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BEST CHOICE
INSURANCE AGENCY

Application For Home Health Care & Nurse Registries

1. Name of Applicant ________________

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Explain) ________________
   Date your company established: ________________

3. Street address ________________
   City ________________ State ________________ Zip ________________
   Applicant's Web Site Address ________________

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

5. Receipts from employees $ ________________ Receipts from Independent Contractors $ ________________
   Receipts from non-nursing operations $ ________________ Total Receipts $ ________________

6. Do employed nurses have own Professional Liability coverage? ☐ Yes ☐ No Limits required? $ ________
   Do you require Certificates of Insurance for all independent contractors? ☐ Yes ☐ No Limits required? $ ________

7. Description 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						
Physicians						
Physician Assistant						
Others (Specify)						

8. Are background checks made with all prior employers and educational institutions? ☐ Yes ☐ No
   Does background check include Police record? ☐ Yes ☐ No
   If either answer is "No", refer risk to Company.

9. Is chemotherapy performed? ☐ Yes ☐ No
   Describe types of IV therapy performed: ________________

10. Describe services performed by any other professionals: ________________

11. Do you want your policy to cover your employees? There is a premium charge. ☐ Yes ☐ No

    (NOTE: The policy already protects *you* for the acts of your employees.)

12. Do you want sexual molestation coverage to protect you for alleged or actual acts of your employees? If yes, please complete sexual molestation section on back page. ☐ Yes ☐ No

13. Are your personnel responsible for monitoring any equipment? ☐ Yes ☐ No
If yes, describe ____________________

14. Please list any medical equipment you supply to clients. ____________________
____

15. Do you want coverage for the equipment sold or rented to clients? ☐ Yes ☐ No
Receipts-Sales: $ __________ Receipts-Rental: $ __________

16. Provide details of licensing or certification needed for this operation: ____________________
____

17. How long have you been licensed/certified? ____________________

18. Has your license ever been suspended or revoked? ☐ Yes ☐ No If yes, provide details on back.

19. Is your facility Medicare approved? ☐ Yes ☐ No Medicare receipts? $ __________

20. Your premium is adjustable based on your **total** receipts. Our auditor needs to be able to verify your total receipts.

- If this information is kept by your accountant, please provide your accountant's name, address and telephone number: ____________________
- If this information is kept by you, 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: ____________________
- Your telephone number if not previously given: ____________________

21. Prior coverage:

Insurance Company	Year	Premium	Any Claims	Description

22. Is the applicant aware of any circumstances which may result in a claim? ☐ Yes ☐ No
If yes, please describe: ____________________

23. LIMITS OF INSURANCE WANTED

General Aggregate Limit (Other than Products-Completed Operations)	$ __________	
Products-Completed Operations Aggregate Limit	$ __________	
Personal and Advertising Injury Limit	$ __________	
Each Occurrence Limit	$ __________	
Fire Damage Limit	$ __________	any one (1) fire
Medical Expense Limit (up to $5,000 limit available)	$ __________	any one (1) person
Each Professional Incident Limit (if applicable)	$ __________	

24. Effective Dates Desired: From __________ To __________

25. If sexual molestation coverage is <u>not</u> desired, proceed to signature block at bottom of next page.

SUPPLEMENTAL APPLICATION
FOR SEXUAL MOLESTATION COVERAGE

26. Please indicate the liability limits you are requesting.
☐ $25,000/50,000 ☐ $50,000/100,000 ☐ $100,000/300,000

27. Please describe your hiring practices: ______________________

28. Describe all background checks performed (prior employer, schools, police, references, etc.) ______________________

29. Do you have written guidelines regarding sexual misconduct: ☐ Yes ☐ No

30. What steps have you taken to prevent or avoid a sexual misconduct incident?
(e.g., same gender caregiver/client) ______________________

31. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, give details ______________________

32. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, give details ______________________

33. 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
If yes, give details ______________________

34. **Notice to applicants: In most states any person who knowingly, and with intent to defraud, files an application for insurance containing any materially false information, or conceals, for the purposes of misleading, information concerning any fact material hereto, commits a fraudulent act, which is a crime.**

APPLICANT'S NAME (PLEASE PRINT): ______________________

TITLE: ______________________

APPLICANT'S SIGNATURE: ______________________

DATE: ______________________