



Name of Organization: \_\_\_\_\_ Requested effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
(street) (county) (city) (state) (zip code)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ FEIN No.: \_\_\_\_\_

Email address: \_\_\_\_\_ Web site address: \_\_\_\_\_

Administrator or CEO/Insurance Contact Person: \_\_\_\_\_

Years in Business: \_\_\_\_\_ Annual Revenue: \_\_\_\_\_

Additional Locations: \_\_\_\_\_  
(Attach extra sheet, if necessary)

Additional Entities/Named Insureds: \_\_\_\_\_  
(Attach extra sheet, if necessary)

- Home health care; # of annual patient visits \_\_\_\_\_; Annual # of patients treated \_\_\_\_\_
- 24-hour "live-in" nurses or aides; # of assigned personnel \_\_\_\_\_; Annual # of patients \_\_\_\_\_
- Aides (nonskilled companion care domestic services): Annual # of clients \_\_\_\_\_; # of aides providing services \_\_\_\_\_
- % of pediatric care provided (compared to your overall operations) \_\_\_\_\_% Annual # of pediatric patients: \_\_\_\_\_
- % of patients receiving infusion therapy (compared to your overall operations) \_\_\_\_\_%.
- Are you Medicare Certified?  Yes  No
- Are you licensed by the state, local or county agencies?  Yes  No **(If "yes", please attach a copy of the license along with your latest inspection report, and a copy of the documented remedial actions taken to correct any deficiencies cited in the report.)**
- Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier?  Yes  No
- Where are employees/independent contractors placed (by percentage)?  
 Private Homes \_\_\_\_% Hospitals \_\_\_\_% Nursing Homes \_\_\_\_% Assisted Living \_\_\_\_%  
 Medical Clinics \_\_\_\_% Doctor's Offices \_\_\_\_% Other (describe) \_\_\_\_\_%

Employees / Contracted Services	# of Emp	# Ind Contractors	Est. Hours Employees	Est. Hours Contractors	Est. Ann Payroll Employees	Est. Ann Payroll Ind. Contractors
Physical & Respiratory Therapist						
Nurses -- Temporary Staffing						
Nurses – Other than Temporary						
Aides/ Homemakers						
Medical Technicians						
Pharmacists						
Occ/ Speech/ Hearing Therapists						
Social Workers						
Physician						
PA/ NP/ Clinic Nurse Specialist						
Live-in Companions						
All Others (Describe)						

\_\_\_\_\_  
 Submitter's Name / Signature

\_\_\_\_\_  
 Date

**Please attach:** 1- Resume/CV on primary clinical staffer, if available or on Company Principal(s)/Administrator;  
 (Resume is only required for start up or new operations.)  
 2- Declarations Page of Existing Policy showing retro date (if applicable)