Admiral INSURANCE GROUP | a Berkley Company

HOME HEALTHCARE, HOSPICE AND STAFFING PROFESSIONAL LIABILITY APPLICATION and GENERAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of Applicant:

(Include all dba's and subsidiaries seeking coverage under the policy for which you are applying)

2) Mailing Address:

3) Website Address:

4) Date Established (mm/dd/yy):

5) FEIN:

6) Type of Entity:

Corporation   Partnership   Individual   LLC   Other (Specify):

7) Is this entity owned by, associated with or controlled by any other entity? Yes No

If Yes, provide details:

8) Type of Firm (check all that apply):

Home Health Care Agency   Visiting Nurse Agency   Nurse Registry   Hospice

Staffing Company (not including physician staffing)   Other (Specify):

9) Location of where services are provided (total must equal 100%):

% Patient's Home   % Stand Alone Hospice   % Nursing Home   % Assisted Living Facility

% Clinic   % Physician's Office   % Hospital ER   % Hospital OB

% Hospital ICU   % Hospital Other   % Surgery   % Schools

% Other (please explain):

10) Are you aware of any of your services provided in, or under contract with a facility or entity that you own, operate or are somehow affiliated with? Yes No

If Yes, provide details:

11) Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No
If Yes, provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program:

SECTION II – FACILITY OPERATIONS

12) Gross Revenue:

Projected for Next 12 Months	Current Year to Date	1st Year Prior	2nd Year Prior
$	$	$	$

13) Does your practice include Pain Management? Yes No

If Yes, specify the percentage of your practice derived from Prescription Only Pain Management. %

14) Does your practice include prescribing of opioids? Yes No

If Yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? Yes No

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? Yes No

d. Do you also dispense the opioids? Yes No

15) Provide the number of employees or independent contractors:

	Number of Employees	Number of Independent Contractors	Annual Billable Hours
Certified Nurse Assistant			
Companion/Home Health Aide			
Counselors (MFT & PhD)			
CRNA			
Dieticians/Nutritionists			
Licensed Practical Nurse			
Live-In Companions			
Nurse Practitioner			
Occupational Therapists			
Personal Care Attendants			
Pharmacists & Pharm Assistants			
Physical Therapists			
Physician Assistant			
Registered Nurse			
Respiratory Therapists			
Social Worker			
Speech Therapists			
Volunteers			
Others (Explain):			

16) Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)		
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)		
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)		
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)		

17) Provide the Percentage of your patients/clients that are any of the following:

(Does not need to equal 100%)

Developmentally Disabled	%	Personal Care	%
Hospice Care	%	Prenatal Care	%
IV / Infusion Therapy	%	Respiratory Therapy	%
Live In Care – Non Ambulatory	%	Skilled Nursing Care	%
Live In Care – Ambulatory	%	Tracheostomy Care	%
OB Services	%	Ventilation Care	%
Pediatric Care	%	Wound Care	%

18) If providing Hospice Services, please detail below, otherwise check this box: Do not provide Hospice Services

a. Number of home care visits:

b. Number of inpatient licensed beds:

c. Are the inpatient beds included above located in a nursing home or assisted living facility? Yes No N/A

If Yes, provide details:

SECTION III – RISK MANAGEMENT

19) Are you accredited by any accrediting organizations? Yes No

If Yes, provide details:

20) List the associations in which you are a member:

21) Explain your Quality Assurance and Risk Management Program:

22) Are background checks performed for all employees, independent contractors and volunteers? Yes No

If Yes, what level or type are the criminal background checks:

County State Federal Sexual Offender Registry

If No, provide details:

23) Are all employees, independent contractors and volunteers screened for drugs and alcohol? Yes No

If Yes, how often are screens performed?

24) How are patients referred to your firm?

25) Does each patient have their own attending physician? Yes No

If No, provide details:

26) Do you have a Medical Director? Yes No

If Yes, provide the following details:

a. What is the name and specialty of your Medical Director?

b. Does the Medical Director provide direct patient care? Yes No

i. If Yes, does the Medical Director carry a medical malpractice policy? Yes No

ii. What limits of liability are carried?

c. Does the Medical Director have supervisory duties over allied healthcare professionals? Yes No

If Yes, provide details:

27) Do you have back-up procedures if assigned staff is not able to make a scheduled visit? Yes No

28) Do you require any of your independent contractors to carry professional liability? Yes No

If Yes, provide details:

29) Do you have a policy in place to prevent sexual abuse or allegations of sexual abuse? Yes No

If Yes, explain and advise how often it is reviewed:

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

1) Do you currently purchase a standalone cyber policy? Yes No

   If Yes, provide the following information:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

2) Do you employ the following tools to protect private sensitive data?
   a. Anti-Virus and Firewalls Yes No
   b. Encryption Yes No
   c. Formal Password Management Procedures Yes No

3) Are you compliant with the Health Information Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Critical Health Act (HITECH)? Yes No

4) Have you ever experienced a security breach, data loss or denial of service attack? Yes No

   If Yes, complete a Supplemental Claim Information Form for each and every claim.

SECTION V – CURRENT COVERAGE

5) Provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If none, state NONE.)

Company	Policy Term	Limits of Liability	Retro Date	Premium

6) What is the retroactive date on your current policy?

7) Is the applicant currently insured under a Commercial General Liability policy? Yes No

   If Yes, attach a copy of the declarations page.

8) Are you interested in a quote for General Liability? Yes No

   If Yes, complete the General Liability Supplemental Application below.

SECTION VI – CLAIMS

9) Has any application for Professional Liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? Yes No

   If Yes, please provide details including name of carrier and date:

10) Has any claim ever been made against the applicant or any of its employees? Yes No

   If Yes, complete the Supplemental Claim Information Form for each and every claim.

11) Is the applicant aware of any circumstances which may result in any claim against them or their employees? Yes No

If Yes, provide full details on each incident including name of parties involved, date of treatment and current status of incident:

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1)

Loc #	Facility Name	Address	Description / Use	Square Footage
1				
2				
3				
4				
5				

	Location 1	Location 2	Location 3	Location 4	Location 5
Own or Lease	Own Lease	Own Lease	Own Lease	Own Lease	Own Lease
% occupied by applicant	%	%	%	%	%
Are there other occupants?	Yes No	Yes No	Yes No	Yes No	Yes No
# of beds / units (if applicable)					

SECTION II – MAINTENANCE

2) Does the Applicant have a full-time maintenance staff? Yes No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.
NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

Type	Direct	Subbed
Snow & Ice Removal	%	%
Janitorial/Cleaning Services	%	%
General Maintenance & Repairs	%	%
Landscaping	%	%
Other:	%	%

3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? Yes No

If Yes, are records of the completed inspections and repairs retained for at least five years? Yes No

4) Are there any construction projects planned for the upcoming policy term? Yes No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? Yes No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? Yes No

SECTION III – FIRE-LIFE SAFETY INFORMATION

5) Are all of your locations equipped with:

a. Complete sprinkler system? Yes No

b. At least two clearly marked exits on each floor? Yes No

c. Smoke detectors? Yes No

d. Emergency electrical system? Yes No

e. Heat sensors? Yes No

f. Fire escape(s)? Yes No

g. Posted emergency evacuation procedures? Yes No

h. Properly maintained fire extinguishers? Yes No

Attach a separate sheet detailing any No answers.

SECTION IV – HIRED AND NON-OWNED AUTO

6) Indicate the types and corresponding numbers of Non-Owned Autos:

Private Passenger: Multi-Passenger Van: Bus: Truck:

7) Indicate how Non-Owned Autos will be used:

Errands Regular Sales/Service Calls Product Delivery Transportation of Patient

Transportation of Cargo Other:

If Other, provide details:

8) What percentage of the drivers are under 25 years old? %

9) Are MVR's checked for all drivers? Yes No

If Yes, how frequently?

10) Are all drivers required to carry the state mandated minimum limits? Yes No

11) Do any drivers have either moving violations or accidents totally more than two in the past 3 years or more than three in the past 5 years? Yes No

If Yes, provide details:

12) Do you prohibit driving if a driver is unlicensed, has a suspended/revoked license or has a major conviction such as DUI/DWI, reckless driving, leaving the scene or other similar driving conviction? Yes No

13) Do you have any owned, leased or hired autos used in your business? Yes No

If Yes, provide details:

a. What is the estimated number of hired autos on an annual basis?

b. How will hired autos be used?

% Regular Sales/Service Calls | % Business Trips

% Transportation of Clients/Patients | % Others

14) Have any auto claims been made or occurrences reported during the past five years? Yes No

If Yes, provide auto loss runs and complete descriptions, open/close status, payments and reserves for each claim.

SECTION V – OTHER PREMISES EXPOSURES

15) Are any of the following provided:

a. Sale of any food or drinks? Yes No

b. Recreational facilities? Yes No

c. Gym or exercise equipment available to members or the public? Yes No

d. Swimming pool on any premises? Yes No

e. Daycare or childcare services? Yes No

f. Sponsor any sporting or social events? Yes No

g. Hold any fundraising events? Yes No

h. Provide alcohol with any of your events or services? Yes No

i. Participation in trade shows, exhibits or conventions? Yes No

j. Any plans for new construction or renovations during the next twelve (12) months? Yes No

Attach a separate sheet detailing any Yes answers.

SECTION VI – PRODUCTS AND EQUIPMENT SOLD OR LEASED

16) Do you loan, lease or rent equipment to others? Yes No

a. Annual gross revenue **for equipment rental**? $

b. With or without operator (technician)? With Without
Provide details:

c. Who is responsible for equipment maintenance?

SECTION VII – ADVERTISING

17) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? N/A Yes No

18) Are you making any structure/function claims for your products on labels, websites or other marketing materials? Yes No

Do you maintain documentation that substantiates each claim you make? Yes No
If Yes, explain the documentation and length of time records are retained:

SECTION VIII – ADDITIONAL INSUREDS

19) List all parties that should be considered for Additional Insured status under the General Liability. Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

Name and Address	Relationship to Applicant

SECTION IX – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

20) Do you sell any products? Yes No
If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

21) Total gross revenue **from product sales**:

a. Last twelve (12) months: $

b. Next twelve (12) months: $

22) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? Yes No

23) Do any of your products include:

a. Caffeine exceeding 300 mg per servicing (all sources)? Yes No

b. Cannabidiol (CBD) hemp products? Yes No

c. Class I & Class II Medical Products / Devices? Yes No

24) Do you mix or compound any ingredients? Yes No

25) Is a prescription required for any of the products you sell? Yes No

26) Are products of others sold or re-packaged under your label? Yes No

27) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? Yes No

28) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? Yes No

29) Are foreign products sold, distributed, or used as components? Yes No

30) Have any of your products been recalled, discontinued or changed? Yes No

31) Do you offer training or instruction to the user of your products? Yes No

32) Do you offer guarantees, warranties or Hold Harmless agreements with your products? Yes No

33) Do you install, service of demonstrate products? Yes No

34) Is research and development conducted or new products? Yes No

35) Are any new products planned in the next year? Yes No
If Yes, provide explanation:

36) Are you a manufacturer, wholesaler or importer of products to others? Yes No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

a. Are all warning labels and instructions for use reviewed by outside legal counsel? Yes No

b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? Yes No

c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? Yes No

SECTION X – PRIOR GENERAL LIABILITY COVERAGE HISTORY

37) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box

Insurance Company	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?	Retro Date
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

SECTION XI – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

38) Has any General Liability claim or suit been brought against you and/or any of your employees? Yes No
If Yes, complete a Supplemental Claim Information Form for each and every claim or suit.

39) Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier? None to Report Yes No
If Yes, provide details:

40) Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above? None to Report Yes No
If Yes, provide details:

Please attach the following information:

- Advertisements, brochures, descriptive literature
- Informed consent document

Provide any additional details in the space provided:

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: 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 Agencies.

Applicable in FL and OK: 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 (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other 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 conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.