles			
EX.	2020	Nissan	Altima	Private Passenger	1-5	0-50	1BAAGCSA9XF082111	\$24,000	1
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Do you have any Customized vehicles?	Have any vehicles been customized from a previous use? Yes No	Describe:
	If yes, indicate vehicle number(s):	

Add'l Insured Lessor Loss Payee	Name:	City:	State:	Zip:
Applies to Vehicle #'s:	Street:			

Add'l Insured Lessor Loss Payee	Name:	City:	State:	Zip:
Applies to Vehicle #'s:	Street:			

Auto Fleet Management Information	Do you pre-screen all drivers before they are permitted to drive your vehicles?	Yes	No	
	Do you have procedures in place to regularly check their Motor Vehicle Records?	Yes	No	
	Do you have specific criteria in place used to evaluate driver acceptability?	Yes	No	
	Do you provide driver training?	Yes	No	
	Do your drivers meet CDL requirements based on the vehicle's passenger capacity?	Yes	No	N/A
	Do you provide non-emergency patient transportation in your owned vehicles? If yes, please describe:	Yes	No	
	Do you have a formalized documented vehicle safety program which includes vehicle preventative maintenance and required safety inspections?	Yes	No	
	Do you own or use any 15 passenger vans? If yes: Have vans been modified with dual rear wheels or changed seating capacity? If yes, describe:	Yes	No	
	Are van models prior to 2009 equipped with Electronic Stability Controls?	Yes	No	N/A
	Is there a requirement that vans are not overloaded? Is there a requirement that no loads are placed on the roof of the vans?	Yes	No	

HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY **Yes** **No**

If your organization is a non-profit organization and coverage is being requested, please complete a **Healthcare Organization Management Liability Application**.

EXCESS LIABILITY **Yes** **No**

What Coverages and Limits do you desire?	Limits desired: \$ occurrence / \$ aggregate
	<p>Note: Underlying liability limits of \$1,000,000 are required. All underlying coverage to be scheduled must be provided by the program. Exceptions are permitted for Employer's Liability coverage. For Employer's Liability Coverage insured elsewhere, provide the following:</p> <p>Policy Number: _____ Effective Date: _____ Policy Limits: _____ Carrier Name: _____</p>

OCCUPATIONAL ACCIDENT / BUSINESS TRAVEL ACCIDENT **Yes** **No**

If your organization is a non-profit organization and coverage is being requested, please complete the **Supplement on our website**.

WRAP-UP INFORMATION

Any significant changes to your organization during the policy year must be reported to Glatfelter Underwriting Services, Inc. to ensure coverage.

Name of Producing Agency:	_____
Agency's Address:	_____
Agency's Phone:	_____
If you are not licensed as a broker, are you a property/casualty agent?	Yes No
Producer or CSR (for contact purposes): Name:	_____
Email:	_____
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:	_____

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 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:

HOSPICE BEREAVEMENT CAMP SUPPLEMENT

(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
15. Describe any other athletic or recreational activities that are planned and indicate any precautions that will be taken to ensure camper safety:

MEDICAL STAFFING SUPPLEMENT

1. Name of Applicant:

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 |
| Schools | Outpatient Facilities | Other |
| Nursing Homes/ALF's | | |
| 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) | | |

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? | <u>Staffed Workers</u> | |
| Current Licensure, certification, and registration | Yes | No |
| Criminal background checks | Yes | No |
| Sexual Abuse Registry 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) <i>if placement requires driving responsibilities</i> | 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 question the appropriateness of their assignments? Yes No
 10. Do you provide ongoing education, including in-services and other activities? Yes No

RISK MANAGEMENT AND LOSS CONTROL

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 it include an on-site visit and 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

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