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

HOSPICE APPLICATION

This application includes questions pertaining to your hospice 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.

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? ☐ Non-profit ☐ For-profit ☐ Governmental

☐ State Hospice Association: Number of member organizations represented: _________________

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 included 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.

____

____

II. PROFESSIONAL SERVICES

HOSPICE SERVICES

1. How many hospice Patient Days on Service (total number of service days for all hospice patients) during the last 12 months? _____________ Next 12 months? __________
2. Number of hospice patients during the last 12 months: ____________
3. How many licensed inpatient/residential beds (Include both owned and contracted hospice beds)? _____________
4. Do you provide hospice or palliative care for children? ☐ Yes ☐ No If "yes," what percentage of your total services includes pediatric care? _________%
5. Do you provide palliative care for non-hospice patients? ☐ Yes ☐ No If "yes," how many palliative care patient visits will you complete during the next 12 months? ___________________________________
6. Do you participate in any clinical trials, pharmaceutical testing, or research? ☐ Yes ☐ No If "yes," please describe: ____
____
7. Do you provide pet therapy? ☐ Yes ☐ No If "yes," have the pets been specially trained or certified for use in the therapy program by Therapy Dogs International or the American Kennel Club? ☐ Yes ☐ No
8. Do you sponsor any special events or fund-raisers? ☐ Yes ☐ No If "yes," **please complete Supplement No. 1.**
9. Do you sponsor any bereavement camps? ☐ Yes ☐ No If "yes," **please complete Supplement No. 3.**

HOME HEALTH CARE SERVICES
If your organization only provides hospice care and you do not provide home health services, please skip this section and proceed to Section III, Operations.

1. Do you provide **skilled** home healthcare services? ☐ Yes ☐ No If "yes," how many total patient visits during the past 12 months? ____________ Next 12 months? ___________
2. Number of skilled home health care patients did you treat during the past 12 months? ________
3. Please indicate which of the following skilled home health services are provided by your organization:
   - ☐ Adult Day Care ***(Complete Supplement No. 6)***
   - ☐ Cardiac Care
   - ☐ Case Management
   - ☐ Child Day Care ***(Complete Supplement No. 5)***
   - ☐ Gastrostomy Tube (GT) Care
   - ☐ Infusion Therapy
   - ☐ Medical Equipment Supplier ***(Complete Supplement No. 4)***
   - ☐ Medical Social Services
   - ☐ Obstetrical Services
   - ☐ Palliative Care. Number of Annual Visits: _______
   - ☐ Pharmacy (***Complete Supplement No. 2)***
   - ☐ Rehab Services (PT,OT, Speech Therapy)
   - ☐ Respiratory Therapy
   - ☐ Trach/ventilator
   - ☐ Respite Care
   - ☐ Special Care (Alzheimer's/Dementia, etc.)
   - ☐ Supplemental Staffing (***Complete Supplement No. 10)***
   - ☐ Telehealth
   - ☐ Thrift Shops: Annual Gross Sales $_______
   - ☐ Other: ______________________________
4. Please indicate the locations 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** services (Do not include ADL services provided by skilled personnel)? ☐ Yes ☐ No If "yes," what is the number of annual clients? __________ How many of these clients are provided 24-hour "live-in" care? _________
7. Do you provide home health 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 operate? ☐ Yes ☐ No
   If "yes," in what state(s) 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?

	Employees		Volunteers (if any)	
Social Security number verification and search	☐ Yes	☐ No	☐ Yes	☐No
Home telephone/residency verification	☐ Yes	☐ No	☐ Yes	☐No
Present employment and two previous employers' verification	☐ Yes	☐ No	☐ Yes	☐No
Education and professional licensing verification	☐ Yes	☐ No	☐ Yes	☐No
Driver's license information (MVR)	☐ Yes	☐ No	☐ Yes	☐No
County, state (if available) and federal criminal checks	☐ Yes	☐ No	☐ Yes	☐No
Drug screening	☐ Yes	☐ No	☐ Yes	☐No

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

   Name and title: ____
7. 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.

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. HEALTH CARE PROFESSIONALS

1. Do you have any employed, volunteer or contracted physicians? ☐ Yes Number: _____ ☐ No
2. Do you have any employed, volunteer or contracted nurse practioners? ☐ Yes Number: _____ ☐ No

   Complete Supplement No. 7 for each employed, volunteer, or contracted Physician or Nurse Practitioner serving your agency. Note: Physicians and Nurse Practitioners must be specifically endorsed onto your policy as an Additional Insureds for coverage to apply.

3. Do you engage in a credentialing process for your physicians and all health care professionals prior to hire or at inception of their contract? ☐Yes ☐ No
   How often do you re-credential? ☐ Annually ☐ Every three years ☐ No re-credentialing process in place
4. 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 specially endorsed onto your policy as an Additional Insured for coverage to apply.

Physician's Assistant ___________	Dentist ________________	Psychiatrist __________________
Resident Intern _______________	Extern ________________	Chiropractor _________________
Acupuncturist _________________	Nurse-Midwife __________	Certified Nurse Anesthetist ______

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

Name	**Title or Position**

VII. 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 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, visit 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 this 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. 9**.

DIRECTORS AND OFFICERS 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 complete Supplement No. 8.**

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.

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: ____

Hospice and Community Care
INSURANCE SERVICES℠
A Division of Glatfelter Insurance Group

FUND-RAISING AND SPECIAL EVENT SUPPLEMENT (No. 1)

(Complete only if you sponsor fund-raising or Special Events)

1. **Name of Applicant:** ____

2. Name of Event   Date   Number Attending   Alcoholic Beverages Served?

____
____
____
____
____
____
____
____
____

3. Do any of the above events involve dance, casino nights, carnivals, races, sports, animals, water or vehicles?
☐ Yes ☐ No If "yes," please identify:

____
____
____
____

4. Does your organization require the facility to maintain liability insurance? ☐ Yes ☐ No
If "yes," do you obtain copies of Certificates of Insurance and require that you are named as an Additional Named Insured? ☐ Yes ☐ No

5. Do you require a mutual hold harmless agreement in the contract? ☐ Yes ☐ No

6. Are any Certificates of Insurance required? If so, list name and address of each organization below:

____
____
____
____
____

PHARMACY SUPPLEMENT (No. 2)

(Complete only if you operate an in-house pharmacy.)

1. **Name of Applicant:** ____

2. Annual Gross Revenue from Pharmacy: ____________

3. Are drugs dispensed to anyone other than the insured's hospice or home health patients? ☐ Yes ☐ No

4. How many pharmacists are on-staff? ____________

5. Are all licensed pharmacists credentialed by your organization prior to hire? ☐ Yes ☐ No

6. Who has access to stock? ____

7. Where/how is stock stored? ____

8. Does your pharmacy operate in compliance with the Controlled Substances Act (CSA)? ☐ Yes ☐ No

9. Does your pharmacy store, dispense and dispose of all drugs as required by state & federal regulation?
   ☐ Yes ☐ No

10. Describe disposal process for unused, spoiled or radioactive drugs:
    ____
    ____
    ____

11. Describe security measures, security systems or alarms that have been installed to protect the pharmacy unit:
    ____
    ____
    ____

12. Describe the policies that have been instituted to ensure that prescription drugs are stored under appropriate conditions and properly dispensed:
    ____
    ____
    ____

13. Are drugs delivered to the patient's home? ☐ Yes ☐ No If "yes," do you have a policy to ensure proper security and safe home delivery? ☐ Yes ☐ No

14. Does your organization have an "in-home" policy for disposal of unused prescription drugs? ☐ Yes ☐ No

HOSPICE BEREAVEMENT CAMP SUPPLEMENT (No. 3)

(If more than one camp is scheduled, please provide information for each camp.)

1. **Name of Applicant:** ____
2. Dates of Camp: ___________________________ Overnight? ☐ Yes ☐ No
3. Location of Camp: ____
4. Does the campground maintain its own liability insurance? ☐ Yes ☐ No If "yes," please request a Certificate of Insurance for your records.
5. How many children are enrolled? _____ What is the age of campers? ____ to ____ years of age. What is your ratio of staff to children? _______ Does the ratio of staff to children meet state requirements? ☐ Yes ☐ No
6. Are you securing a signed release form from guardians? ☐ Yes ☐ No
7. How are the children being transported to and from camp? ___________________________________

   (If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.)
8. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following?
   - ☐ Isolated settings
   - ☐ Individual meetings
   - ☐ Sleeping arrangements (if applicable)
   - ☐ Changing clothes/showering
9. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No
10. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No If "yes," please provide complete details.

    ____

    ____
11. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse?
    ☐ Yes ☐ No If "yes," please provide complete details.

    ____

    ____
12. Will there be a licensed RN or LPN on premises at all times? ☐ Yes ☐ No
13. Recreational activities:

    Are recreational swimming or boating activities included? ☐ Yes ☐ No
    If "yes," is there a certified lifeguard on duty? ☐ Yes ☐ No

    If boating activities are planned, are all participants required to wear life safety jackets at all times?
    ☐ Yes ☐ No ☐ N /A
14. Describe any other athletic or recreational activities that are planned and indicate any precautions that will be taken to ensure camper safety:

    ____

    ____

    ____

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. 9.

CHILD DAY CARE CENTER SUPPLEMENT (No. 5)

1. **Name of Applicant:** ____

2. Address of day care center: ____
   (Street) *(City)* *(State)* *(Zip Code)*

3. Hours of operation: _______________ Average daily attendance: ______

4. Is this a licensed day care facility? ☐ Yes ☐ No If "yes," what is the licensed capacity? (# of children): __________

5. Does the day care center comply with Board of Health regulations and building code requirements? ☐ Yes ☐ No

6. Ages of children: from ______ to ____________

7. Are the director and staff members certified and trained? ☐ Yes ☐ No

8. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following:
   - ☐ Isolated settings
   - ☐ Individual meetings
   - ☐ Sleeping arrangements
   - ☐ Changing clothes/showering

9. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No

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

    ____

    ____

11. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse?
    ☐ Yes ☐ No If "yes," please provide complete details.

    ____

    ____

12. Do you or your employees provide transportation to or from the facility? ☐ Yes ☐ No

13. Are children taken off-site for any activities? ☐ Yes ☐ No If "yes," who provides transportation?

    ____

    (If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.)

ADULT DAY CARE SUPPLEMENT (No. 6)

1. **Name of Applicant:** ____

2. Address of adult day care center: ____
   (Street) *(City)* *(State)* *(Zip Code)*

3. Hours of operation: ___________ Average daily enrollment: ____________

4. Is this a licensed adult day care facility? ☐ Yes ☐ No If "yes," what is the licensed capacity? (# of clients): ______

5. Does the day care center comply with Board of Health regulations and building code requirements? ☐ Yes ☐ No

6. Are policies and procedures in place regarding one-on-one contact between staff and clients addressing isolated settings?: ☐ Yes ☐ No

7. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No

   If "yes," please provide complete details.

   ____

   ____

8. Have you ever had to administer any disciplinary action against any current or previous staff members because of improper care or treatment of clients? ☐ Yes ☐ No

   If "yes," please provide complete details.

   ____

   ____

9. Is there a Registered Nurse on-site? ☐ Yes ☐ No

10. Is fall prevention training provided? ☐ Yes ☐ No

11. Clients served: (Please check all that apply)

    ☐ Dementia ☐ Frail Elderly ☐ Mental Retardation/Developmentally Disabled ☐ Physically Disabled
    ☐ Chronic Mental Illness ☐ HIV/AIDS ☐ Brain Injury ☐ Other: ______________________

12. Services provided: (Please check all that apply)

    ☐ Therapeutic Activities
    ☐ Health-related services (medication administration, blood sugar testing, and weight monitoring, etc.)
    ☐ Activities of Daily Living ☐ Meals ☐ Medical Escort
    ☐ Nursing services (wound care, injections colostomy care, etc.)
    ☐ Respite ☐ Rehabilitation Therapy ☐ Hospice ☐ Emergency respite ☐ Overnight care

13. Do you or your employees/volunteers pick up or transport clients to or from your day care facility? ☐ Yes ☐ No

14. Describe security measures or precautions taken to protect adult day care clients and to prevent them from leaving your facility unattended. ____

    ____

15. Have you ever had any prior incidents arising out of your day care facility that required notification to your insurance carrier, state or local authorities? ☐ Yes ☐ No If "yes," provide complete details. ______________________

    ____

    ____

STAFF PHYSICIAN / NURSE PRACTITIONER SUPPLEMENT (No. 7)

(applicable to Physicians and Nurse Practitioners who are not currently endorsed as Additional Named Insureds)

A printed or typed response is required for all questions. This application must be signed by the licensed physician or nurse practitioner. Please attach a curriculum vitae.

1. **Name of Applicant Organization:** ____

2. Physician/Nurse Practitioner Name: ____
   (First) *(Middle Initial)* *(Last)*

3. Date of birth: ______________________

4. Home address:____
   ____

5. Indicate the number of hours worked per month for this organization:______________________

6. Do you serve as: ☐ paid employee ☐ volunteer ☐ independent contractor

7. Do you maintain separate personal medical malpractice insurance coverage? ☐ Yes ☐ No **If "yes," please include a Certificate of Insurance.**

   Insurance Company Name: ______________________________ Limits of Liability: ______________

8. Does your policy cover you while performing work for this hospice/home health care agency? ☐ Yes ☐ No

9. Does the insurance include coverage for this hospice/home health care agency? ☐ Yes ☐ No

10. List all the states in which you are currently licensed:

State	License Number	Percentage of Practice

11. Has your license or medical staff privileges or appointment to a hospital ever been suspended, voluntarily withdrawn, reduced, withheld, denied, revoked or subjected to any disciplinary action? ☐ Yes ☐ No **If "yes," describe circumstances.** ____
    ____

12. Has any professional liability insurer ever canceled, declined or refused renewal of your professional liability insurance? ☐ Yes ☐ No

13. In the past ten years, has a professional liability claim or suit against you been filed or closed, or are you aware of any pending or potential claim or suit? ☐ Yes ☐ No

    IF "YES," PLEASE PROVIDE NARRATIVE DESCRIPTION OF MEDICAL FACTS AND COMPLETE THE FOLLOWING CHART FOR EACH INCIDENT. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF THIS APPLICATION. (PLEASE NOTE THAT A HARD COPY LOSS RUN FROM YOUR PREVIOUS CARRIER(S) MAY BE REQUIRED.)

Plaintiff	Incident Date	Report Date	Status (Open or Closed)	Settlement Amount	Date Paid	Insurance Company

14. Have all known potential claims or suits, if any, been reported to your current insurance carrier? ☐ Yes ☐ No

15. Are you board certified? ☐ Yes ☐ No

16. Name of certifying board: ____

STAFF PHYSICIAN / NURSE PRACTITIONER PROFILE SUPPLEMENT (No. 7)

Please continue with the following questions if you are a Physician.

17. Licensed Specialty: ____
18. Do you participate in the State Patient Compensation Fund (PCF)? ☐ Yes ☐ No ☐ Not Applicable
    If "yes," please include the PCF Certificate of Insurance.
19. Medical school: ____
20. If foreign-trained, are you ECFMG-certified? ☐ Yes ☐ No
21. Degree: ______________________ Date completed: ____________
22. Residency: ______________________ Date completed: ____________
23. Fellowship: ______________________ Date completed: ____________
24. First practice date (post residency, fellowship or military service): (Mo/Yr.) ____________
25. Have you participated in any continuing medical education within the last three years? ☐ Yes ☐ No
26. List all hospitals or facilities where you have admitting privileges: ______________________
    ____
27. Has your license to prescribe or dispense narcotics ever been refused, suspended or revoked? ☐ Yes ☐ No
    If "yes," attach a copy of the Medical Board Order.
28. Are you employed solely as a Medical Director of this organization? ☐ Yes ☐ No
29. Do your assigned duties entail clinical care while serving as Medical Director? ☐ Yes ☐ No

Note: A signature is required below for both Physicians and Nurse Practitioners.

______________________________ ____________

Signature of Physician/Nurse Practitioner Date

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ERISA BOND APPLICATION SUPPLEMENT (No. 8)

1. **Name of Applicant:** ______________________________

2. Plan Name: ______________________________
(As filed with the Department of Labor)

3. Address: ______________________________

4. Plan Assets: ______________________________

   Do any of the plans contain non-qualifying assets? ☐ Yes ☐ No

   Do any of the plans contain employer securities? ☐ Yes ☐ No

5. Bond Amount:

   ☐ $25,000 ☐ $125,000 ☐ $350,000
   ☐ $50,000 ☐ $200,000 ☐ $400,000
   ☐ $75,000 ☐ $250,000 ☐ $450,000
   ☐ $100,000 ☐ $300,000 ☐ $500,000
   Limit Other than Above: $________________

6. Effective Date: ______________________________ No. of Trustees: ______________________________
(3-year policy term)

7. Nature of Sponsor Business: ______________________________
   Agency (if applicable): ______________________________
   Prior Carrier: ______________________________
   Prior Losses (Past Three Years): ______________________________
   Completed by: ______________________________

This Bond is a requirement of the Employee Retirement Income Security Act of 1974. The Act requires the assets of any Employee Benefit Plan to be insured against loss due to employee dishonesty in the amount of 10% of the plan assets. The Bond must be at least $1,000 and need not be greater than $500,000. Please keep this in mind when determining the bond amount.

An Inflation Guard endorsement is added to each ERISA bond. This endorsement automatically provides a limit of liability equal to that required by ERISA for your benefit plans (provided the amount required by ERISA is purchased at the policy's inception). As long as the bond is in force, the bond amount will be in compliance with the ERISA limit requirement and you will not have to monitor the amount, or request periodic increases, saving you time and money.

PROPERTY SCHEDULE SUPPLEMENT (No. 9)

(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)

	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)

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.

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MEDICAL STAFFING SUPPLEMENT (No. 10)

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%)

☐ Hospitals / Health Systems	_____%	☐ Non-skilled personal care agencies	_____%
☐ Nursing Homes / Assisted Living Facilities	_____%	☐ Hospices	_____%
☐ Private Physician Practices	_____%	☐ Social Services Agencies	_____%
☐ Home Healthcare Agencies	_____%	☐ Surgical Centers	_____%
☐ Pharmacies	_____%	☐ 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?

	Staffed Workers
Current Licensure, certification, and registration	☐ Yes ☐ No
Criminal background checks	☐ Yes ☐ No
Present employment and two previous employers' verification	☐ Yes ☐ No
Pre-employment verification of convictions for abuse/neglect	☐ Yes ☐ No
Social Security number verification and search	☐ Yes ☐ No
Education	☐ Yes ☐ No
Home telephone/residency verification	☐ Yes ☐ No
Driver's license information (MVR) *if placement requires driving responsibilities*	☐ Yes ☐ No
Drug screening	☐ Yes ☐ 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