PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR HOME HEALTH CARE AGENCIES and MEDICAL PERSONNEL STAFFING SERVICES (Edition 04.01.24)

1. Name of Applicant: ____

2. Mailing Address: ____

3. Location Address: ____
(If multiple name and locations, please attach list)

4. Telephone Number: ______________________ Fax Number: ______________________

5. a.) Date Established: _______________

   b.) Entity Type: Corp.: ________ Partnership: _________ Prof. Assoc.: ________ Individual: _________

   c.) For Profit: ________ Non-Profit: _______

6. Funding is: Medicare: _________% Medicaid: _________% Private Pay: _________%

7. a.) Desired Effective Date: ____________________

   b.) Desired Limits of Liability: $ ________________ / $ _________________

   c.) Desired Deductible: $ _______________

8. a.) Gross Receipts for the Past 12 Months: $ ___________________

   b.) Gross Receipts Estimated for the Next 12 Months: $ ____________________

9. Entity is: Home Health Agency (medical services): __________ % (non-medical services) __________ %

   Medical Personnel Staffing/Nurse Registry for Home Health Care Services Only: _________ %

   Medical Personnel Staffing/Nurse Registry (Other than Home Health Care): __________ %

   Other (please describe): ____

10. Full description of services provided:
____
____
____

11. Does the applicant have any ancillary operations not stated above? Yes: __________ No: __________
If Yes, please provide details: ____
____
____

12. Is the applicant engaged in, owned by, associated with, or controlled by any other business? Yes: _______ No: ________
If Yes, please provide details:

____

____

13. a.) List the number and type of **EMPLOYEES**:
(If Owner Operated, please provide details on backup plan if the owner is unavailable)

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_______	_______	Physician (patient contact)	_______	_______
Licensed Practical Nurse	_______	_______	Physician (no patient contact)	_______	_______
Certified Nurse Assistant	_______	_______	Caregiver / Home Health Aide	_______	_______
Nurse Practitioner	_______	_______	CRNA/Surgical Technician	_______	_______
Physician Assistant	_______	_______	Massage Therapist	_______	_______
Medical Assistant	_______	_______	Chiropractor	_______	_______
Other (please describe):	_______	_______	Clerical/Admin	_______	_______

____

b.) List the number and type of **INDEPENDENT CONTRACTORS**:

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_______	_______	Physician (patient contact)	_______	_______
Licensed Practical Nurse	_______	_______	Physician (no patient contact)	_______	_______
Certified Nurse Assistant	_______	_______	Caregiver / Home Health Aide	_______	_______
Nurse Practitioner	_______	_______	CRNA/Surgical Technician	_______	_______
Physician Assistant	_______	_______	Massage Therapist	_______	_______
Medical Assistant	_______	_______	Chiropractor	_______	_______
Other (please describe):	_______	_______	Clerical/Admin	_______	_______

____

c.) Are all individuals shown in response to questions 13 a and b who are subject to state or federal licensing requirements so licensed? Yes: __________ No: __________ If No, attach explanation.

14. Do you require independent contractors (if any) to carry their own Professional Liability Insurance and secure certificates of Insurance as evidence of such coverage? Yes: __________ No: __________
If yes, what is the minimum limit required? $____________ / $____________

If no, is coverage desired with shared limits on this policy? Yes: __________ No: __________

15. Enter where services are provided, broken down by percentage for each category, by employees and independent contractors (please estimate if this is a start-up):

Private Homes	__________ %
Hospitals	__________ %
Nursing Homes	__________ %
Assisted/Independent Living	__________ %
Medical Clinics/Private Doctors	__________ %
Other (please describe)	__________ %

16. For Medical Personnel Staffing Agencies, if staffing is provided for hospitals, enter which hospital departments/areas staff are provided for, broken down by percentage (please estimate if this is a start-up):

Emergency Room __________ %
Intensive Care Unit __________ %
Urgent Care __________ %
Operating Room __________ %
Labor & Delivery Rooms __________ %
Other (please describe) __________ %

17. Enter the percentages for the following exposures based on total services provided (please estimate if this is a start-up):

IV Therapy _________ %
Live-in Care ________ %
Cardiac Care _________ %
Overnight Care ________ %
Respiratory Support ________ %
Wound Care (including the % exposure for each of the stages) ________ %
Pediatric/Infant Childcare _______ %
High-Tech Care (including trach/vent, g-tube feeding, etc.) ________ %

18. If the Insured is providing pediatric services, are any medical services provided? Yes: __________ No: __________

If Yes, what percentage of services are provided (please estimate if this is a start-up): __________ %

19. Does the applicant provide any beds for overnight stays or provide any treatment or services on their premises?

Yes: __________ No: __________ If Yes, give details: ____

20. Do you sell, rent, or otherwise provide any equipment or products to others?

Yes: __________ No: __________ If Yes, please complete the Huntersure Durable Medical Equipment Supplement.

21. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes: __________ No: __________ If No, give details: ____

22. a.) Do you conduct pre-employment screening and investigation? Yes ______ No _____

b.) Are employees required to actively participate in continuing education? Yes ______ No _____

c.) Do you prepare job descriptions and instructional manuals for your staff? Yes ______ No _____

d.) Do you have a written incident/occurrence reporting policy and procedures? Yes ______ No _____

23. Check all the following that apply if obtained, verified, and kept on file as part of the employee hiring and screening process:

Applications / Resumes ________
Criminal Background Checks ________
Drug Testing ________
Licenses Held ________
Education/Training/Competence ________

24. Is the applicant a member of any association or certified or accredited by any governing body?

Yes: __________ No: __________ If Yes, give details: ____

25. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:

	YES	NO
a.) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?	________	________
b.) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	________	________
c.) Ever been treated for alcoholism or drug addiction?	________	________
d.) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	________	________

26. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?

Yes: __________ No: __________ If Yes, give details, including name, location size and number of beds.

27. Give Professional Liability coverage for last 5 years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________

If expiring insurance is a claims made policy, what is the retroactive date? _________________________________

28. Give General Liability coverage for last 5 years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________

If expiring insurance is a claims made policy, what is the retroactive date? _________________________________

29. Is the applicant aware of any circumstances which may result in any claim against the proposed insured entity or any individual who would be covered by this policy?

Yes: __________ No: __________ If Yes, please give details ____

30. Has any insurer cancelled or refused to renew any similar insurance during the past 5 years?

Yes: __________ No: __________ If Yes, please give details ____

31. Has any claim been made against the proposed insured or any of its employees in the last 5 years?
Yes: __________ No: __________
If Yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

32. Is the applicant aware of any circumstances which may result in any claim against the insured or any of its employees that would be covered by this policy?
Yes: __________ No: __________ If Yes, please give full details.

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date and time stamp.

Name of Applicant: ____
Please Print Title

Signature: ____
Name Date

(NOTE: Application must be signed by the owner or president or principal)