








KINSALE INSURANCE

REQUESTED COVERAGE – HOME HEALTH AND MEDICAL STAFFING

☐ **Requesting Professional Liability:**

Requested Retro Date: _____

Professional Liability Limits		Professional Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting General Liability:**

Requested Retro Date: _____ or ☐ Occurrence Based Coverage

General Liability Limits		General Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: _____

Employee Benefits Liability Limits		Employee Benefits Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $1,000	☐ $10,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $2,500	☐ $15,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $5,000	☐ $20,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $7,500	☐ $25,000

☐ **Requesting Non-Owned Auto Liability:**

Non-Owned Auto Liability Limits	
☐ $100,000	☐ $500,000
☐ $200,000	☐ $1,000,000
☐ $250,000	☐ Other: _____

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.

Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

ALLIED HEALTH – HOME HEALTH AND STAFFING APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full Name of Applicant (Including DBA's): _____

2. Mailing Address:_____
   STREET CITY COUNTY STATE ZIP

3. Location Address(es): Check here if same as mailing: ☐

   (1) _____
   STREET CITY COUNTY STATE ZIP

   (2) _____
   STREET CITY COUNTY STATE ZIP

   (3) _____
   STREET CITY COUNTY STATE ZIP

   (4) _____
   STREET CITY COUNTY STATE ZIP

   Attach Additional Pages as Needed

4. Website Address: **www.** _____ 5. Telephone: _____

6. Inspection/Risk Management Contact Name: _____

7. Inspection/Risk Management Contact E-mail: _____

8. Date Established: _____ Years under current management: _____

9. Applicant is a:

   ☐ Individual
   ☐ Corporation
   ☐ LLC
   ☐ Other:_____
   ☐ Professional Associations
   ☐ Partnership
   ☐ Joint Venture

10. Enterprise is: ☐ For Profit ☐ Not For Profit

11. Is this entity owned by, associated with or controlled by any other entity? Yes ☐ No ☐

If yes, please provide details:

_____

_____

_____

OPERATIONS

12. Type of Operations (check **all** that apply)

☐ Home Health Care ☐ Medical Staffing/Nurse Registry ☐ Medical Equipment Supplier

☐ Other (specify)_____

13. Are you accredited by the Joint Commission, Community Health Accreditation Program (CHAP) or any other accrediting organization? If "yes" please specify: Yes ☐ No ☐

_____

_____

14. Please state sources and amounts of total revenue:

Source	Last 12 months	Next 12 months
Charitable contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for services	$_____	$_____
Other	$_____	$_____
Total Gross Revenue	$_____	$_____

15. Please indicate percentage of time spent in the following work locations:

Private Home	_____%	Hospital Staffing	
Assisted Living	_____%	Operating Room	_____%
Nursing Home	_____%	Emergency Room	_____%
Institutional Hospice	_____%	Labor & Delivery	_____%
Ambulatory Surgery Center	_____%	Neonatal (NICU)	_____%
Adult Day Care	_____%	Adult Intensive Care Unit	_____%
Clinic	_____%	Pediatric Intensive Care Unit	_____%
Physician's Office	_____%		
Jail, Prison or other Correctional Facility	_____%		
Other (specify where) _____	_____%	Other Hospital (specify where) _____	_____%

16. Percentage of Types of Services Provided (total **must** equal 100%)

Personal Care Chore or Companion	_____%	Respiratory Therapy	_____%
Rehabilitation – including Physical, Occupational, or Speech Therapy	_____%	Radiation Therapy	_____%
Infusion Therapy	_____%	Skilled Nursing Care	_____%
Hospice – In Home	_____%	Pediatric Care	_____%
Supplemental Staffing	_____%	Skin Care or Bedsore Wound Care	_____%
Obstetrical Services	_____%	Medical Equipment Supplier	_____%
Chemotherapy	_____%	In Home Dialysis	_____%
Cardiac Care	_____%		

17. Does the applicant provide any overnight bed facilities? Yes ☐ No ☐

18. Does the applicant perform any treatment or services on the applicant's premises? Yes ☐ No ☐

19. Does the applicant care or treatment to ventilator or tracheotomy patients? Yes ☐ No ☐
    If yes – please advise the percent of services _____%

20. Does the applicant perform any permanent placements of staff? Yes ☐ No ☐
    If "yes" – please indicate:
    percent of permanent placements _____% and temporary placements _____%

STAFF

21.

Type of Health Care Provider	# of Employees	Annual Employee Hours Worked	# of Independent Contractors	Annual Contractors Hours Worked
Personal Companion/ Homemaker				
Live In Companions				
Certified Nurse Aid (CNA)				
Licensed Practical Nurse (LPN)				
Registered Nurse (RN)				
Medical Technician				
Nurse Practitioner				
Speech Therapist				
Occupational Therapist				
Physical Therapist				
Social Worker				
Physician Assistant				
CRNA				
Nurse Midwife				
Physicians (all types)				
Other:				
Other				

22. Are all above individuals licensed in accordance with applicable state and federal regulations? (if licensure is required) Yes ☐ No ☐

23. Do **ALL** employees carry their own professional liability insurance? Yes ☐ No ☐
    a. If "yes" what are the minimum limits of liability they carry?
    _____Per Occurrence
    _____Aggregate

24. Do **ALL** independent contractors carry their own professional liability insurance? Yes ☐ No ☐
    a. If "yes" what are the minimum limits of liability they carry?
    _____Per Occurrence
    _____Aggregate
    b. If "no" are you requesting direct coverage for your independently contracted staff? Yes ☐ No ☐

25. Please provide the name and specialty of the applicant's Medical Director: _____
☐ Full Time or ☐ Part Time - Does the applicant's Medical Director have direct patient care? ☐ YES ☐ NO

26. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services on your behalf:
    - ☐ Check of educational background, or residency program, when applicable.
    - ☐ Check of previous employers (☐ In writing ☐ By Telephone)
    - ☐ Criminal background check (☐ STATE ☐ FEDERAL)
    - ☐ Drug / Alcohol / Abuse Screening (circle all that are used)
    - ☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
    - ☐ Require information on any professional liability or work-related claim that has previously been made against any Individual?

27. Does your facility have written job descriptions? Yes ☐ No ☐

PREMISES INFORMATION – Complete ONLY if you are requesting General Liability Coverage

Building Description

	Buildings/Wings			
	#1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

28. Do any of the Applicant's locations have any(explain any "yes" answers on page 8):
    a. Exposure to flammables, explosive, chemicals? ☐ YES ☐ NO
    b. Catastrophe exposure? ☐ YES ☐ NO
    c. Exposure to radioactive materials? ☐ YES ☐ NO

NON-OWNED AUTO - Complete ONLY if you are requesting Non-Owned Auto Coverage

29. Limits requested:
    - ☐ $100,000
    - ☐ $250,000
    - ☐ $500,000
    - ☐ $1,000,000
    - ☐ Other: (please specify)_____

30. Number of **OWNED** autos? _____

31. Do you have auto liability for owned autos? Yes ☐ No ☐

32. Is Non-Owned auto liability coverage under the owned auto policy? Yes ☐ No ☐

33. What type(s) of non-owned autos will be used in your business?

		Number of Autos
☐	Private Passenger	
☐	Other (specify)	

34. How will they be used?_____
_____
_____

35. What is the **maximum** distance which a non-owned auto may be driven from your premises? _____***miles***

36. What percentage of your business involves client transportation? _____%

37. Do your employees or contractors EVER drive a client's car? Yes ☐ No ☐

38. How often are non-owned autos used in your business ☐ Daily ☐ Weekly ☐ Monthly ☐ Seldom

39. Please confirm what driver screening procedures are utilized (check **ALL** that apply):
    - ☐ Obtain and verify valid driver's license on all employees yearly
    - ☐ Obtain and verify valid personal auto insurance yearly
      If indicated, what limits of liability are required? _____
    - ☐ Order and review MVR's on all employees yearly
    - ☐ Prohibit employees from driving if license is suspended, revoked, or has serious violation such as DUI, etc.

Explain any exceptions should the applicant NOT use or follow **ALL** of the above driver screening methods noted above:
_____
_____
_____

MEDICAL EQUIPMENT or SUPPLIES – RENTAL OR SALES - Complete ONLY if you have these operations

40. TYPE OF EQUIPMENT SOLD OR RENTED (complete table below)

		SALES REVENUE	RENTAL REVENUE
CATEGORY I.	**EXPENDABLE ITEMS** – intended for one time usage and disposed (ie adhesive tape, bandages, hypodermic needles, etc.)	$_____	$_____
CATEGORY II.	**NON-EXPENDABLE ITEMS** – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, lifts, or hoists, walkers, strollers, canes, crutches, wheelchairs, etc.	$_____	$_____
CATEGORY III.	**DIAGNOSTIC OR TREATMENT DEVICES** – This category includes oxygen and other medical gases used in conjunction with respitory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also include are blood pressure gauges, IV pump, portable EKG machines or sending devices.	$_____	$_____
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/failure or improper function could result in death or serious deterioration in health condition.	$_____	$_____

41. Does the applicant **REPAIR or PERFORM MAINTENANCE** on any medical supplies and/or equipment? Yes ☐ No ☐
    a. If "yes" please advise the total Annual Sales: _____
    b. Types of equipment serviced?
    _____
    _____
    _____

COVERAGE HISTORY

42. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg.	Deductible	Premium	Retroactive date

43. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Occurrence or Claims – Made?

If the current expiring GL policy is claims- made what is the retroactive date? _____

CLAIMS AND HISTORY – Please explain or complete a supplemental claim for form for all "Yes" answers.

44. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 9 or attach additional pages as needed.** ☐ YES ☐ NO

45. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on page 9 or attach additional pages as needed**. ☐ YES ☐ NO

46. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 9 or attach additional pages as needed.** ☐ YES ☐ NO

47. Has any claim or suit ever been made against the applicant **OR** any other person proposed for this insurance? **How Many? _____ (Complete Supplemental Claims form for Each.)** ☐ YES ☐ NO

48. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

49. Has any claim or suit been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION (reference question number if applicable)

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **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 the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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 denial of insurance benefits.

NOTICE TO 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.

NOTICE TO NEW MEXICO APPLICANTS: 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.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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.

NOTICE TO 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO VIRGINIA APPLICANTS: 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle?
☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____