COLONIAL GENERAL INSURANCE AGENCY, INC.

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5373 S. Green St., Suite 525, Murray, UT 84123
(801) 290-1144 WATS (800) 594-8900
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Agent's E-mail Address____________________ Preferred Method of Correspondence? E-Mail Fax Regular Mail

Applicant's E-mail Address _________________ Preferred Method of Correspondence? E-Mail Fax Regular Mail

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) ____________________

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

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 **Has license ever been revoked?** ....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 ___% Mentally Impaired ___% Non-ambulatory ___% 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 Em-ployees	Est. Hrs. Last 12 Months Contractors	Est. Hrs. Next 12 Months Em-ployees	Est. Hrs. Next 12 Months Contractors	Est. Total Payroll Next 12 Months Em-ployees	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 canceled, 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	POLICY 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.

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.

FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):

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.

FRAUD WARNING 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.

APPLICANT'S NAME AND TITLE: ______________________________

APPLICANT'S SIGNATURE: ______________________________ DATE: ______________

(Must be signed by an owner, partner or executive officer)

PRODUCER'S SIGNATURE: ______________________________ DATE: ______________

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.