

COLONY INSURANCE COMPANY
HOME HEALTH CARE AGENCY



1. Name of Applicant _____
 Name of Business _____
2. Street Address _____
 Street _____

 City State Zip
3. Address of location of location to be insured _____
 Street _____

 City State Zip
 same as above
4. Type of enterprise: Individual Corporation Partnership Joint Venture
 For Profit Non-Profit Other _____
 Type of firm: Home Health Care Supplemental Staffing Medical Equipment Supplier
 Nurse Registry Other _____
5. Full description of services rendered. Coverage will only apply to disclosed premises and operations.
 Attach all brochures and promotional materials: _____

6. Provide full names of individual and partners: _____

7. Date your company was established: _____
8. Number of employees: _____ Payroll of employees: \$ _____
9. Number of independent contractors: _____ Cost of independent contractors: \$ _____
10. Receipts for last 12 months \$ _____ Receipts for next 12 months \$ _____
11. Do you require and keep certificates of insurance for all independent contractors? Yes No
12. Does the applicant utilize a formal written Quality Assurance & Risk Management Program. ... Yes No
 If no, explain. _____
 Is the overall responsibility for Risk Management assigned to one individual in your firm? Yes No
 If yes, explain. _____
 If no, how these functions are monitored. _____
 Is an "informed consent" document placed in the patient's medical record. Yes No
 Does the applicant conduct patient/client surveys? (If yes, attach sample) Yes No
 Are the results of patient/client surveys used to improve day to day operations? Yes No

13. Description of employees or contracted personnel:

| | Number Employeed | Number Contracted | Carries Own Insurance | Hospital | % in Nursing Home | Home |
|------------------------|---------------------|----------------------|--------------------------|----------|----------------------|-------|
| Aids | _____ | _____ | _____ | _____ | _____ | _____ |
| LPN's | _____ | _____ | _____ | _____ | _____ | _____ |
| RN's | _____ | _____ | _____ | _____ | _____ | _____ |
| Nurse Practitioner | _____ | _____ | _____ | _____ | _____ | _____ |
| Physical Therapist | _____ | _____ | _____ | _____ | _____ | _____ |
| Respiatory Therapist | _____ | _____ | _____ | _____ | _____ | _____ |
| Speech Therapits | _____ | _____ | _____ | _____ | _____ | _____ |
| Occupational Therapits | _____ | _____ | _____ | _____ | _____ | _____ |
| Social Worker | _____ | _____ | _____ | _____ | _____ | _____ |
| Pharmacist | _____ | _____ | _____ | _____ | _____ | _____ |
| Special Training | _____ | _____ | _____ | _____ | _____ | _____ |
| Other _____ | _____ | _____ | _____ | _____ | _____ | _____ |

14. Are employees/contractors references contacted before hired/placed? Yes No
 How are references checked? Written Verbal Both

If verbal only, please explain. _____

Do you question prospective employees as to any criminal record? Yes No

If no, please explain. _____

Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? Yes No

If no, please explain. _____

Do you verify certification and/or professional licensure status of employees and independent contractors? Yes No

Are employees screened to rule out drug, alcohol and/or sexual abuse? Yes No

Are job descriptions provided for all professional and nonprofessional employees? Yes No

15. Describe services performed by your LPN's. _____

16. Describe services performed by your RN's. _____

17. Describe services performed by any other professional. _____

18. Do you supply any medical equipment or are your personnel responsible for monitoring any equipment? Yes No

If yes, describe all such equipment. _____

19. Do you sell or lease any equipment? Yes No

If yes, describe all such equipment. _____

20. Do you repair or maintain any medical equipment? Yes No

If yes, describe. _____

21. Receipts from equipment sales, leasing or repair: \$ _____

22. Provide details for licensing or certification needed for this operation: _____

23. How long have you been licensed/certified? _____

24. Has your license ever been suspended or revoked? Yes No
If yes, explain. _____

25. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts.
If this information is kept by your accountant, provide the accounts name, address and phone number.
_____ () - _____

If this information is kept by you, provide the telephone number and address where the records are kept.
_____ () - _____

26. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? Yes No

27. Has applicant had previous insurance for this enterprise? Yes No

If yes, please complete the following:

Insurance Company _____

Policy Period _____ to _____

Limits of Liability _____

Premium _____ Type of Coverage: Occurrence Claims Made

Current General Liability Carrier _____

Limits requested _____

28. During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? Yes No

If yes, please provide full details (Include description of claim, amounts paid, and reserves) _____

29. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? Yes No

If yes, please provide full details. _____

30. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy canceled, or non-renewed in the past five (5) years? Yes No

If yes, please provide full details. _____

Additional Comments or Interests: _____

Applicant's signature **Must have signature to quote*

Title

Date

PRODUCER