

4. Please indicate the location where services are provided: Private Homes Hospitals Clinics
 Nursing Homes/ALF's Schools Outpatient Facilities Other _____
5. Do you participate in community wellness programs, including immunizations or vaccination programs?
 Yes No If "yes," please provide the number of immunizations: _____
6. Do you provide **non-skilled personal care or ADL** ("Assistance with Daily Living") services? Yes No
 If "yes," what is the number of annual clients? _____ How many of these clients are provided 24-hour "live-in" services? _____
7. Do you provide any services for children? Yes No If "yes," what percentage of your total services includes pediatric care? _____%

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? JCAHO CHAP ACHC NCQA COA
3. Are you Medicare-certified? Yes No
4. Licensure:
 Are you required to be licensed in any states in which you are operating? Yes No
 If "yes," in what states are you currently licensed? _____
 Are any license applications currently pending? Yes No If "yes," what state(s)? _____
Please attach a copy of your most recent state agency's inspection report, together with corrective actions completed, if any.
5. Does your organization participate in the State Patient Compensation Fund? Yes No Not Applicable
6. 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.

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

8. 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 _____ Volunteers
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. Which of the following background check methods do you use?

Social Security number verification	<u>Employees</u>	<u>Volunteers (if any)</u>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- | | | |
|-------------------------------------|--|--|
| Criminal background checks | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Residency verification | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Professional licensing verification | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prior employment | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information (MVR) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Note: Only required if the employee/volunteer operates a company vehicle or their personal vehicle on the organization's behalf.

- Who is responsible for human resources in your organization?
Name and title: _____
- Is annual training provided and attendance documented for all employees and volunteers?
 Yes No If "yes," briefly describe your in-service training program:

V. RISK MANAGEMENT AND LOSS CONTROL

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

- 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.
- 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.
- 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: _____
- Do you have an active Safety Committee? Yes No
- Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? Yes No
- 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. CREDENTIALING

Information to be supplied by the Medical Director (or individual responsible for professional credentialing)

- Do you have a formalized credentialing process? Yes No
- Does your physician credentialing process include primary source verification of:

<input type="checkbox"/> Physician/Nurse Practitioner licensure	<input type="checkbox"/> Training and Experience
<input type="checkbox"/> Certifications	<input type="checkbox"/> DEA registration
<input type="checkbox"/> Education	
- Do your physician files include:

<input type="checkbox"/> Completed application	<input type="checkbox"/> Criminal background check	<input type="checkbox"/> Query of NPDB (malpractice history)
<input type="checkbox"/> Copy of current license	<input type="checkbox"/> Copy of current DEA registration	<input type="checkbox"/> Evidence of continuing education
<input type="checkbox"/> Copy of current Certificate of Insurance, if primary liability insurance is maintained		
<input type="checkbox"/> Authorization and information relating to any past/pending claims, suits, or settlements		
- Has there even been a review by a state medical board or other oversight organization of any physician or nurse practitioner?
 Yes No If "yes," please provide details: _____

- Has there ever been a license suspension, revocation, restriction, or voluntary surrender of license of any physician or nurse practitioner? Yes No If "yes," please provide details: _____

- Is there a recredentialing process? Yes No If "yes," how often do you recredential? _____

7. Does your organization require that contracted physicians/nurse practitioners maintain primary professional liability insurance?
 Yes No Not Applicable

If "yes", what are the minimum professional liability limits required? _____
 Is proof of coverage (Certificate of Insurance) required? Yes No

8. What is the total number of physicians/nurse practitioners in your organization? (Please include volunteers and independent contractors.) _____

Please provide the following information for each physician/nurse practitioner:

Name	State of Licensure	Employed, Volunteer, or Independent Contractor?	Average Hours per Month	Board Certified (Yes/No)	Primary Insurance Elsewhere (Yes/No) *

*Answer "yes" if the physician or nurse practitioner maintains primary liability insurance elsewhere which would respond to an incident or claim while performing duties on your behalf.

Do any of the above-named physicians participate in a state's Patient Compensation Fund (PCF)? Yes No
 If "yes", please include a copy of the PCF Certificate of Insurance.

VII. HEALTH CARE PROFESSIONALS

1. Indicate the number of each of the following types of medical professionals, whether volunteer or employed, if insurance is to be provided on our policy.

Each of the following medical professionals must be specifically endorsed onto your policy as an Additional Insureds for coverage to apply.

Physician's Assistant _____ Dentist _____ Psychiatrist _____
 Resident Intern _____ Extern _____ Chiropractor _____
 Acupuncturist _____ Nurse-Midwife _____ Certified Nurse Anesthetist _____

2. Please identify the respective individuals below, along with their title or position:

<u>Name</u>	<u>Title or Position</u>
_____	_____
_____	_____
_____	_____

VIII. 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:

a) *No more than three moving violations or more than one chargeable accident during the past 36 months, AND*

b) *No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven years, AND*

c) *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 - Please indicate if this coverage is desired: 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

Please indicate if coverage is desired: Yes No If "yes," 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. 8.**

MANAGEMENT LIABILITY

If your organization is a nonprofit organization and you desire a proposal, please contact us for an application.

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.

HOME HEALTH CARE AGENCY APPLICATION 08/11

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: _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

Contact's name: _____

Contact's email: _____

Contact's direct phone number: _____



DURABLE MEDICAL EQUIPMENT SUPPLEMENT (No. 4)

If this service is subcontracted, please confirm that Certificates of Insurance are required of the DME provider, and leave the remainder of the form blank:

Certificates Required Certificates Not Required

1. Name of Applicant: _____

2. Do you supply medical equipment to only your patients? Yes No If "no," what percentage of annual revenue is derived from the general public? ____%

3. What services do you provide for this equipment? Sell Lease Repair medical equipment

4. Annual revenue from sales/leases/repairs: \$ _____

5. Types of Durable Medical Equipment

Category III – Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines or sending devices.

Number of inventory items in this category _____

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/fail or improperly function which could result in death or serious deterioration in health condition.

Number of inventory items in this category _____

6. Do you accept donated equipment? Yes No If "yes," is there an equipment maintenance policy in place for repairs and general maintenance? Yes No

7. Who trains your clients/families regarding proper operation of the equipment? _____

8. Do you provide written instructions to your customers? Yes No _____

9. Do your employees deliver equipment? Yes No
If "yes," do you provide driver safety training to drivers? Yes No

10. Do you repackage, re-label, modify or manufacture any medical equipment or products? Yes No

11. Is all equipment checked and its condition documented prior to release? Yes No

12. Do you distribute oxygen cylinders? Yes No If "yes," are the cylinders pre-filled? Yes No

13. Do you subcontract labor for any maintenance, installation services or repair of medical equipment or supplies?
 Yes No If "yes," do you require Certificates of Insurance? Yes No

Note: If Property insurance is desired for durable medical equipment, please include these items under Business Personal Property on the Property Supplement No. 8.



PROPERTY SCHEDULE SUPPLEMENT (No. 8)

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. 8)

PAGE 2 OF 3

	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: | |

<i>Operating Expenses</i>	<i>Annual Amount</i>	<i>Non-Continuing During Loss</i>	<i>Continuing During Loss</i>
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. 8)

PAGE 3 OF 3

PROPERTY PACKAGE COVERAGE OPTIONS
--

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.



MEDICAL STAFFING SUPPLEMENT (No. 9)

1. Name of Applicant: _____

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

I. STAFFING OPERATIONS

Please attach a copy of your Agency Staffing Agreement.

1. Do you staff any non-medical positions? Yes No
2. What type of staffing services do you offer? Per diem Temporary Staffing (less than one month) Long-term Staffing Temporary-to-Direct Hire Placement
3. Do you employ 100% of the individuals that you place for your clients? Yes No
4. Please estimate which of the following are your typical staffing clients: (Total must equal 100%)

<input type="checkbox"/> Hospitals / Health Systems _____%	<input type="checkbox"/> Non-skilled personal care agencies _____%
<input type="checkbox"/> Nursing Homes / Assisted Living Facilities _____%	<input type="checkbox"/> Hospices _____%
<input type="checkbox"/> Private Physician Practices _____%	<input type="checkbox"/> Social Services Agencies _____%
<input type="checkbox"/> Home Healthcare Agencies _____%	<input type="checkbox"/> Surgical Centers _____%
<input type="checkbox"/> Pharmacies _____%	<input type="checkbox"/> Other _____%
5. Please indicate the location(s) where staffing services are provided: Private Homes Hospitals Clinics Nursing Homes/ALF's Schools Outpatient Facilities Other _____
6. Do you also offer human resources consulting services on a fee-for-service basis? Yes No
 If "yes," what is your estimated annual revenue from these services? \$ _____
7. What is your total estimated annual revenue from staffing for your current fiscal year? \$ _____ Last year? \$ _____
(If your revenue exceeds \$5,000,000 please attach a copy of your latest audited financial statement)

II. EMPLOYEE SELECTION

1. Do you perform employee background checks on staffed workers based on the requirements of the state or the healthcare facility? Yes No
2. Which of the following background check methods do you use?

	<u>Staffed Workers</u>
Current Licensure, certification, and registration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Criminal background checks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present employment and two previous employers' verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-employment verification of convictions for abuse/neglect	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security number verification and search	<input type="checkbox"/> Yes <input type="checkbox"/> No
Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home telephone/residency verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver's license information (MVR) <i>if placement requires driving responsibilities</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug screening	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do your staffing contracts stipulate that you are responsible for performing criminal background checks? Yes No
4. Do you conduct face-to-face interviews with all prospective staffed workers? Yes No

5. Do you have a process in place to assure that the staffed worker's qualifications and competencies are consistent with job placement responsibilities? Yes No
6. Do you require that your clients orient the staffed workers to the facility setting, the unit, and policies and procedures on each staffing assignment? Yes No
7. Do you seek regular feedback from your clients on employee performance on all staffed workers? Yes No
8. Do you have a written description of your complaint process that is supplied to each of your clients? Yes No
9. Do you have a process in place for temporary staffed workers to contact you if they question the appropriateness of their assignment? Yes No
10. Do you provide ongoing education, including in-services and other activities? Yes No

III. RISK MANAGEMENT AND LOSS CONTROL

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

1. Do you carry Workers Compensation insurance? Yes No
2. Do you have processes in place for reporting and investigating allegations of hostile work environments? Yes No
3. Do you have a process in place to evaluate prospective clients before offering staffing services? Yes No
 If "yes," does this process include an on-site visit as well as a review of the facility's orientation program for staffed workers? Yes No
4. Does this process include an on-site visit as well as a review of the facility's orientation program for staffed workers? Yes No
5. Do your staffing agreements include defined roles and responsibilities of both parties? Yes No
6. Do your staffing agreements include mutual hold harmless agreements? Yes No
7. Is the use of personal vehicles by staffed workers addressed in your agency staffing agreement? Yes No
8. Are staffing agreements reviewed by legal counsel? Yes No

IV. EMPLOYEE INFORMATION – ANNUAL STAFFING

1. Please provide the estimated number annual billable hours and annual payrolls for each type of staffed employee for the next twelve months. Do NOT include your own internal agency staff.

Employee Type (staffed workers)	Estimated Annual Billable Hours	Estimated Annual Payroll
Nurse (RN)		\$
LPN		
Nurse Aid / Nursing Assistant		
Home Health Aid		
Homemaker		
Social Worker		
Physical Therapist		
Speech Pathologist		
Occupational Therapist		
Pharmacy Assistant		
Lab Technician		
EKG Technician		
X-ray Technician		
Radiology Technician		
Medical Technician		
Certified Medical Assistant		
Dietician/Nutritionist		
Dialysis Technician		
Enterostomal Therapist		
Respiratory Therapist		
Phlebotomist		
Radiation Therapist		
Clerical/Administrative		
Other: _____ _____		
Total		\$

Note: Staffing agencies which staff physicians, medical directors, physician assistants, surgeons, dentists, psychiatrists, residents, interns, externs, chiropractors, acupuncturists, nurse practitioners, nurse midwives, certified registered nurse anesthetists and pharmacists are not eligible for coverage

2. What percentage of these total staff workers are assigned to Critical Care, Emergency, Obstetrics, Radiology or Pediatric Departments? _____%
3. What percentage of your business includes staffing travel nurses? None _____%
4. Do you employ international healthcare workers on work visas? Yes No
5. Do you place staffed workers in prisons or correctional facilities? Yes No