

Renewal Application for Insurance Coverages for Health Care Organizations

Coverage provided by:

Name of Insurance Company To Which Application is Made

INSTRUCTIONS:

1. Answer all questions completely for desired coverages.

2 For answers that require more space: Electronic adobe fields will provide multiple lines where the applicant may need more space. If this form is submitted by fax or printed copy, continue question on your company letterhead and indicate the question number.

****4. This form must be electronically signed by a Principal or Officer of the firm.

****5. Attach current annual financial statements.

Check here to Apply for the Following Coverages:

- | | | |
|---|--|---|
| <input type="checkbox"/> Professional Liability | <input type="checkbox"/> General Liability | <input type="checkbox"/> Non-owned Auto Liability |
| <input type="checkbox"/> Products Liability | <input type="checkbox"/> Fidelity Bond | <input type="checkbox"/> Excess Coverage |

Applications available upon request

- | | | |
|---|--|--|
| <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Director's and Officer's Liability / EPLI Liability | <input type="checkbox"/> Employee Benefits Liability |
| <input type="checkbox"/> Property - Acord Application | <input type="checkbox"/> EDP Coverage - Acord Application | |

I. APPLICANT INFORMATION

a) Firm Name:

(if more than one entity/subsidiary, please attach description and % owned for each)

b) Address:
Street Address PO Box

City State Zip County

c) Total # of Employees: d) Total Annual Gross Receipts:

e) Medicare Provider Number (if applicable): f) FEIN Number:

Please advise if you have had any changes with Items II-IV **below** from the previous year:

II. HIRING/SCREENING AND CREDENTIALING PROCEDURES (may not be applicable in all states)

If changes, please explain:

III. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

If changes, please explain:

IV. RISK MANAGEMENT/QUALITY IMPROVEMENT

If changes, please explain:

V. CLAIMS HISTORY

Is the applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical records)?

If yes, please explain:

**PROFESSIONAL LIABILITY SECTION
(THIS SECTION MUST BE COMPLETED) ***

I. EMPLOYEES - ANNUAL STAFFING:

Employee Type	# Full Time	# Part Time	Annual Hours	Annual Payroll
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide/CNA				
Homemaker				
Sitter/Companion				
Physician				
X-Ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Doula				

other spec

II. INDEPENDENT CONTRACTORS - ANNUAL STAFFING:

Contractor Type	# 1099s	Annual Hours	Amount Paid per 1099s
Nurse (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Home Health Aide/CNA			
Homemaker			
Sitter/Companion			
Physician			
X-Ray Technicians			
Medical Directors			
Pharmacy Ass't/Techs			
Doula			

(other specify)

* If applicant offers services in more than one state, please provide total annual hours and payroll by state.

III. TYPES OF LOCATIONS WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)

Service	%	Service	%
Private Homes		Clinics	
Nursing Homes/Asst/Independent Living		Doctor's Offices	
Hospitals		Laboratories	
Prison Facilities			
Schools		(specify other location)	
		Total must equal 100%	

GENERAL UNDERWRITING SECTION

(Please complete for ALL lines of coverage)

I. OWNED OR LEASED PREMISES

Please attach a separate list of any changes since the previous year to your other locations owned, rented, and operated (including those sold, acquired, or discontinued). Include occupancy of each and list: address of each location; state if you own or lease the location; and describe the occupancy of each building.

List all changes to entities to be named as Additional Insureds with names and insurable interest:

Name(s)	Address	Insurable Interest

a) Is the applicant considering any changes in operations or products handled in the next 12 months?

PRODUCTS LIABILITY SECTION I. MEDICAL

EQUIPMENT/SUPPLIERS.

a) Does the applicant SELL any medical supplies and or/ equipment? Yes No

Total Annual Sales:

b) Does the applicant provide pharmaceutical products? Yes No

Total Annual Sales:

c) Does the applicant RENT or LEASE any medical supplies and/or equipment? Yes No

Total Annual Lease/Rental Receipts:

d) Does the applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? Yes No

Total Annual Repair/ Maintenance Receipts:

Total Annual Repair/ Maintenance Payroll:

PRODUCTS LIABILITY SECTION

I. MEDICAL EQUIPMENT/SUPPLIERS.CONTINUED

e) Does the applicant manufacture any products? Yes No

f) In the past twelve months, has the applicant gone through a change as a medical equipment supplier or is planning to change in the next twelve months? Yes No

If yes, please explain

II. MAINTENANCE AND/OR REPAIR OF EQUIPMENT

a) Does the applicant SELL other supplier's used equipment? Yes No

If yes, please list the gross revenue derived from this operation:

b. Does the applicant REPAIR other supplier's used equipment? Yes No

If yes, please list the gross revenue derived from this operation:

c. Please list all types of equipment you repair:

FIDELITY COVERAGE SECTION

I. LIMIT REQUESTED: \$ (minimum limit is \$10,000)

II. INTERNAL CONTROLS:

Have there been any changes to the internal control procedures since last year? Yes No

Non-Owned Automobile SECTION

1) Does the applicant have any company owned vehicles? Yes No

2) How many of the applicant's employees drive their own vehicles during the course of business other than driving to and from a single work site? Please include those employees which drive to multiple work-sites in a single work day.

Yes No

3) Does the applicant require Employees to carry their own automobile liability insurance coverage?

a) If yes, what personal automobile liability limits does the applicant require employee drivers to carry?

b) How does the applicant verify the Employee owned automobile liability insurance coverage is in force?

Non-Owned Automobile SECTION Continued

4) Do any of the applicant's employees drive Client owned vehicles during the course of your business? Yes No

a) How does the applicant verify Client owned automobile liability insurance coverage is in force

5) Does the applicant access and review Motor Vehicle Reports as a condition of employment? Yes No

a) If yes, how frequently is this review conducted

b) What standards are applied to qualify an acceptable employee driver?

6) Do any of the applicant's employees provide client transportation services? Yes No

7) What protocols has the applicant put in place to manage the use of employees and client owned vehicles during the course of applicant's business (i.e., written authorization for use of vehicle, specified acceptable use of vehicles radius of use, frequency of use, passenger restrictions)?

Please provide a copy of your firm's protocols.

8) Does the applicant require evidence of regular preventative maintenance? Yes No

9) Does the applicant require participation in a safe/defensive driver training/education program? Yes No

10) Does the applicant provide or require completion of medical emergency training for transportation of clients? Yes No

THIS SECTION TO BE COMPLETED BY ALL APPLICANTS

I/WE herby declare that the above statements and particulars are true to the best of my/our knowledge and that I/we have not suppressed or misstated any material facts and I/we agree that this application shall be the basis of the contract with the Company. If a policy is issued, this application will be attached to and become part of the policy.

NOTICE TO APPLICANTS: 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.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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 AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: 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 IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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 (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: 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 MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: 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 MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the applicant to purchase the insurance.

Applicant Firm Name:
Signature: Date:

(Must be signed and dated by Principal or Officer of Firm):

Title:

PRINT NAME (Required if printed/faxed and not signed/submitted electronically)

Agent/Broker Information:

Agency Name:

Contact Name:

Street Address:

City, State, Zip:

Telephone: Fax:

Agent/Broker Email: Agent/Broker License: