FIRST INSURANCE SERVICES

HOME HEALTH APPLICATION

I. APPLICANT INFORMATION

Applicant: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Physical Address (if different): _____

City:_____ County:_____ State: _____ Zip:_____

Phone: _____ _____ Fax: _____ _____ Email: _____

Requested Policy Period: _____ / _____ / _____ 12:01 a.m. to _____ / _____ / _____ 12:01 a.m.

Website: _____ Federal Tax ID: _____

II. OPERATIONS

Are you part of a franchise system or membership group? ☐ YES ☐ NO Name:_____

Type of Operation: (✓)

1. ☐ Home Health Care
2. ☐ Non-Medical Services
3. ☐ Medical Staffing
4. ☐ Durable Medical Equipment
5. ☐ Adult Day Care
6. ☐ Other _____

Years in Business under this name: _____

Gross Receipts for the last 12 months: $_____

Estimated Gross Receipts for the next 12 months: $_____

Do you provide services in any of the following areas? If so, please note what % of total revenue comes from that service.

☐ Nursing Home, Assisted Living or Independent facilities	_____%	☐ Prisons	_____%
☐ Private Homes	_____%	☐ Hospitals	_____%
☐ Pediatrics	_____%	☐ Physicians Offices/Clinics	_____%

Do you use independent contractors in lieu of employees? ☐ YES ☐ NO

Do employees provide incidental patient/client transportation in their personal vehicles? ☐ YES ☐ NO

If YES, number of transports per year _____

Are MVRs checked annually for all employees driving for company business or transporting patients/clients? ☐ YES ☐ NO

Do you require your employees to carry at least minimum liability limits on their personal auto policy? ☐ YES ☐ NO

Do you keep a copy of evidence of insurance for your employees driving their vehicle for company business? ☐ YES ☐ NO

III. GENERAL UNDERWRITING INFORMATION

Are you currently insured for General & Professional Liability? ☐ YES ☐ NO

If YES, please complete the following items:

a) Name of Insurance Company _____

b) ☐ Claims Made Form ☐ Occurrence Form

c) If Claims-Made

   a. GL Retroactive Date: _____

   b. PL Retroactive Date: _____

d) Limits of Insurance: $_____

e) Premium: $_____

f) Liability Deductible: $_____

g) Physical Sexual Abuse sublimit: $_____

NOTE: This information can be found on your current policy declarations page – or attach a copy of your policy.

Has the Applicant (including owners, managers, partners or administrators) ever:
(If yes, attach complete explanation)

a. Been involved in any personal or business bankruptcy? Yes ☐ No ☐
b. Been arrested, charged or convicted of any civil or criminal violations? Yes ☐ No ☐
c. Had insurance cancelled or non-renewed? Yes ☐ No ☐

Have any claims/suits been made within the last 5 years against the applicant? ☐ *YES ☐ NO
**If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical info? ☐ *YES ☐ NO
**If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Has any insurance company declined, cancelled or refused to renew any of the applicant's insurance? ☐ *YES ☐ NO
**If YES, please attach information describing why coverage was denied or cancelled.*

Has the applicant had any incidents or claims reported for physical sexual abuse or any other allegation of abuse? ☐ *YES ☐ NO
**If YES, please provide FULL details.*

Are there written guidelines regarding sexual misconduct? ☐ *YES ☐ NO
**If YES, please provide copies of all policies and procedures, including training materials.*

Does the applicant perform background checks on all employees? ☐ *YES ☐ NO
**If YES, please describe all background checks performed.*

What steps have been taken to prevent or avoid a sexual misconduct incident?

_____

_____

_____

IV. DESIRED COVERAGE INFORMATION (Please provide ACORD apps*)

Professional Liability:	☐	General Liability:	☐
Hired & Non-Owned Auto:	☐	*Workers Comp:	☐
Property:	☐	*Crime:	☐

Check the professional categories below that are applicable to your operation and provide head count, billed hours and receipts for each:

Profession	Full Time Equivalent (40 Hr. Week)		Billed Hours		% of Receipts
	Employed (W-2)	Contracted (1099)	Employed (W-2)	Contracted (1099)	
Admin/Clerical					
Home Health Aide					
LPN/LVN					
Nurse Aide					
CNA					
Registered Nurse					
Occupational/Speech Therapist					
Social Worker					
Physical Therapist					
Resp. Therapist					
Rehab Therapist					

NOTE: MD's, DD's, DDS's, Paramedics, PA's, EMT's, Nurse Midwives and Nurse Anesthesiologists are not eligible for coverage.

List states of operation: _____

If multiple states, please complete Multi-state Supplemental at end of application

Are there any medical doctors on the premises? ☐ YES ☐ NO

If YES – are they operating in an administrative capacity? ☐ YES ☐ NO

If NO – Please describe their duties:

_____

_____

Important: If you are a start-up, please describe your home health care experience (or the experience of the person that will run the operations)

_____

_____

_____

Applicant's Affidavit and Signature: I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied coverage. I further understand that the completion and signing of this application does not bind the applicant or the company to complete the insurance and supplemental information may be requested to produce a binding quote.

Signature: _____ Date:_____

Please return your completed application to:

Randal Cade
rcade@1stinsurance.net
First Insurance Services
300 S. Wheeler, Jasper TX 75951
409-384-2578 x228
FAX TO: 409-384-3341

FIRST INSURANCE SERVICES

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DURABLE MEDICAL EQUIPMENT SUPPLEMENT

Will you provide any durable medical equipment? Yes ☐ No ☐
(If yes, complete this page)

If yes, ☐Sale Only ☐Rental ☐Sales &Rental

Receipts broken down by category:

Category I: **EXPENDABLE ITEMS –** Intended for one time usage and disposed (i.e., adhesive tape, bandages, or hypodermic needles, etc.)

a. Annual Sales: $ _____

Category II: **NON-EXPENDABLE ITEMS –** Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc, and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

b. Annual Sales: $ _____

c. Annual Lease / Rental Receipts: $ _____

Category III: **DIAGNOSTIC OR TREATMENT DEVICES –** This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

d. Annual Sales: $ _____ e. Annual Lease / Rental Receipts: $ _____

Do you distribute oxygen tanks? Yes ☐ No ☐

If yes, are they: Pre-Filled ☐ Self-Filled ☐

If yes, does storage meet NFDA standards? Yes ☐ No ☐

Category IV: **LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES –** This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

f. Annual Sales: $ _____ g. Annual Lease / Rental Receipts: $ _____

Category V: **DURABLE MEDICAL EQUIPMENT –** Does the account sell or rent any of the following types of durable medical equipment? (If yes, please check type below)

☐Surgical Implant Devices ☐Anesthesia Equipment

☐Radiology Equipment ☐Laboratory Equipment

☐Blood Cleansing Equipment ☐Laser Equipment

h. Annual Sales: $ _____ i. Annual Lease / Rental Receipts: $ _____

TOTAL ANNUAL RECEIPTS OF MEDICAL SUPPLIES AND / OR EQUIPMENT (ADD A – I) $ _____

Does applicant rent, lease, repair or do maintenance on any medical or therapeutic supplies or equipment? Yes ☐ No ☐

If yes, total annual rental receipts of such medical supplies and or equipment: $ _____

List type of equipment rented or attached schedule:

_____

_____

Are service records kept on rentals? Yes ☐ No ☐

FIRST INSURANCE SERVICES

MULTI-STATE SUPPLEMENTAL

Location Addresses:

	Street	City	County	ST	ZIP
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

Combined Revenue By State:

State:_____ Gross Receipts Last 12 Months:_____ Gross Receipts Next 12 Months:_____

State:_____ Gross Receipts Last 12 Months:_____ Gross Receipts Next 12 Months:_____

State:_____ Gross Receipts Last 12 Months:_____ Gross Receipts Next 12 Months:_____

State:_____ Gross Receipts Last 12 Months:_____ Gross Receipts Next 12 Months:_____

State:_____ Gross Receipts Last 12 Months:_____ Gross Receipts Next 12 Months:_____

FIRST INSURANCE SERVICES

WORKERS COMPENSATION

Workers Compensation coverage is based on a percentage of your payroll.

To get coverage for the first year of business, we need an estimate of what you plan to pay your employees over the next 12 months. If you're unsure, we can give a quote based on $30,000 to $50,000 worth of payroll to get your started.

# of Full Time		# of Part Time		Annual Payroll by Class	Classification or Description
W-2	1099	W-2	1099		
					Certified Caregivers (CNA, LVN, RN)
					Non-Certified Caregivers (Comp. Care Aide)
					Clerical
					Outside Sales
					Other

Total Number of Employees: _____

Total Payroll: $_____

FEIN: _____

Ownership Information:

Name	DOB	% Ownership	Corporate Title