NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

RENEWAL APPLICATION FOR HOME HEALTH AND STAFFING

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Current Kinsale Policy Number: _____

3. MAILING ADDRESS: _____
   STREET CITY COUNTY STATE ZIP

4. LOCATION ADDRESSES: - ☐ Check here if no changes OR indicate all current locations below

   (1) _____
   STREET CITY COUNTY STATE ZIP

   (2) _____
   STREET CITY COUNTY STATE ZIP

   (3) _____
   STREET CITY COUNTY STATE ZIP

   (4) _____
   STREET CITY COUNTY STATE ZIP

5. Inspection/Risk Management Contact Name: _____

6. Inspection/Risk Management Contact E-mail: _____

OPERATIONS

7. **Please check the category which best describes your organization (check all that apply)** :

☐ Home Health Care	☐ Medical Staffing
____% of overall services*	____% of overall services*
*If the insured provides Home Health and Staffing services, please note the percentage split between operations. (Total **must** equal 100%)	

8. Please state sources and amounts of total revenue and patient contacts:

REVENUES / SALES		
Source:	**LAST** 12 months	**NEXT** 12 months
Charitable contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for services	$_____	$_____
Other – specify _____	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

9. Please indicate percentage of time spent in the following work locations:

Private Home	_____%
Assisted Living	_____%
Nursing Home	_____%
Institutional Hospice	_____%
Ambulatory Surgery Center	_____%
Adult Day Care	_____%
Clinic	_____%
Physician's Office	_____%
Correctional / Prison /Jail	_____%
Hospital * complete table on right	_____%
Other (specify where) _____	_____%

***Hospital Based Staffing** (only if hospital is noted)	
Operating Room	_____%
Emergency Room	_____%
Labor & Delivery	_____%
Neonatal (NICU)	_____%
Adult Intensive Care Unit	_____%
Pediatric Intensive Care Unit	_____%
Other Hospital (specify where) _____	_____%

10. Percentage of Types of Services Provided (total **must** equal 100%)

Personal Care Chore or Companion	_____%	Respiratory Therapy	_____%
Rehabilitation – including PT, OT, ST	_____%	Radiation Therapy	_____%
Infusion Therapy	_____%	Skilled Nursing Care	_____%
Hospice – In Home	_____%	Pediatric Care	_____%
Chemotherapy	_____%	Medical Equipment Supplier	_____%
Skin Care or Bedsore Wound Care	_____%	In Home Dialysis	_____%
Other: _____	_____%	Other: _____	_____%

11. Have there been any other major changes in exposures (acquisitions, new or discontinued procedures or services, etc) which are not reflected above? If yes, please provide details. ☐ YES ☐ NO

_____
_____
_____
_____

STAFF

12. Please indicate the current number of employed and contracted staff:

Type of Health Care Provider	# of Employees	Annual Employee Hours Worked	# of Independent Contractors	Annual Contractors Hours Worked
Personal Companion/ Homemaker				
Live In Companions				
Certified Nurse Aid (CNA)				
Licensed Practical Nurse (LPN)				
Registered Nurse (RN)				
Medical Technician				
Nurse Practitioner				
Speech Therapist				
Occupational Therapist				
Physical Therapist				
Social Worker				
Physician Assistant				
CRNA				
Nurse Midwife				
Physicians (all types)				
Other:				
Other				

13. Please provide the name and specialty of the applicant's Medical Director: _____

☐ Full Time or ☐ Part Time

Does the applicant's Medical Director have direct patient care? ☐ YES ☐ NO

MEDICAL EQUIPMENT or SUPPLIES – RENTAL OR SALES - Complete ONLY if you have these operations (12&13)

14. **TYPE OF EQUIPMENT SOLD OR RENTED (complete table below)**

		SALES REVENUE	**RENTAL REVENUE**
CATEGORY I.	**EXPENDABLE ITEMS** – intended for one time usage and disposed (ie adhesive tape, bandages, hypodermic needles, etc.)	$_____	$_____
CATEGORY II.	**NON-EXPENDABLE ITEMS** – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, lifts, or hoists, walkers, strollers, canes, crutches, wheelchairs, etc.	$_____	$_____
CATEGORY III.	**DIAGNOSTIC OR TREATMENT DEVICES** – This category includes oxygen and other medical gases used in conjunction with respitory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also include are blood pressure gauges, IV pump, portable EKG machines or sending devices.	$_____	$_____
CATEGORY IV.	**LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES** – this category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function could result in death or serious deterioration in health condition.	$_____	$_____

15. Does the applicant **REPAIR or PERFORM MAINTENANCE** on any medical supplies and/or equipment? Yes ☐ No ☐

1. If "yes" please advise the total Annual Sales: _____
2. Types of equipment serviced?

_____
_____
_____

CLAIMS HISTORY -Provide details for all "Yes" answers to questions 14-19 as noted - attach additional pages as needed

16. In the last 12 months, has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain below or attach additional pages as needed.**	☐ YES ☐ NO
17. In the last 12 months, has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on below or attach additional pages as needed.**	☐ YES ☐ NO
18. In the last 12 months, has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on below or attach additional pages as needed.**	☐ YES ☐ NO
19. In the last 12 months, has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance (to include any reports to previous carriers)? **How Many? _____ (Complete Supplemental Claims form for Each.)**	☐ YES ☐ NO
20. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.**	☐ YES ☐ NO
21. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.**	☐ YES ☐ NO

SUPPLEMENTAL INFORMATION Use the remainder of this page as needed or to address questions referenced within the application

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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 denial of insurance benefits.

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 MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 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/she 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 a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE 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 VIRGINIA 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary judgment in your favor

Court outcome in YOUR favor:

☐ Jury verdict

☐ Directed verdict

Unresolved/Open

☐ Awaiting mediation

☐ Awaiting court action

Reserve amount:

$_____

☐ Suit settled out of court

a. Date claim paid: _____

b. Amount paid: $_____

c. Did you want to settle?

☐ Yes ☐ No

Court outcome in favor of plaintiff:

☐ Jury verdict

☐ Directed verdict

Amount of loss payment:

$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____