



AGENTS INSURANCE MARKETS, INC.

P. O. Box 71360
 Richmond, VA 23255-1360

HOME HEALTH CARE BASIC NON-NURSING SERVICES

800-627-0505 (Phone)/804-285-4945

1. Name of Applicant: _____
2. Individual Corporation Partnership Other (Explain) _____
 Date Established _____
3. Street Address: _____
 City: _____ State: _____ Zip: _____
 Applicant's Web Site Address: _____
4. Provide full name(s) of individual and partners. _____

5. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.

6. Has applicant's license ever been suspended or revoked? Yes No
 Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? Yes No
If yes to either question above, provide full details on Attachment to A102.
7. Is applicant's operation Medicare approved? Yes No Medicare sales? \$ _____
8. Is applicant accredited by any of the following?
 National Homecareing Council Yes Joint Commission on Accreditation of Healthcare Organizations Yes
 National Association of Home Care Yes Community Health Accreditation Program Yes
9. Sales from employees: \$ _____ Sales from independent contractors: \$ _____
 Sales from non-nursing operations: \$ _____ Total Sales: \$ _____
10. Do employed nurses have their own Professional Liability coverage? Yes No
 Limits Required? \$ _____
 Does the applicant require Certificates of Insurance from all nursing (RNs, LPNs) independent contractors? Yes No
 Limits Required? \$ _____
11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
 If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.

 If this information is kept by the applicant, 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:
 Applicant's telephone number if not previously given: _____
12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made		Any Claims (Check One)		Description
_____	_____	_____	<input type="checkbox"/> Occ	<input type="checkbox"/> CM	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ	<input type="checkbox"/> CM	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ	<input type="checkbox"/> CM	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ	<input type="checkbox"/> CM	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ	<input type="checkbox"/> CM	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
13. Is the applicant aware of any circumstances which may result in a claim? Yes No
If yes, provide full details on Attachment to A102.
14. Does the applicant want the policy to cover employees? *There is a premium charge.* Yes No
 (Note: The policy already protects the applicant for the acts of his/her employees.)
15. Are applicant's employees or independent contractors responsible for monitoring any equipment? Yes No
 If yes, please provide full description. _____
 Check if continued on Attachment to A102.

16. Are employees required to complete daily work reports? Yes No
 Does applicant utilize a formal Quality Assurance/Risk Management program? Yes No
 Does applicant conduct patient/client surveys? Yes No
 Is there an informed consent process in place? Yes No
 Are there written policies in place for:
- | | | | |
|---------------------------------|--|---|--|
| Drug administration procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient acceptance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergencies in the field? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient rights? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Employee training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physician orders? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food preparation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Proper lifting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Handling of complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reporting of suspected physical/sexual abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical equipment training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Termination of Care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to any question is no, refer risk to Company.

17. Please provide details of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in:		
				Hospital	Nursing Home*	Home
Aides/Homemaker Health Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Home Companions	_____	_____	_____	_____	_____	_____
Certified Nursing Assistants	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%

* If yes, is contract with client for private duty work? Yes No *If no, please explain on Attachment to A102.*

18. Are the following background checks performed?
- | | | | |
|---|--|--------------------------------------|--|
| All prior employers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Home telephone verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All educational institutions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Professional licensing verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Residency information? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug screening required? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex offender registry search? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Federal, State (if possible) and County criminal record search? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security No. verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to any question is no, refer risk to Company.

19. Is 24 Hour Service provided? Yes No If Yes, Percent of Operations _____ %
 If Yes, is this Live-in? Yes No Shift Work? Yes No

20. Please describe services performed by any other professionals. _____

 Check if continued on Attachment to A102.

21. Please list any medical equipment applicant supplies to clients. _____

22. Does the applicant sell or rent equipment to clients? Yes No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____
 Check if continued on Attachment to A102.

24. **Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations)	\$	_____
Products-Completed Operations Aggregate Limit	\$	_____
Personal and Advertising Injury Limit	\$	_____
Each Occurrence Limit	\$	_____
Damage to Premises Rented to You (Up to \$100,000 limit available)	\$	_____ Any One (1) Premises
Medical Expense Limit (Up to \$5,000 limit available)	\$	_____ Any One (1) Person
Each Professional Incident Limit (if applicable)	\$	_____

25. Effective Dates Desired – From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE, PLEASE COMPLETE QUESTIONS 26. THROUGH 30.

\$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No

Please provide details: _____

27. 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

Describe: _____

28. Does your facility do background checks on all employees and volunteers? Yes No

Describe type of checks performed (prior employer, police, etc.): _____

29. Are there written guidelines in place regarding sexual misconduct? Yes No

If NO, please explain: _____

30. Please check the limits you are requesting: \$25,000/50,000 - included
 \$50,000/100,000 \$100,000/300,000 \$300,000/600,000 \$500,000/1MM \$1MM/2MM

FOR HIRED AND NON-OWNED AUTO COVERAGE, PLEASE COMPLETE QUESTIONS 31. THROUGH 35.

31. What types of non-owned autos will be used in your business? _____

32. Total Number of Non-owned autos used in your business? _____

33. Do you require your employees to have their own insurance? Yes No

If YES, what are the minimum liability limits required? _____

34. Will you use Non-owned autos other than those owned by your employees? Yes No

If YES, describe relationship and use: _____

35. Please check the limits you are requesting:
 \$100,000 \$300,000 \$500,000 \$1MM

Applicant's Signature _____ Date _____

Title _____ Producing Agent _____

