atlantic specialty lines

Submit Application

HOME HEALTHCARE APPLICATION

NOTICE: PART OR ALL OF THE POLICY FOR WHICH THIS APPLICATION IS MADE IS WRITTEN ON A CLAIMS MADE AND REPORTED BASIS, WHICH MEANS THAT THE POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED IN WRITING TO THE INSURER DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

Requested Attachments:

1. Loss History for the last FIVE years.
2. Most recent local and/or State accreditation agency reports (if applicable).
3. Copy of expiring declarations page if retroactive coverage is being requested

I. APPLICANT INFORMATION:

a) Name of Applicant/Entity(s)_____

_____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____

_____

d) Telephone_____ Website_____

e) List names, location, and descriptions of all legal entities, including subsidiaries for which Applicant is a part (continue on a separate sheet if necessary)

Loc. #	Business Name and Address	Description	Date Acquired	Ownership %	Retroactive Date

f) Have you sold, discontinued, changed, or acquired any operations in the past 5 years, or do you plan to in the upcoming year? (Please including name of entity and date acquired) ☐ Yes ☒ No

_____

_____

g) List all licenses and/or any/all accreditation from governmental agencies/clients held by your facility including type and expiration dates.

II. COVERAGE HISTORY:

a) Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

b) Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

c) Do you currently carry employee benefits liability coverage? ..... ☐ Yes ☐ No
If yes, what is the employee count, limit, deductible, and retroactive date?

_____

d) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? ..... ☐ Yes ☐ No
If yes, please explain.

_____

III. PROFESSIONAL SERVICE/PRODUCT AND MEDICAL STAFF PROFILE:

a) Please provide a full description of services rendered.

1. Locations where services are provided (total must equal **100%**):

_____% Private Home _____% Nursing Home _____% Assisted Living Facility

_____% Hospice _____%Hospital _____% Physician's Office

_____% Physical Rehab Facility _____% Psychiatric Facility _____%Substance Abuse Facility

_____% Correctional Facility _____% Other Facility (please specify)_____

2. Type of services (identify percentage, if any):

_____% Skilled Nursing _____% Assistive Nursing _____% Labor & Delivery/Obstetrics

_____% Correctional _____%Pain Management _____% Sitter/Companion Care

_____% ICU (Intensive Care) _____% Surgical/OR _____% Tracheostomy/Ventilator

_____% Emergency Department _____% Other Facility (please specify)_____

3. Age of Clients: _____% younger than 18; _____% 18 to 60 yrs old; _____% older than 60

4. Projected annual revenue:

	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Gross Revenues:			

5. Annual Employee Staffing:

Type of Employee	Full-Time	Part-Time	Billable Hours Last 12 Months	Billable Hours Next 12 Months	Annual Payroll
Registered Nurses					
Licensed Practical Nurses					
Licensed Vocational Nurses					
Nurse Practitioners					
Physician Assistants					
Certified Nurse Assistants					
Home Health Aids					
Sitters/Companions (non-medical)					
Homemakers (non-medical)					
Social Workers/Counselors					
Respiratory Therapists					
Speech/Occupational/Physical Therapists					
Other (specify)					

6. Do you run criminal background checks on all staff? ..... ☐ Yes ☐ No

7. Are sex offender registry checks performed on all staff? ..... ☐ Yes ☐ No

8. Annual Independent Contractor Staffing:

Type of Independent Contractor	Full-Time	Part-Time	Billable Hours Last 12 Months	Billable Hours Next 12 Months	Annual Payroll
Registered Nurses					
Licensed Practical Nurses					
Licensed Vocational Nurses					
Nurse Practitioners					
Physician Assistants					
Certified Nurse Assistants					
Home Health Aids					
Sitters/Companions (non-medical)					
Homemaker (non-medical)					
Social Worker/Counselor					
Respiratory Therapist					
Speech/Occupational/Physical Therapists					
Other (specify)					

9. Do independent contractors carry their own insurance? ..... ☐ Yes ☐ No
If yes, what limits?

_____

10. Are you requesting coverage for independent contractors? ..... ☐ Yes ☐ No

11. Do you require all Nursing Homes/Assisted Living/Long Term Care Facilities to carry Professional and General Liability Coverage?..... ☐ Yes ☐ No

If yes, what limits?

_____

12. Are all health professionals credentialed prior to hiring?..... ☐ Yes ☐ No

13. Prior to hiring any employee, does the applicant verify:
    - Education background and training?..... ☐ Yes ☐ No
    - Employment references with at least two previous employers?..... ☐ Yes ☐ No
    - Criminal record, on a Local, State and National scale? (Please indicate which apply)

      _____
    - Driving record?..... ☐ Yes ☐ No
    - Credit record?..... ☐ Yes ☐ No
    - Drug tests?..... ☐ Yes ☐ No
    - Sex Offender Registry?..... ☐ Yes ☐ No

14. Does the applicant keep all information on file and verify its completion prior to employment commencement?..... ☐ Yes ☐ No

15. Does the applicant confirm that the Insured annually checks MVRs and requires all drivers to carry a minimum of $100,000/$300,000 in personal auto insurance?..... ☐ Yes ☐ No

IV: PRIVACY

a) Does the Applicant have a written corporate-wide privacy policy? ..... ☐ Yes ☐ No
If yes, please attach a copy.

b) Does the Applicant collect, store, maintain or transmit personally identifiable consumer information? ..... ☐ Yes ☐ No

If yes, does such information include:
- Information subject to regulation under HIPAA..... ☐ Yes ☐ No
- Information subject to regulation under GLB..... ☐ Yes ☐ No
- Credit card information..... ☐ Yes ☐ No
- Other personally identifiable consumer information (please describe): ..... ☐ Yes ☐ No

c) Does any Applicant, director, officer, employee or other proposed Insured have knowledge or information of any fact, circumstance, situation, event or transaction which may give rise to a Claim against any Insured for invasion of or interference with any right of privacy, wrongful disclosure of personal information, or violation of any privacy related statute or regulation?
If "yes", please explain: ..... ☐ Yes ☐ No

_____

d) During the past three years, has anyone made any Claim against the Applicant for invasion of or interference with any right of privacy, wrongful disclosure of personal information, or violation of any privacy related statute or regulation? ..... ☐ Yes ☐ No

_____

V. INSURED HISTORY - CLAIMS, LOSSES, AND INCIDENTS:

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?..... ☐ Yes ☐ No
If Yes, how many? _____Complete a copy of our Supplemental Claim form for each

b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability, or products liability claim or suit?..... ☐ Yes ☐ No
If Yes, has each of these been reported to the current or any prior insurer?..... ☐ Yes ☐ No
How many? _____ Complete a copy of our Supplemental Claim form for each

c) Has the applicant or any staff:
   i. ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? ☐ Yes ☐ No
   ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... ☐ Yes ☐ No
   iii. ever been treated for alcoholism or drug addiction? ..... ☐ Yes ☐ No

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? ..... ☐ Yes ☐ No
(If yes, please provide an explanation on any/all incidents)

_____

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer to defraud or attempt to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines and an insurer may deny insurance benefits if false information materially related to a claim made by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

LOUISIANA AND MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurer to defraud the insurer. Penalties may include imprisonment, fines or denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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.

NEW YORK AND KENTUCKY: Any person who knowingly and with intent to defraud an insurer or other person files an application for insurance or statement of claims 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. New York applicants are subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. Pennsylvania applicants are subject to criminal and civil penalties.

Signed: _____.

Date:_____

Print Name: _____

Title: _____

(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: _____

Florida Agent's License Number: _____

Agent's Signature: _____