



183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800)233-1957 or (717)741-0911
Fax: (717) 747-7021
www.hccis.com

HOME HEALTH CARE AIDE (Non-Medical) APPLICATION

This application includes questions pertaining to your home health care aide (non-medical) organization. As a response is required for all questions, please indicate "NA" if any question does not apply to your organization. Supplemental applications are also included which may apply to your organization.

Please Note: If your services consist of other than providing unskilled domestic services, do not complete this application.

I. GENERAL INFORMATION

Policy Effective Date: ___/___/___ Current Professional Liability Retro Date: ___/___/___ OR N/A (Occurrence)
Current General Liability Retro Date: ___/___/___ OR N/A (Occurrence)

(Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.)

Name of applicant (legal name): _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

Mailing address: _____
(Street) (City) (State) (Zip Code) (County)

Phone: (____) _____ Fax: (____) _____ FEIN (Federal Tax ID) #: _____

E-mail address: _____ Web site address: _____

Insurance contact and title: _____

How many years have you been in operation? _____

Is your organization? For-profit Non-profit Governmental

What is your organizational structure? (Choose one): Corporation Partnership Privately/Individually-owned

Joint Venture Limited Liability Company Other (describe): _____

Are there additional entities that are to be added as Additional Named Insureds? Yes No

If "yes," please list the name of each entity and a brief description of their operations. Please include a copy of your organizational chart.

Do you engage in any business other than non-medical home health care services? Yes No If yes, please describe:

II. PROFESSIONAL SERVICES

1. How many clients did you provide services to in the last 12 months? _____ Next 12 months? _____

2. How many clients receive 24-hour "live-in" care? _____

3. How many clients are children (18 years of age or under)? _____

4. Please indicate the services provided by your organization:

Activities of Daily Living (ADL)

Bathing/Dressing

Doctor Visits

Errands

Bill Paying

Hospice Support

Medication Reminders

Respite for Family Caregivers

Supplemental Staffing

Other _____

5. Do you provide medical equipment to your patients other than Class I and II items (e.g. crutches, wheel chairs, walkers, etc.)? Yes No If "yes," please contact us for a Durable Medical Equipment Supplement.
6. Please indicate the locations where services are provided: Private Homes Hospitals Clinics
 Nursing Homes/ALF's Other: _____
7. Are you a franchise owner? Yes No If "yes", what is the franchise? _____

III. OPERATIONS

1. What is your total annual operating budget? _____ (If budget exceeds \$5,000,000 please attach a copy of your latest audited financial statement)
2. Are you accredited by? CHAP ACHC NCQA COA
3. Are you Medicare-certified? Yes No
4. Has your organization merged, acquired, or consolidated with any other organization within the last ten years?
 Yes No If "yes," please provide the name(s) of the organization(s) and the date of acquisition.

5. Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions.

6. Within the last three years has your organization or any of its senior managers, officers or other "insureds" been a part of any civil or criminal litigation or arbitration proceedings related to the applicant's activities?
 Yes No If "yes," please provide details on a separate attachment.

IV. EMPLOYEE INFORMATION

1. Total number of employees: _____ Full Time _____ Part Time/Per Diem
 2. Is Employer's Stop Gap Liability desired? (Only applicable in ND, OH, WA, WY) Yes No
If "yes," provide current annual payroll \$ _____
 3. Do you engage the use of Independent Contractors to provide any services? Yes No
If "yes," what percentage of services is provided by Independent Contractors? _____%
What services do they provide?

- Do you require that all Independent Contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year? Yes No
4. What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies?
_____%
 5. Do you employ or contract with any licensed physicians or nurse practitioners? Yes No If "yes," please contact us for a Physician Application Supplement. **These professionals must be endorsed for coverage to apply.**
 6. Which of the following background check methods do you use?

Social Security number verification and search	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home telephone/residency verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present employment and two previous employers' verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Education and professional licensing verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver's license information (MVR)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Criminal background checks - federal, state (if available), county	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug screening	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Who is responsible for human resources in your organization?

Name and Title: _____

8. Is training provided and attendance documented for all employees? Yes No If "yes," briefly describe your in-service training program for new hires and existing staff:

V. RISK MANAGEMENT AND LOSS CONTROL

Please attach a copy of your currently valued three-year loss experience from your insurance carrier.

1. Within the last three years has your organization been a part of any civil or criminal litigation or arbitration proceeding?
 Yes No If "yes," please provide details on a separate attachment.
2. Does your organization have knowledge of any incidents which have not been reported to your current insurance carrier that may result in a claim or suit? Yes No If "yes," please provide details on a separate attachment.
3. Does your organization have a formal Quality Assurance or Risk Management program? Yes No
If "yes," name and title of who is responsible for the program: _____
4. Do you have an active Safety Committee? Yes No
5. Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? Yes No
6. Has any insurer ever refused to renew or cancelled any insurance coverage during the past five years?
 Yes No If "yes," please provide the reason for cancellation: _____

VI. OPTIONAL COVERAGES

HIRED AND NON-OWNED AUTOMOBILE LIABILITY Please indicate if this coverage is desired: Yes No
If "yes", please answer the following questions:

NOTE: If you have owned or leased vehicles titled or contracted under your organization's name, please contact us for an automobile application. If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned automobile policy.

1. Do your employees and volunteers utilize their personal vehicles to provide services on behalf of your organization?
 Yes No
2. Do you annually order MVR's on each employee and volunteer with driving responsibilities? Yes No
3. Do you agree to extend driving privileges only to employees and volunteers with acceptable driving records?
 Yes No
Note: Acceptable driving records are:
 1. No more than three moving violations or more than one chargeable accident during the past 36 months, AND
 2. No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven years, AND
 3. No license suspensions or revocations within the past seven years.
4. Do you require that all employees and volunteers who operate their personal autos on behalf of your organization maintain minimum state financial responsibility limits? Yes No
5. Do your employees and volunteers transport patients or clients in their personal autos? Yes No
If "yes," does your employee or volunteer maintain auto liability limits of at least \$100,000 Combined Single Limit?
 Yes No
6. Do you allow your employees and volunteers to operate a patient's or client's vehicle? Yes No
If "yes," do you:
Restrict use to business use? Yes No
Secure prior written permission from each client regarding use of their vehicle and maintain a copy for your records? Yes No
Secure written verification that each client maintains current in-force limits of at least \$100,000 Combined Single Limit? Yes No
Include driver safety education to your staff? Yes No

SEXUAL ABUSE LIABILITY Yes No If "yes", please answer the following questions:

Does your organization have a written "zero tolerance" sexual abuse and molestation policy? Yes No

Does your written policy include?

Definition of sexual abuse/molestation Yes No

Reporting procedures at least two persons to report to internally Yes No

Investigation procedures Yes No

Disciplinary procedures Yes No

Retaliation warning Yes No

Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy? Yes No

Have procedures been established to monitor the implementation of the program? Yes No

Is sexual abuse training conducted for all employees and volunteers in the program and is documentation maintained on attendees? Yes No

Have you ever had any prior incidents, allegations or claims involving sexual abuse? Yes No
If "yes", please provide details.

Please attach a copy of your current sexual abuse and molestation prevention policy. (If you would like to view a copy of a standardized version of an acceptable sexual abuse and molestation prevention policy for reference in developing your own, contact our web site, www.hccis.com.)

EMPLOYEE BENEFITS LIABILITY

\$25,000 each employee/\$50,000 aggregate is automatically provided, but additional limits may be available. Please indicate desired coverage limit if different from automatic coverage:

\$50,000/\$50,000 \$100,000/\$100,000 \$250,000/\$250,000 \$500,000/\$500,000

\$750,000/\$750,000 \$1,000,000/\$1,000,000

EXCESS LIABILITY

If you would like a quotation for Excess Liability coverage, please indicate the limit of liability desired:

\$1,000,000 \$2,000,000 \$3,000,000 \$4,000,000 \$5,000,000

COMMERCIAL PROPERTY

If you have any owned or leased property and desire a quote, please indicate Yes No **If "yes," please complete Supplement No. 9.**

EMPLOYEE RETIREMENT INCOME SECURITY ACT INSURANCE (ERISA)

We can offer you a proposal for a bond to insure your organization's liability in the proper administration of employer-administered employee benefit plans. The act is designed to protect the rights of employees and beneficiaries covered under the benefit plans your organization administers.

If a quote is desired, please indicate Yes No **If "yes," please request a Supplement.**

ANY SIGNIFICANT CHANGES TO YOUR ORGANIZATION DURING THE POLICY YEAR MUST BE REPORTED TO GLATFELTER UNDERWRITING SERVICES, INC. TO ENSURE COVERAGE.

PLEASE READ CAREFULLY --- GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another 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 act, which is a crime and may subject the person to criminal and civil penalties.

STATE-SPECIFIC FRAUD WARNING NOTICES

Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Fraud Warning

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.

District of Columbia Fraud Warning

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 an applicant.

Florida Fraud Warning

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.

Hawaii Fraud Warning

Intentionally or knowingly misrepresenting or concealing a material fact, opinion or intention to obtain coverage, benefits, recovery or compensation when presenting an application for the issuance or renewal of an insurance policy or when presenting a claim for the payment of a loss is a criminal offense punishable by fines or imprisonment, or both.

Kentucky Fraud Warning

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.

Louisiana Fraud Warning

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.

Maine Fraud Warning

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 a denial of insurance benefits.

Maryland Fraud Warning

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of \$2,000 and the denial of coverage for any loss, not occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

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New Jersey Fraud Warning

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

New Mexico Fraud Warning

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.

New York Fraud Warning

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

Other Types of Insurance: 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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he 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.

Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Fraud Warning

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Fraud Warning

All Types of Insurance: 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.

Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

Tennessee Fraud Warning

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.

Virginia Fraud Warning

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.

Washington Fraud Warning

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.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Authorized Signature of Applicant: _____ **Date:** _____

Print Name and Title: _____

THIS APPLICATION MUST BE SIGNED BEFORE WE CAN PROCESS.

INSURANCE AGENT INFORMATION:

Agency name: _____

Contact person: _____

Agency address: _____

Telephone number: _____ Fax number: _____

E-mail address: _____



PROPERTY SCHEDULE SUPPLEMENT (No. 9)
PAGE 1 OF 3

(If more than two locations exist, please make copies of the supplements, as required, complete and attach.)

Name of Applicant: _____

General Property Information:

	Location #1	Location #2
1. Street address		
2. City, County, State, Zip Code		
3. Construction code of building*		
4. Your occupancy (office, residential inpatient, garage, etc.)		
5. If residential facility, number of beds		
6. List other occupants in building (office, retail, manufacturing, etc)		
7. Do you own or lease?		
8. Mortgagee name & address, if applicable		

**Construction Codes of Building: (select one only) (1) Frame, (2) Joisted Masonry, (3) Non-combustible, (4) Masonry Non-combustible, (5) Modified Fire Resistive, (6) Fire Resistive, (7) Heavy Timber Joisted Masonry, (8) Superior Non-Combustible, (9) Superior Masonry Non-Combustible*

9. Year building built		
10. Square footage of TOTAL building		
11. Square footage YOU occupy		
12. % of TOTAL building sprinklered		
13. # of floors in building		
14. Basement (Y/N)		
15. If building is over 25 years, provide date of updates to:		
Wiring		
Heating/Ventilation		
Roof		
16. Type of fire alarms (heat/smoke detectors, remote alarms, central station, none)		
17. Other alarms (hourly watchman, security guard, surveillance cameras, intrusion alarms, none)		

Property Coverage:

1. Deductible (\$250, \$500, \$1,000, \$5,000)	\$	\$
2. Building Limit (if Building owner)	\$	\$
3. Business Personal Property (includes but not limited to contents, furniture, fixtures, laptops, computer hardware and software, communication systems, durable medical equipment, phone systems, fax machines)	\$	\$

PROPERTY SCHEDULE SUPPLEMENT (No. 9)

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	Location #1	Location #2
4. Equipment Breakdown Coverage is automatically included at a limit equal to your building and business personal property limit, not to exceed \$100,000. This applies to loss caused by or resulting from an accident to computers and electronic equipment. Please indicate here if a higher coverage limit is requested.		
5. Thrift Store merchandise (actual cash value)	\$ _____	\$ _____
6. Loss Payee's Name and Address for Business Personal Property, if applicable. Identify items.		

Business Income/Extra Expense - A combined Business Income and Extra Expense limit of \$50,000 is provided for any one occurrence at each described location in your policy. If an additional limit is desired for any location, please complete the worksheet below to calculate the additional coverage desired. This simplified worksheet may help you determine your potential business income/extra-expense loss that may result due to suspension of operations during the period of restoration. Please note that there must be direct physical loss or damage at a scheduled location on your policy for this coverage to apply.

- | | |
|--|----------|
| 1. Total estimated revenues for the 12-month period | \$ _____ |
| 2. Less operating expenses | - _____ |
| 3. Net profit/loss before income tax | = _____ |
| 4. Estimate of annual amount of noncontinuing and continuing operating expenses: | |

Operating Expenses	Annual Amount	Non-Continuing During Loss	Continuing During Loss
Ordinary Payroll			
Executive Payroll			
Payroll Taxes			
Rent			
Telephone			
Power/Heat/Cooling			
Group Insurance			
Pension Plan			
Interest on Loans			
Advertising			
Repairs/Maintenance			
Miscellaneous			
Totals	(a)	(b)	(c)

- | | |
|---|----------|
| 5. Estimated maximum recovery [Line 3 + continuing expenses total 4 (c)] | \$ _____ |
| 6. Estimated longest foreseeable shutdown% (i.e., 3 months 25%, 6 months 50%, 12 months 100%) | _____ % |
| 7. Amount needed for period of restoration (Line 5 times Line 6) | \$ _____ |
| 8. Estimated additional expenses to avoid or minimize loss (i.e., relocation expenses, temporary equipment, et al.) | \$ _____ |
| 9. Total Estimate of Required Limit of Insurance: | \$ _____ |

PROPERTY SCHEDULE SUPPLEMENT (No. 9)

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PROPERTY PACKAGE COVERAGE OPTIONS
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1. **Commercial Crime** – Crime coverage is offered if property insurance is provided. Please indicate the coverage limit requested.

\$25,000 \$50,000 \$100,000 \$250,000 \$400,000

Do checks require at least two signatures? Yes No

Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes No

Are financial records audited by outside parties? Yes No

2. **Accounts Receivable**

\$10,000 Accounts Receivable coverage is provided, but additional limits may be available. Please indicate if a higher limit is requested.

\$20,000 \$30,000 \$40,000 \$50,000 Other \$ _____

3. **Valuable Papers & Records**

\$10,000 Valuable Papers coverage is provided, but additional limits may be available. Please indicate if a higher limit is requested.

\$20,000 \$30,000 \$40,000 \$50,000 Other \$ _____

How often do you back up your records? _____ Are duplicate records kept off premises? Yes No

4. **Building Ordinance Coverage**

Coverage is available as an option. The coverage will respond to property losses that are a consequence of the enforcement of local ordinances or building code laws regulating demolition and/or restoration of buildings that have been damaged by a covered cause of loss. If this coverage is provided, it would:

a) **extend** the replacement cost coverage for damage to your building to include loss to the undamaged portion of the building and:

b) ****provide an additional limit** to cover the cost to demolish and clear the site of undamaged parts of the property and,

c) *****provide an additional limit** to pay for increased costs to repair or reconstruct damaged and undamaged portions of the building.

Complete the following for each location where *building ordinance coverage is to be provided:**

Building Ordinance (b)** Additional limit for demolition costs	\$ _____	\$ _____
Building Ordinance (c)*** Additional limit increased cost of construction	\$ _____	\$ _____

Please be certain that the limits of coverage you select for insuring your buildings or business personal property are sufficient to meet your obligation to insure your property to at least 90% of the estimated replacement cost values.