Member Companies of Western World Insurance Group

☐ Western World Insurance Company

☐ Tudor Insurance Company

Application For
Home Health Care & Nurse Registries
Skilled Professional Services

1. Name of Applicant: _____

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Explain) _____
   Date Established _____

3. Street Address: _____
   City: _____ State: _____ Zip: _____
   Applicant's Web Site Address: _____

4. Provide full name(s) of individual and partners. _____

5. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.

6. Has applicant's license ever been suspended or revoked? ☐ Yes ☐ No
   Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? ☐ Yes ☐ No
   If yes to either question above, provide full details on Attachment to A62.

7. Is applicant's operation Medicare approved? ☐ Yes ☐ No Medicare sales? $ _____

8. Is applicant accredited by any of the following?
   National Homecaring Council ☐ Yes
   Joint Commission on Accreditation of Healthcare Organizations ☐ Yes
   National Association of Home Care ☐ Yes
   Community Health Accreditation Program ☐ Yes

9. Sales from employees: $ _____ Sales from independent contractors: $ _____
   Sales from non-nursing operations: $ _____ Total Sales: $ _____

10. Do employed nurses have their own Professional Liability coverage? ☐ Yes ☐ No
    Limits Required? $ _____
    Does the applicant require Certificates of Insurance from all nursing independent contractors? ☐ Yes ☐ No
    Limits Required? $ _____

11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
    If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.

    If this information is kept by the applicant, please provide the telephone number and address where the records are kept.

    If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached:

    Applicant's telephone number if not previously given: _____

12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made	Any Claims (Check One)	Description
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	

13. Is the applicant aware of any circumstances which may result in a claim? ☐ Yes ☐ No
    If yes, provide full details on Attachment to A62.

14. Does the applicant want the policy to cover employees? *There is a premium charge.* ☐ Yes ☐ No
    (Note: The policy already protects the applicant for the acts of his/her employees.)

15. Are applicant's employees or independent contractors responsible for monitoring any equipment? ☐ Yes ☐ No
    If yes, please provide full description. _____

☐ *Check if continued on Attachment to A62.*

16. Are employees required to complete daily work reports? ☐ Yes ☐ No

If patient is receiving skilled care, does patient have a current and regularly updated physician treatment plan on file with your agency? ☐ Yes ☐ No

Does applicant utilize a formal Quality Assurance/Risk Management program? ☐ Yes ☐ No

Does applicant conduct patient/client surveys? ☐ Yes ☐ No

Is there an informed consent process in place? ☐ Yes ☐ No

Are there written policies in place for:

Drug administration procedures?	☐ Yes ☐ No	Patient acceptance?	☐ Yes ☐ No
Emergencies in the field?	☐ Yes ☐ No	Patient rights?	☐ Yes ☐ No
Employee training?	☐ Yes ☐ No	Physician orders?	☐ Yes ☐ No
Food preparation?	☐ Yes ☐ No	Proper lifting?	☐ Yes ☐ No
Handling of complaints?	☐ Yes ☐ No	Reporting of suspected physical/sexual abuse?	☐ Yes ☐ No
Medical equipment training?	☐ Yes ☐ No	Termination of Care?	☐ Yes ☐ No

** If the answer to any question is no, refer risk to Company.

17.

Please provide details of employed or contracted personnel:	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in: Hospital	Nursing Home*	Home
Aides						
LPN's						
RN's						
Nurse Practitioners						
Dialysis Technicians						
Medical Social Workers						
Mental Health Professionals						
Phlebotomists						
Physician Assistants						
Physicians/Medical Director						
Therapists (Physical, Speech Occupational or Respiratory)						
Others (Specify)						

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%

* If yes, is contract with client for private duty work? ☐ Yes ☐ No *If no, please explain on Attachment to A62.*

18. Are the following background checks performed?

All prior employers?	☐ Yes ☐ No	Home telephone verification?	☐ Yes ☐ No
All educational institutions?	☐ Yes ☐ No	Professional licensing verification?	☐ Yes ☐ No
Driver's license information?	☐ Yes ☐ No	Residency information?	☐ Yes ☐ No
Drug screening required?	☐ Yes ☐ No	Sex offender registry search?	☐ Yes ☐ No
Federal, State (if possible) and County criminal record search?	☐ Yes ☐ No	Social Security No. verification?	☐ Yes ☐ No

** If the answer to any question is no, refer risk to Company.

19. Are any of the following services performed or offered? Show percentage of receipts.
If the answer to any question is yes, provide full details on Attachment to A62.

AIDS case management?	☐ Yes _____% ☐ No	Medical lab services?	☐ Yes _____% ☐ No
Ambulatory dialysis?	☐ Yes _____% ☐ No	Operating room?	☐ Yes _____% ☐ No
Cardiac recovery programs/cardiac monitoring?	☐ Yes _____% ☐ No	Pain management?	☐ Yes _____% ☐ No
Chemotherapy?	☐ Yes _____% ☐ No	Parenteral and enteral feeding through gastros-tomy tube or central line?	☐ Yes _____% ☐ No
Chronic/terminal illness management?	☐ Yes _____% ☐ No		
Complex wound management?	☐ Yes _____% ☐ No	Pediatric home care?	☐ Yes _____% ☐ No
Crisis intervention of psychiatric patients?	☐ Yes _____% ☐ No	Rehabilitative services?	☐ Yes _____% ☐ No
Infusion (IV therapy)?	☐ Yes _____% ☐ No	Short-stay surgery home recovery?	☐ Yes _____% ☐ No
Description of IV therapy performed: _____		Telemedicine?	☐ Yes _____% ☐ No
		Tracheostomy/ventilator care?	☐ Yes _____% ☐ No
Labor/delivery room?	☐ Yes _____% ☐ No	Twenty-four hour service / live-in service?	☐ Yes _____% ☐ No
Maternal/newborn assessment or neonatal monitoring?	☐ Yes _____% ☐ No	If Yes, is this shift work?	☐ Yes _____% ☐ No

Other? _____

** If the answer to any question is yes, refer risk to Company.

20. Please describe services performed by any other professionals. _____

_____

_____

☐ *Check if continued on Attachment to A62.*

21. Please list any medical equipment applicant supplies to clients. _____

_____

22. Does the applicant sell or rent equipment to clients? ☐ Yes ☐ No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____

_____

☐ *Check if continued on Attachment to A62.*

24. **Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations)	$	_____	
Products-Completed Operations Aggregate Limit	$	_____	
Personal and Advertising Injury Limit	$	_____	
Each Occurrence Limit	$	_____	
Damage to Premises Rented to You (Up to $100,000 limit available)	$	_____	Any One (1) Premises
Medical Expense Limit (Up to $5,000 limit available)	$	_____	Any One (1) Person
Each Professional Incident Limit (if applicable)	$	_____	

25. Effective Dates Desired – From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE, PLEASE COMPLETE QUESTIONS 26. THROUGH 30.

$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here ☐ Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
Please provide details: _____

_____

27. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? ☐ Yes ☐ No
Describe: _____

_____

28. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
Describe type of checks performed (prior employer, police, etc.): _____

_____

29. Are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No
If NO, please explain: _____

30. Please check the limits you are requesting: ☐ $25,000/50,000 - included
☐ $50,000/100,000 ☐ $100,000/300,000 ☐ $300,000/600,000 ☐ $500,000/1MM ☐ $1MM/2MM

FOR HIRED AND NON-OWNED AUTO COVERAGE, PLEASE COMPLETE QUESTIONS 31. THROUGH 35.

31. What types of non-owned autos will be used in your business? _____

_____

32. Total Number of Non-owned autos used in your business? _____

33. Do you require your employees to have their own insurance? ☐ Yes ☐ No
If YES, what are the minimum liability limits required? _____

34. Will you use Non-owned autos other than those owned by your employees? ☐ Yes ☐ No
If YES, describe relationship and use: _____

35. Please check the limits you are requesting:
☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1MM

Applicant's Signature _____ Date _____

Title _____ Producing Agent _____

Name of Applicant ______________________________

#	Description or Full Details