Admiral INSURANCE GROUP | a Berkley Company

HOME HEALTHCARE, HOSPICE AND STAFFING PROFESSIONAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of Applicant: (Include all dba's and subsidiaries seeking coverage under the policy for which you are applying)

2) Mailing Address:

3) Website Address:

4) Date Established (mm/dd/yy):

5) Type of Entity:

☐ Corporation ☐ Partnership ☐ Individual ☐ LLC ☐ Other (Specify):

6) Is this entity owned by, associated with or controlled by any other entity? ◯ Yes ◯ No

If yes, provide details:

7) Type of Firm (check all that apply):

☐ Home Health Care Agency ☐ Visiting Nurse Agency ☐ Nurse Registry ☐ Hospice

☐ Staffing Company (not including physician staffing) ☐ Other (Specify):

8) Location of where services are provided (total must equal 100%):

☐ % Patient's Home ☐ % Stand Alone Hospice ☐ % Nursing Home ☐ % Assisted Living Facility

☐ % Clinic ☐ % Physician's Office ☐ % Hospital ER ☐ % Hospital OB

☐ % Hospital ICU ☐ % Hospital Other ☐ % Surgery ☐ % Schools

☐ % Other (please explain):

9) Are you aware of any of your services provided in, or under contract with a facility or entity that you own, operate or are somehow affiliated with? ◯ Yes ◯ No
If yes, provide details:

10) Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ◯ Yes ◯ No
If yes, provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

SECTION II – EXPOSURES

11) Gross Revenue:

Projected for Next 12 Months	Current Year to Date	1st Year Prior	2nd Year Prior $
$	$	$	

12) Does your practice include Pain Management? ◯ Yes ◯ No

If yes, specify the percentage of your practice derived from Prescription Only Pain Management. ____ %

13) Does your practice include prescribing of opioids? ◯ Yes ◯ No

If yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: ____ %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? ◯ Yes ◯ No
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? ◯ Yes ◯ No

d. Do you also dispense the opioids? ◯ Yes ◯ No

14) Provide the number of employees or independent contractors:

	Number of Employees	Number of Independent Contractors	Annual Billable Hours
Certified Nurse Assistant			
Companion/Home Health Aide			
Counselors (MFT & PhD)			
CRNA			
Dieticians/Nutritionists			
Licensed Practical Nurse			
Live-In Companions			
Nurse Practitioner			
Occupational Therapists			
Personal Care Attendants			
Pharmacists & Pharm Assistants			
Physical Therapists			
Physician Assistant			
Registered Nurse			
Respiratory Therapists			
Social Worker			
Speech Therapists			
Volunteers			
Others (Please Explain)			

15) Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)		
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)		
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)		
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)		

16) Provide the Percentage of your patients/clients that are any of the following:

(Does not need to equal 100%)

Developmentally Disabled		%	Pediatric Care		%
Hospice Care		%	Personal Care		%
IV / Infusion Therapy		%	Prenatal Care		%
Live In Care – Non Ambulatory		%	Respiratory Therapy		%
Live In Care – Ambulatory		%	Skilled Nursing Care		%
OB Services		%	Wound Care		%

17) If providing Hospice Services, please detail below, otherwise check this box: ☐ Do not provide Hospice Services

a. Number of home care visits:

b. Number of inpatient licensed beds:

c. Are the inpatient beds included above located in a nursing home or assisted living facility? ◯ Yes ◯ No ◯ N/A

If yes, provide details:

SECTION III – RISK MANAGEMENT

18) Are you accredited by any accrediting organizations? ◯ Yes ◯ No

If yes, provide details:

19) List the associations in which you are a member:

20) Explain your Quality Assurance and Risk Management Program:

21) Are background checks performed for all employees, independent contractors and volunteers? ◯ Yes ◯ No

If yes, what level or type are the criminal background checks:

☐ County ☐ State ☐ Federal ☐ Sexual Offender Registry

If no, provide details:

22) Are all employees, independent contractors and volunteers screened for drugs and alcohol? ◯ Yes ◯ No

If yes, how often are screens performed?

23) How are patients referred to your firm?

24) Does each patient have their own attending physician? ◯ Yes ◯ No

If no, provide details:

25) Do you have a Medical Director? ◯ Yes ◯ No

If yes, provide the following details:

a. What is the name and specialty of your Medical Director?

b. Does the Medical Director provide direct patient care? ◯ Yes ◯ No

i. If yes, does the Medical Director carry a medical malpractice policy? ◯ Yes ◯ No

ii. What limits of liability are carried?

c. Does the Medical Director have supervisory duties over allied healthcare professionals? ◯ Yes ◯ No

If yes, provide details:

26) Do you have back-up procedures if assigned staff is not able to make a scheduled visit? ◯ Yes ◯ No

27) Do you require any of your independent contractors to carry professional liability? ◯ Yes ◯ No

If yes, provide details:

28) Do you have a policy in place to prevent sexual abuse or allegations of sexual abuse? ◯ Yes ◯ No

If yes, explain and advise how often it is reviewed:

SECTION IV – HIRED AND NON-OWNED AUTO

29) Number of employees, volunteers or contractors driving their personal auto in connection with your business:

a. Regular use of personal auto

b. Occasional use of personal auto

30) What percentage of the drivers are under 25 years old? %

31) Are MVR's checked for all drivers? Yes No

If yes, how frequently?

32) Are all drivers required to carry the state mandated minimum limits? Yes No

33) Do any drivers have either moving violations or accidents totally more than two in the past 3 years or more than three in the past 5 years? Yes No

If yes, provide details:

34) Do you prohibit driving if a driver is unlicensed, has a suspended/revoked license or has a major conviction such as DUI/DWI, reckless driving, leaving the scene or other similar driving conviction? Yes No

35) Do drivers transport patients:

a. In the client's vehicle? Yes No

If yes, provide details:

b. In the driver's vehicle? Yes No

c. Explain the frequency and circumstances of any transporting of clients:

36) Do you have any owned, leased or hired autos used in your business? Yes No

If yes, provide details:

a. What is the estimated number of hired autos on an annual basis?

b. How will hired autos be used?

% Regular Sales/Service Calls % Business Trips

% Transportation of Clients/Patients % Others

37) Have any auto claims been made or occurrences reported during the past five years? Yes No

If yes, provide auto loss runs and complete descriptions, open/close status, payments and reserves for each claim.

SECTION V – CURRENT COVERAGE

38) Provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

Company	Policy Term	Limits of Liability	Retro Date	Premium

39) What is the retroactive date on your current policy?

40) Is the applicant currently insured under a Commercial General Liability policy? ◯ Yes ◯ No

If yes, attach a copy of the declarations page.

SECTION VI – CLAIMS

41) Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? ◯ Yes ◯ No

If yes, please provide details including name of carrier and date:

42) Has any claim ever been made against the applicant or any of its employees? ◯ Yes ◯ No

If yes, complete the Supplemental Claim Information Form for each and every claim.

43) Is the applicant aware of any circumstances which may result in any claim against them or their employees? ◯ Yes ◯ No

If yes, provide full details on each incident including name of parties involved, date of treatment and current status of incident:

Please attach the following information:

- Advertisements, brochures, descriptive literature
- Informed consent document

Provide any additional details in the space provided:

RESET SAVE PRINT EMAIL

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD only.

Applicable in CO: 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.

Applicable in FL and OK: 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)*. * Applies in FL only.

Applicable in KS: 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 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 which 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.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.