

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application
For
**Home Health Care & Nurse
Registries**

1. Name of Applicant _____

2. Individual Corporation Partnership Other (Explain) _____
Date your company established: _____

3. Street address _____
City _____ State _____ Zip _____
Applicant's Web Site Address _____

4. Provide full name(s) of individual and partners: _____

5. Receipts from employees \$ _____ Receipts from Independent Contractors \$ _____
Receipts from non-nursing operations \$ _____ Total Receipts \$ _____

6. Do employed nurses have own Professional Liability coverage? Yes No Limits required? \$ _____
Do you require Certificates of Insurance for all independent contractors? Yes No Limits required? \$ _____

7. Description of employed or contracted personnel:

	<u>Number Employed</u>	<u>Number Contracted</u>	<u>Contractors Ins. Limits required</u>	Percentage working in:		
				<u>Hospital</u>	<u>Nursing Home</u>	<u>Home</u>
Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____	_____	_____
Physicians	_____	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

8. Are background checks made with all prior employers and educational institutions? Yes No
Does background check include Police record? Yes No
If either answer is "No", refer risk to Company.

9. Is chemotherapy performed? Yes No
Describe types of IV therapy performed: _____

10. Describe services performed by any other professionals: _____

11. Do you want your policy to cover your employees? There is a premium charge. Yes No

(NOTE: The policy already protects *you* for the acts of your employees.)

12. Do you want sexual molestation coverage to protect you for alleged or actual acts of your employees? If yes, please complete sexual molestation section on back page. Yes No

13. Are your personnel responsible for monitoring any equipment? Yes No
 If yes, describe _____

14. Please list any medical equipment you supply to clients. _____

15. Do you want coverage for the equipment sold or rented to clients? Yes No
 Receipts-Sales: \$ _____ Receipts-Rental: \$ _____

16. Provide details of licensing or certification needed for this operation: _____

17. How long have you been licensed/certified? _____

18. Has your license ever been suspended or revoked? Yes No If yes, provide details on back.

19. Is your facility Medicare approved? Yes No Medicare receipts? \$ _____

20. Your premium is adjustable based on your **total** receipts. Our auditor needs to be able to verify your total receipts.
- If this information is kept by your accountant, please provide your accountant's name, address and telephone number: _____
 - If this information is kept by you, please provide the telephone number and address where the records are kept: _____
 - If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: _____
 - Your telephone number if not previously given: _____

21. Prior coverage:

Insurance Company	Year	Premium	Any Claims	Description
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

22. Is the applicant aware of any circumstances which may result in a claim? Yes No
 If yes, please describe: _____

23. LIMITS OF INSURANCE WANTED

General Aggregate Limit (Other than Products-Completed Operations)	\$ _____	
Products-Completed Operations Aggregate Limit	\$ _____	
Personal and Advertising Injury Limit	\$ _____	
Each Occurrence Limit	\$ _____	
Fire Damage Limit	\$ _____	any one (1) fire
Medical Expense Limit (up to \$5,000 limit available)	\$ _____	any one (1) person
Each Professional Incident Limit (if applicable)	\$ _____	

24. Effective Dates Desired: From _____ To _____

25. If sexual molestation coverage is not desired, proceed to signature block at bottom of next page.

SUPPLEMENTAL APPLICATION FOR SEXUAL MOLESTATION COVERAGE

26. Please indicate the liability limits you are requesting.
 \$25,000/50,000 \$50,000/100,000 \$100,000/300,000
27. Please describe your hiring practices: _____

28. Describe all background checks performed (prior employer, schools, police, references, etc.) _____

29. Do you have written guidelines regarding sexual misconduct: Yes No
30. What steps have you taken to prevent or avoid a sexual misconduct incident?
(e.g., same gender caregiver/client) _____

31. Have you or any employee, volunteer or other person working for you ever been arrested or
convicted of a crime? Yes No
If yes, give details _____

32. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of
misconduct? Yes No
If yes, give details _____

33. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought
against it while you were there? Yes No
If yes, give details _____

34. **Notice to applicants: In most states any person who knowingly, and with intent to defraud, files an
application for insurance containing any materially false information, or conceals, for the purposes of
misleading, information concerning any fact material hereto, commits a fraudulent act, which is a crime.**

APPLICANT'S NAME (PLEASE PRINT): _____

TITLE: _____

APPLICANT'S SIGNATURE: _____

DATE: _____