NEW ENGLAND
EXCESS EXCHANGE

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PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR HOME HEALTH CARE AGENCIES & MEDICAL PERSONNEL STAFFING SERVICES

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 a: Home Health Agency (medical services provided) ______

   Home Health Agency (only non-medical services provided) ______

   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 firm engaged in, owned by, associated with or controlled by any other business? If yes, give detail

____

____

13. a) List the number and type of applicant's employees estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	__________	Physician (patient contact)	__________
Licensed Practical Nurse	__________	Physician (medical director only)	__________
Physical Therapist	__________	Aide/Homemaker	__________
Occupational Therapist	__________	Social Worker	__________
Respiratory Therapist	__________	Pharmacists	__________
Speech Therapist	__________	Clerical/Admin	__________
Nurse Practitioner	__________	Other (please describe)	__________
Physician Assistant	__________		

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	__________	Physician (patient contact)	__________
Licensed Practical Nurse	__________	Physician (medical director only)	__________
Physical Therapist	__________	Aide/Homemaker	__________
Occupational Therapist	__________	Social Worker	__________
Respiratory Therapist	__________	Pharmacists	__________
Speech Therapist	__________	Clerical/Admin	__________
Nurse Practitioner	__________	CRNA/Surgical Technician	__________
Physician Assistant	__________	Other (please describe)	__________

c. Are all the above individuals licensed in accordance with applicable state and federal regulations

Yes ______ No ______ If no, attach explanation.

14. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ______ No ______ If yes, at what limits? $____________ / $____________

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 & independent contractors:

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

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

Emergency Room	________ %
Urgent Care	________ %
Labor & Delivery Rooms	________ %
Intensive Care Unit	________ %
Operating Room	________ %
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 Services	________ %
Pediatric/Infant Childcare	________ %
Cardiac Care	________ %
Respiratory Support	________ %

18. Does the applicant provide any beds for overnight stays or provide any treatment or services on their premises? If yes, give details: ____

19. Do you sell, rent or otherwise provide any equipment to products or others? If yes, give details including types of products & gross receipts from each: ____
____

20. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone? If so, please provide details: ____

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) Do you question prospects about previous claims or suits? Yes ______ No _____

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

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

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

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

Applications	________	Criminal Background Checks	________
Drug / HIV/ Hepatitis Testing	________	Licenses Held	________
Education/Training/Competence	________	Multi-State Registry	________

24. Is the applicant a member of any association or certified or accredited by any governing body? 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 five 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 five 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. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes_____ No_____

If yes, please give details ____

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

Yes_____ No_____

If yes, please give details ____

31. Has any claim ever been made against the firm or any of its employees?

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 him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

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.

Name of Applicant: ____

Please Print Title

Signature: ____

Name Date

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