



Home Healthcare Agency / Nurse Registry / Allied Healthcare Staffing Renewal Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):
 Street: County:
 City: State: Zip:
 Phone: Website:

3. Type of operations (check all that apply):

<input type="checkbox"/> Home health care	<input type="checkbox"/> Nurse registry	<input type="checkbox"/> Infusion therapy
<input type="checkbox"/> Hospice-homebound	<input type="checkbox"/> Hospice-institutional	<input type="checkbox"/> Other medical staffing

If other medical staffing, please specify:

4. Please state sources and amounts of total revenue:

	last 12 months	next 12 months
Charitable contributions		
Government funding		
Fee for services		
Other – specify: <input style="width: 40%;" type="text"/>		
Total gross revenue:		

Operations and Activities

5. Where are services provided? (Total must equal 100%):

Private home	%	Doctor's office/clinic	%	Hospital	%
Hospice	%	Adult day care	%	Child day care	%
Surgicenter	%	Nursing home/assisted living facility		%	
Other – please specify: <input style="width: 40%;" type="text"/>				%	

6. If staffing to a hospital, please indicate the percentage of time staff spends in each of the following:

Emergency room	%	Intensive care unit	%	Labor and Delivery	%
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7. If staffing to nursing homes and/or assisted living facilities:

a. Does the applicant require the nursing home/assisted living facility(s) to carry professional liability insurance? Yes No

If Yes, please indicate what limits of liability are required:



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b. Is there any common ownership between the nursing homes and/or assisted living facilities and the applicant in question 1? Yes No

If Yes, please describe/explain:

8. Does the applicant maintain any beds for overnight occupancy? Yes No

If Yes, please give total number:

Staffing Information

9.

Type of healthcare provider	Number of employees	Number of independent contractors	Annual billable hours in last 12 months	Annual billable hours projected for next 12 months
Registered nurse				
Licensed practical nurse				
Nurse practitioner/ physician assistant				
Certified nurse assistant				
Physical/speech/occupational therapist				
Respiratory therapist				
Social worker				
Companion/home health aide				
Other (specify):				
TOTALS:				

10. a. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No

If No, please explain in the comments section.

b. i. Do you require contracted staff to carry their own professional liability insurance? Yes No

ii. Do you maintain Certificates of Insurance to confirm such coverage? Yes No

Insurance and Claims History

11. Has the applicant notified Hiscox Inc. of all matters that may result in a potential claim including any litigation, administrative proceedings, demand letters, formal or informal investigations or inquiries which have occurred within the expiring policy period?

Yes No None to Report

If No, please attach a detailed explanation or explain in the Comments Section.



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Comments Section

Notice to New York applicants: 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 material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	<div style="border: 1px solid black; height: 20px;"></div>
Signature of person authorized to execute on behalf of the applicant:	<div style="border: 1px solid black; height: 25px;"></div>
Name/title of person authorized to execute on behalf of the applicant:	<div style="border: 1px solid black; height: 25px;"></div>
Date:	<div style="border: 1px solid black; height: 20px;"></div>

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.