



HOME HEALTH CARE GENERAL/PROFESSIONAL LIABILITY APPLICATION RENEWAL APPLICATION

IMPORTANT: ALL OPERATIONS MUST BE DECLARED AND THE APPROPRIATE SECTION OF THE SUPPLEMENTAL APPLICATION COMPLETED WHERE APPLICABLE. THIS IS NOT A BINDER.

INSTRUCTIONS:

- a. This form must be signed and dated by a Principal or Officer of the firm.
- b. **PLEASE ATTACH ANY BROCHURES, LITERATURE OR DESCRIPTIVE MATERIAL PROVIDED TO CLIENTS.**

I. GENERAL INFORMATION	RENEWAL APPLICATION
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1. Full legal name of Insured: _____

2. Mailing Address: If changed, complete here.

Street Address and P.O. Box	City	County	State	Zip
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3. Risk is: Individual Partnership Corporation Non-Profit Other (describe) _____

4 a. Contact person for inspection, etc.: _____

b. Website Address: _____

c. Telephone: _____ d. Fax: _____ e. E-mail: _____

5. a. Total # of Employees: _____ b. Total Annual Gross Receipts: \$ _____

c. Type of Services Provided (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Home Health Care Provider | <input type="checkbox"/> Visiting Nurse Agency | <input type="checkbox"/> Supplemental Staffing |
| <input type="checkbox"/> Infusion Therapy Provider | <input type="checkbox"/> Nurse Registry | <input type="checkbox"/> Closed Pharmacy |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Other (specify) _____ | |

II. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS:

Is the insured a member of, or accredited by, any organizations? Yes No

If Yes, please state which: _____

III. RISK MANAGEMENT/QUALITY ASSURANCE:
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1. Please describe any changes made to your risk management/quality assurance program over the last year:

IV. CLAIMS/COVERAGE HISTORY:

1. Please attach currently valued loss runs for the prior 5 years (not including while insured with QBE Specialty Insurance Company).

**PROFESSIONAL LIABILITY SECTION
(All Applicants must complete this section)**

V. EMPLOYEES – ANNUAL STAFFING:

EMPLOYEE TYPE	NUMBER FULL TIME	NUMBER PART TIME	ANNUAL HOURS	ANNUAL PAYROLL*
NURSE (RN)				
LPN/LVN				
NURSE PRACTITIONER				
PHYSICAL THERAPIST				
RESPIRATORY THERAPIST				
SPEECH THERAPIST				
OCCUPATIONAL THERAPIST				
SOCIAL WORKER				
PHARMACIST				
HOME HEALTH AIDE				
HOMEMAKER				
SITTER/COMPANION				
CLERICAL PLACEMENTS				
OTHER (specify)				
TOTAL				

*If applicant has locations in more than one state, please provide total annual payroll by state.

VI. EMPLOYEES/INDEPENDENT CONTRACTORS (Continued)

1. Are applicant's EMPLOYEES required to carry their own professional liability coverage? Yes No
2. Are applicant's INDEPENDENT CONTRACTORS required to carry their own professional liability coverage?
 Yes No
 a. If yes, are minimum limits of liability required? Yes No
 b. Please specify limits required: \$_____
3. Are certificates of insurance maintained on file for all employees and/or independent contractors?
 Yes No
4. Do you obtain updated certificates of insurance on an annual basis?
 Yes No

VII. TYPES OF SERVICES PROVIDED

1. Are there any changes in the type of services you provide from last year? Yes No
 If yes, please describe: _____
2. Do you provide any supplemental staffing? Yes No
 If yes, to whom? _____

REQUIRED: Please attach any brochures, literature or descriptive materials provided to clients.

GENERAL UNDERWRITING SECTION
(Please complete for ALL lines of coverage)

I. OWNED OR LEASED PREMISES: (Please attach list of all other locations)

	ADDRESS	DO YOU OWN OR LEASE? Square Footage Occupied?	DESCRIBE OCCUPANCY OF BUILDING
#1.			
#2.			

1. Are any professional services provided on your premises? Yes No
 If yes, please explain: _____

2. Are any bed or board or overnight services provided? Yes No
 If yes, please explain: _____

3. Do you provide any "high tech" services?
 (i.e. trach care, ventilator care, chemotherapy, etc.)? Yes No
 If yes, please explain: _____

4. Does the organization enter into any contractual agreements?
 (i.e., with hospitals, nursing homes or other health care facilities, etc.) Yes No
 a. If yes, please list and attach copies of all agreements

b. If yes, do these agreements contain hold harmless or indemnification clauses favorable to the applicant? Yes No

5. Are certificates of insurance obtained from all subcontractors? Yes No

6. List all entities to be named as Additional Insureds with names and insurable interest:

(Please attach a copy of each contractual agreement, excluding landlords.)

1. NAME	2. NAME
ADDRESS	ADDRESS
INTEREST	INTEREST

7. Has applicant sold, acquired, or discontinued any operations in the past five years? Yes No
 If yes, please explain: _____

8. Is the applicant considering any changes in operations or products handled in the next 12 months? Yes No
 If yes, please explain: _____

INCOMPLETE AND UNSIGNED APPLICATIONS WILL BE RETURNED FOR COMPLETION

It is agreed by the applicant and us that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to us shall be the representations of the applicant and the insureds. It is further agreed by the applicant and insureds that this Policy, if issued, is issued in reliance upon the truth of such representations. The undersigned authorized officer of the applicant represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the applicant or us.

The undersigned further declares that any event taking place prior to the effective date of the insurance applied for which any render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to the insurer and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Arizona

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.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Minnesota

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

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York

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.

Ohio

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.

Pennsylvania

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 material 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.

Virginia

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

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

All Other States

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties.

IMPORTANT -- PLEASE READ BEFORE SIGNING

The undersigned certifies that he or she is the Executive Director or Chief Financial Officer of the organization applying for this insurance, that he or she is duly authorized by and acting on behalf of the organization in completing this application, and that all statements and answers set forth in this application are true, complete and correct. The undersigned acknowledges that this application, and the information set forth herein, is material to the Company, and shall form the basis for any coverage provided.

Date: _____

Executive Director's/Chief Financial Officer's Signature: _____

Print or Type Name: _____

Producing Agency: _____ Producer Code: _____ Producer License #: _____

Address: _____ Florida Register # (if applicable): _____

Telephone: _____ Facsimile: _____