

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 RN's are: private practitioners (independent contractors) actual employees of insured

11. Number of contracted physicians: _____ RN's: _____

12. Is proof of insurance required? Yes No

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

14. Does applicant lease employees? Yes No

15. 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.

16. Are all services provided out of a central office? Yes No

17. Does the applicant provide treatment on its own premises or provide bed and board facilities?

Yes No

18. Employees are placed (by percentage):

_____ % Private homes _____ % Nursing homes _____ % Doctor's office
 _____ % Hospitals _____ % Clinics _____ % Other

Describe other: _____

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

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

20. State approximate division of patients:

_____ % Medical _____ % Retarded _____ % Nonambulatory
 _____ % Surgical _____ % Drug addicts _____ % Any other classes
 _____ % Senile or aged _____ % Alcoholics _____ % AIDS/HIV
 _____ % Alzheimer's

21. Employee Classification:

	Number of Employees	Number 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								
Dietitians								
Beauticians/barbers								
Respiratory therapists								
Occupational therapists								
X-ray technicians								
Licensed counselors								
Other (describe)								
NONPROFESSIONAL								

	Number of Employees	Number 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
Nurses'aides								
Student nurses								
Volunteers								
Social workers								
Homemaker health aides								

22. Any off-premises field trips? Yes No If yes, how many? _____ Describe: _____
23. 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.)- _____
24. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangement with hospital, etc.) _____
25. 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: _____
26. Number of AIDS/HIV patients: _____ Are patients isolated? Yes No
If yes, how? _____
27. What training is provided to new/existing staff? _____
28. Is staff informed of all patients with AIDS/HIV? Yes No
29. Does applicant do any blood testing? Yes No
30. Attach a copy of the applicant's written infection control plan.
31. How is infectious waste stored and disposed of? _____
32. Are employees tested for AIDS/HIV? Yes No If yes, how often? _____
33. Actual annual gross revenue last 12 months: _____
Estimated annual gross revenue next 12 months: _____
34. Any infusion therapy? Yes No
35. Does applicant engage in any business or have a majority interest in any business other than home health care/staff relief? Yes No
Does applicant sell or lease products to patients/customers? Yes No If yes, please describe in detail and give gross revenues received from the sale or leasing of products: _____

36. 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 Basis: (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

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

If yes, date: _____ Please explain: _____

38. During the past three years, has any company canceled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri.) Yes No If yes, explain: _____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

YEAR	COMPANY	POL. #	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 _____

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