SCOTTSDALE
SURPLUS LINES INSURANCE COMPANY
8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752
www.scottsdaleins.com

Home Health Care General Liability Application

Applicant's Name _____
Mailing Address _____
_____
Location _____
_____
Web Site Address _____

Agency Name _____
Agent _____
Address _____
_____
E-Mail _____
Phone _____

PROPOSED EFFECTIVE DATE: From _____ **To** _____ **12:01 A.M., Standard Time at the address of the Applicant**

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
☐ Limited Liability Company ☐ Other (Specify) _____

LIMITS OF LIABILITY REQUESTED			PREMIUMS
General Aggregate		$	Premises/Operations
Products & Completed Operations Aggregate		$	$
Personal & Advertising Injury		$	Products/Completed Operations
Each Occurrence		$	$
Fire Damage (any one fire)		$	Other
Medical Expense (any one person)		$	$
Errors and Omissions	Each Claim	$	Other
	Aggregate	$	$
Other Coverages, Restrictions, and/or Endorsements Sexual and/or Physical Abuse: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000			Total
	Deductible	$	$

1. **Number of years in operation:** _____

2. **How long under present management?** _____
   (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the Director of Nursing or the individual responsible for hiring, screening and monitoring the work activities of your employees.)

3. **Operations conducted in the following states:**
   State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____
   State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____
   State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____

4. **Has license ever been revoked?** ☐ Yes ☐ No

   If yes, explain: _____

   _____

5. **Name all subsidiary companies/locations and others coming under applicant's control** (if none, please state):

   _____

   _____

6. **Has the applicant sold, acquired or discontinued any operations in the last five years?** ☐ Yes ☐ No

   If yes, explain: _____

   _____

7. **Is at least one of the principals or an Administrator/Director of Nursing involved in the operation on a full-time basis?** ☐ Yes ☐ No

8. **How does applicant monitor the daily work activities of employees** (i.e., daily work reports, hospital procedures, etc.)? _____

   Please describe: _____

   _____

9. **As part of hiring/screening of new employees, does applicant:**

   a. Obtain copies of their professional licenses/certifications? ☐ Yes ☐ No

   b. Contact applicants' references before they are hired? ☐ Yes ☐ No

   c. Require that they carry their own professional liability policy? ☐ Yes ☐ No

10. **Physicians or RNs are:** ☐ private practitioners (independent contractors) ☐ actual employees of insured

11. **Number of contracted physicians:** _____ RNs: _____

12. **Is proof of insurance required?** ☐ Yes ☐ No

13. **Does applicant have Workers' Compensation coverage in force?** ☐ Yes ☐ No

14. **Does applicant have any contractual agreements wherein applicant assumes the liability of others?** ☐ Yes ☐ No

    If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

15. **Are all services provided out of a central office?** ☐ Yes ☐ No

16. **Does the applicant provide treatment on his/her own premises or provide bed and board facilities?** ☐ Yes ☐ No

17. **Employees are placed (by percentage)**:

    _____% ACLF Homes _____% Clinics _____% Doctor's Office _____% Hospitals

    _____% Hospice Facilities _____% Private Homes _____% Nursing Homes _____% Jails/Detention Centers

    _____% Other: _____

    (Please attach any brochures, literature or descriptive materials provided to the client.)

18. **State patients' ages:** from _____ (youngest) to _____ (eldest).

19. State approximate division of patients:

_____% Medical _____% Retarded _____% Nonambulatory _____% Surgical
_____% Drug Addicts _____% Alcoholics _____% Senile or Aged _____% Any Other Classes
_____% AIDS/HIV _____% Alzheimer's

20. Employee Classification:

	No. of Employees	No. of Contractors	Est. Hrs. Last 12 Months Employees	Est. Hrs. Last 12 Months Contractors	Est. Hrs. Next 12 Months Employees	Est. Hrs. Next 12 Months Contractors	Est. Total Payroll Next 12 Months Employees	Est. Total Fees Next 12 Months Contractors
PROFESSIONAL								
Physicians, interns, residents								
Graduate nurses—RN								
Practical nurses—LPN								
Licensed visiting nurses—LVN								
Physical therapists								
Inhalation therapists								
Dieticians								
Beauticians/barbers								
Respiratory therapists								
Occupational therapists								
X-ray technicians								
Licensed counselors								
Other (describe)								
NON-PROFESSIONAL								
Nurses' aides								
Student nurses								
Volunteers								
Social workers								
Homemaker health aides								

21. Any off-premises field trips? ..... ☐ Yes ☐ No

If yes, how many? _____ Describe: _____

22. Are employees authorized to use their personal vehicles to transport patients? ..... ☐ Yes ☐ No

If yes, please provide details (i.e., under what circumstances, if applicant obtains a waiver of liability from the patients, etc.): _____

23. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangement with hospital, etc.):

_____

24. **What percentage of applicant's professional nursing staff hours entail the rendering of "high-tech" home care** (i.e., home infusion and nutritional therapies)? _____%

Please provide a detailed description of the "high-tech" care: _____

_____

25. **Number of AIDS/HIV patients:** _____

Are patients isolated? ☐ Yes ☐ No

If yes, how? _____

26. **What training is provided to new/existing staff?** _____

_____

_____

_____

27. **Is staff informed of all patients with AIDS/HIV?** ☐ Yes ☐ No

28. **Does applicant do any blood testing?** ☐ Yes ☐ No

29. **Attach a copy of the applicant's written infection control plan.**

30. **How is infectious waste stored and disposed of?** _____

_____

31. **Are employees tested for AIDS/HIV?** ☐ Yes ☐ No

If yes, how often? _____

32. **Actual annual gross revenue last 12 months:** _____

Estimated annual gross revenue next 12 months: _____

33. **Any infusion therapy?** ☐ Yes ☐ No

34. **Does applicant have other business ventures for which coverage is not required?** ☐ Yes ☐ No

If yes, explain and advise where insured: _____

_____

Does applicant sell or lease products to patients/customers? ☐ Yes ☐ No

If yes, describe in detail and give gross revenues received from the sale or leasing of products : _____

_____

_____

35. **Any other premises or operations exposures not stated in this application?** ☐ Yes ☐ No

If yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS

Loc. No.	Classification	Class. Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem./Ops.	Products/ Comp. Ops.	Prem./Ops.	Products/ Comp. Ops.

36. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation? ☐ Yes ☐ No

If yes, date: _____ Please explain: _____

_____

37. During the past three years, has any company ever cancelled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri) ☐ Yes ☐ No

If yes, explain: _____

_____

Previous Insurer and Loss History: Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years. ☐ See loss run attached

YEAR	COMPANY	POL. NO.	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF 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 such violation.

FRAUD WARNING:

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 subjects such person to criminal and civil penalties.

NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only.)

IOWA LICENSED AGENT: _____

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"