

Application  
For  
**Home Health Care & Nurse  
Registries**

1. Name of applicant \_\_\_\_\_

2.  Individual     Corporation     Partnership     Other (Explain) \_\_\_\_\_  
Date your company established: \_\_\_\_\_

3. Street address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Website Address \_\_\_\_\_

4. Provide full name(s) of individual and partners: \_\_\_\_\_

5. Receipts from employees    \$ \_\_\_\_\_    Receipts from Independent Contractors    \$ \_\_\_\_\_  
Receipts from non-nursing operations    \$ \_\_\_\_\_    Total Receipts    \$ \_\_\_\_\_

6. Do employed nurses have own Professional Liability coverage?     Yes     No    Limits required?    \$ \_\_\_\_\_  
Do you require Certificates of Insurance for all independent contractors?     Yes     No    Limits required?    \$ \_\_\_\_\_

7. Description of employed or contracted personnel:

	<u>Number Employed</u>	<u>Number Contracted</u>	<u>Contractors Ins. Limits required</u>	Percentage working in:		
				<u>Hospital</u>	<u>Nursing Home</u>	<u>Home</u>
Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____	_____	_____
Physicians	_____	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

8. Are background checks made with all prior employers and educational institutions?     Yes     No  
Does background check include Police record?     Yes     No  
If either answer is "No", refer risk to Company.

9. Is chemotherapy performed?     Yes     No  
Describe types of IV therapy performed: \_\_\_\_\_

10. Describe services performed by any other professionals: \_\_\_\_\_

11. Do you want your policy to cover your employees? There is a premium charge.     Yes     No

(NOTE: The policy already protects *you* for the acts of your employees.)

12. Do you want sexual molestation coverage to protect you for alleged or actual acts of your employees? If yes, please complete sexual molestation section on back page.  Yes  No

13. Are your personnel responsible for monitoring any equipment?  Yes  No  
If yes, describe \_\_\_\_\_

14. Please list any medical equipment you supply to clients. \_\_\_\_\_

15. Do you want coverage for the equipment sold or rented to clients?  Yes  No  
Receipts-Sales: \$ \_\_\_\_\_ Receipts-Rental: \$ \_\_\_\_\_

16. Provide details of licensing or certification needed for this operation: \_\_\_\_\_

17. How long have you been licensed/certified? \_\_\_\_\_

18. Has your license ever been suspended or revoked?  Yes  No If yes, provide details on back.

19. Is your facility Medicare approved?  Yes  No Medicare receipts? \$ \_\_\_\_\_

20. Your premium is adjustable based on your **total** receipts. Our auditor needs to be able to verify your total receipts.
- If this information is kept by your accountant, please provide your accountant's name, address and telephone number: \_\_\_\_\_  
If this information is kept by you, please provide the telephone number and address where the records are kept: \_\_\_\_\_
  - If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: \_\_\_\_\_
  - Your telephone number if not previously given: \_\_\_\_\_

21. Prior coverage:

Insurance Company	Year	Premium	Any Claims	Description
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

22. Is the applicant aware of any circumstances which may result in a claim?  Yes  No  
If yes, please describe: \_\_\_\_\_

23. LIMITS OF INSURANCE WANTED

General Aggregate Limit (Other than Products-Completed Operations)	\$	_____	
Products-Completed Operations Aggregate Limit	\$	_____	
Personal and Advertising Injury Limit	\$	_____	
Each Occurrence Limit	\$	_____	
Fire Damage Limit	\$	_____	any one (1) fire
Medical Expense Limit (up to \$5,000 limit available)	\$	_____	any one (1) person
Each Professional Incident Limit (if applicable)	\$	_____	

24. Policy effective dates: From \_\_\_\_\_ To \_\_\_\_\_

25. If sexual molestation coverage is not desired, proceed to signature block at bottom of next page.

# SUPPLEMENTAL APPLICATION FOR SEXUAL MOLESTATION COVERAGE

26. Please indicate the liability limits you are requesting.  
 \$25,000/50,000       \$50,000/100,000       \$100,000/300,000
27. Please describe your hiring practices: \_\_\_\_\_  
\_\_\_\_\_
28. Describe all background checks performed (prior employer, schools, police, references, etc.) \_\_\_\_\_  
\_\_\_\_\_
29. Do you have written guidelines regarding sexual misconduct:  Yes  No
30. What steps have you taken to prevent or avoid a sexual misconduct incident?  
(e.g., same gender caregiver/client) \_\_\_\_\_  
\_\_\_\_\_
31. Have you or any employee, volunteer or other person working for you ever been arrested or  
convicted of a crime?  Yes  No  
If yes, give details \_\_\_\_\_  
\_\_\_\_\_
32. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of  
misconduct?  Yes  No  
If yes, give details \_\_\_\_\_  
\_\_\_\_\_
33. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought  
against it while you were there?  Yes  No  
If yes, give details \_\_\_\_\_  
\_\_\_\_\_
34. **Notice to applicants: In most states any person who knowingly, and with intent to defraud, files an application for insurance containing any materially false information, or conceals, for the purposes of misleading, information concerning any fact material hereto, commits a fraudulent act, which is a crime.**

APPLICANT'S NAME (PLEASE PRINT): \_\_\_\_\_

TITLE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_