

PROFESSIONAL & GENERAL LIABILITY
HOME HEALTH CARE PROVIDERS/HOSPICE PROVIDERS

Effective Date Requested: _____ Date Quotation Desired: _____

Limits: \$100,000/200,000 \$1,000,000/\$1,000,000 \$1,000,000/3,000,000 \$2,000,000/6,000,000

GENERAL INFORMATION

1. Applicant: _____
2. Mailing Address: _____
City _____ State _____ Zip _____
3. Person to Contact: Name _____ Title _____
Telephone Number: _____
4. Applicant is: Individual Partnership Corporation Other Describe: _____
5. Type of Business: General Non-Profit Organization For Profit Organization
Year business started or date of incorporation _____
6. Annual Revenue/Budget: \$ _____ Gross sales, if any: \$ _____
7. Major funding source: _____
8. States in which Applicant is licensed to do business: _____
9. Is Applicant a member of any association? Yes No If yes, please state: _____
10. Is Applicant accredited by an association? Yes No If yes, please state: _____
11. Briefly describe the services offered by the Applicant and attach any of the Applicant's brochures.

PRIOR INSURANCE

Does the Applicant carry Professional Liability Insurance now? Yes No General Liability Insurance? Yes No

If yes, describe below for both lines of coverage:

Insurer: GL _____	Occurrence Form: <input type="checkbox"/> Yes <input type="checkbox"/> No
PL _____	Claims Made: <input type="checkbox"/> Yes <input type="checkbox"/> No
Limit of Liability: GL \$ _____ PL \$ _____	If Yes advise retroactive date: _____
Annual Premium GL \$ _____ PL \$ _____	
Inception Date: _____ Expiration Date _____	

Has the prior carrier indicated an intent not to renew? Yes No

If yes, please explain: _____

Is Agent the current broker of record? Yes No

PAST CLAIM ACTIVITIES

Describe all previous lawsuits, claims or incidents resulting in complaints made against the Applicant involving any allegation of a professional nature during the past five years including date of loss and amount paid or reserved.

Are you aware of any facts or circumstances or any actual or alleged act, error or omission which may result in claims being made against the Applicant or its employees or its volunteers? Yes No

If yes, please explain: _____

RISK MANAGEMENT

1. Describe hiring practices: Criminal Background Yes No
 License Verification Yes No
 Personal Interview Yes No
 Reference Checks Yes No
2. Attach a copy of your employment application.
3. Does applicant rent, sell, or service products to Clients or clients? Yes No If yes, describe all products and services: _____

Total annual product receipts? _____ Total annual product rental receipts? _____

Is there any life support equipment sold or serviced? _____

4. Please attach advertising brochure used in your business.

Specialty	Total Hours Worked Weekly Per Specialty	Number of Employees	Number of Contracted Persons	Does Professional Persona Carry Own Liability?
Aids	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Admin/Clerical	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Baby Nurse	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietician/Nutritionist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Homemaker	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalation Therapist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Therapist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
LPN	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Technician	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Optician	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paramedic/EMT	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician's Assistant	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychotherapist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
RN	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
RN (OB/GYN)	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Worker	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech/Lang. Pathologist	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Is Agency performing Infusion Therapy? Yes No
6. Is continuing education or staff development mandatory? Yes No If yes, please describe: _____
7. a. Are Aides and/or Homemakers required to be CPR certified? Yes No
 b. Are Aides and/or Homemakers required to have First Aid Training? Yes No
8. Are all personnel bonded? Yes No
9. Do you place any Nurse Practitioners? Yes No If yes, name specialty: _____
10. Do you place any Nurse MidWives? Yes No Do they carry their own insurance? Yes No
11. Do you have any contracts with any of the following? If yes, **you must** attached copy of contract:
- | | | |
|--------------------|--|----------------------------|
| Hospitals | <input type="checkbox"/> Yes <input type="checkbox"/> No | % of total operation _____ |
| Nursing Homes | <input type="checkbox"/> Yes <input type="checkbox"/> No | % of total operation _____ |
| Any other entities | <input type="checkbox"/> Yes <input type="checkbox"/> No | % of total operation _____ |

12. Do any of your personnel staff the following:

Emergency Room Yes No % of total operation _____
Labor & Delivery Rm. Yes No % of total operation _____
Intensive Care Units Yes No % of total operation _____

13. Do you have a Quality Assurance Dept? Yes No Are reported incidents reviewed? Yes No

14. Do you practice Universal Precautions? Yes No

15. Does your agency have policies and procedures in place regarding medications? Yes No

If yes, describe: _____

16. In case of emergency, is management available seven days a week, 24 hours a day? Yes No

SEXUAL ABUSE

1. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse offenses? Yes No

2.a Does your state permit you to do criminal background investigations on prospective employees? Yes No

b. If yes, do you routinely request and achieve such background investigations? Yes No

3. Do you verify employment-related references? Yes No

4. Do you conduct a personal interview? Yes No

5. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a Client/child reports someone molested him/her? Yes No

6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? Yes No

7. Do you have a written crisis management plan for dealing with staff personnel, victim, parents, authorities, and media if you have an incident of abuse? Yes No If yes, attach copy.

8.a. Have you ever had an incident, which resulted in an allegation of sexual abuse? Yes No

b. Was a claim made against you? Yes No If yes, provide copy of details.

c. Was case settled? Yes No

d. Taken to trial? Yes No

e. How much money was paid as damages to the victim? _____

f. Was a formal investigation conducted by a licensing agency? Yes No If yes, provide a copy of details.

INCOMPLETE AND UNSIGNED APPLICATIONS WILL BE RETURNED FOR COMPLETION

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

DECLARATION AND SIGNATURE

The Applicant represents to the best of his/her knowledge and belief that the statements set forth herein are true and include all material information.

The Applicant further represents that if the information supplied on this application changes between the date of its application and the inception date of the policy period, he/she will immediately notify GBT Insurance Agency Solutions LLC of such change. Signing of this application does not bind GBT Insurance Agency Solutions LLC to offer nor the Applicant to accept insurance, but it is agreed that this application and any attachments thereto shall be the basis of the insurance and the policy will be issued in reliance on those representations.

Signature _____ Date _____
Principal, Partner or Officer

The following statements are required by the regulations of the following state Insurance Departments. It is a requirement of certain states that this signed statement is attached to the policy. Please read the statement applicable to your state and sign where indicated.

CALIFORNIA APPLICANTS: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Applicant Signature Date _____

FLORIDA APPLICANTS: 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.

Applicant Signature Date _____

KENTUCKY APPLICANTS: 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 CONCERNING FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Applicant Signature Date _____

MINNESOTA APPLICANTS: A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Applicant Signature Date _____

NEW YORK APPLICANTS: 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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Applicant Signature Date _____

OHIO APPLICANTS: ANY PERSON WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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.

Applicant Signature Date _____

OKLAHOMA APPLICANTS: 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.

Applicant Signature Date _____

UTAH APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT UNDERWRITING INFORMATION, FILES OR CAUSES TO BE FILED A FALSE OR FRAUDULENT CLAIM FOR DISABILITY COMPENSATION OR MEDICAL BENEFITS, OR SUBMITS A FALSE OR FRAUDULENT REPORT OR BILLING FOR HEALTH CARE FEES OR OTHER PROFESSIONAL SERVICES IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant Signature Date _____

Producing Agency: _____
Address: _____
Telephone: _____ Fax: _____

Are you the current broker of this account? Yes No