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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME HEALTH CARE APPROVED FRANCHISE SUPPLEMENTAL APPLICATION

Effective Date:_____

Firm Name:_____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐For Profit ☐Non Profit ☐Partnership ☐Other:_____

Web site address:_____

Billing Address:_____

Date business established:_____ (Attach current financial statement and principal's resumes if in business less than three years.)

Employer Federal Tax I.D. Number:_____

Risk Management Contact:_____ Cell Phone:_____ Email:_____

This application is to be used for non-skilled Home Health Care Approved Franchise Agencies only. If there is any skilled nursing involved with the Agency, please complete the Home Health Care Supplemental in lieu of this application.

SUBMISSION REQUIREMENTS

- ACORD Application including drivers list
- Franchise employee handbook
- Currently valued loss for the current year plus prior three years
- Brochure and/or Newsletter, if available
- Franchise quality control program
- Resume of owner/principle if less than 3 years in business
- Client contract

SECTION I – ACCOUNT INFORMATION

1. Number of clients / customers per year:_____
2. Applicant's total annual gross receipts: $_____
3. Type of firm: (Please check all those that apply.)
   ☐Companionship ☐Home Helper ☐Personal Care
   ☐Medical Equipment Supplier ☐Other:_____
4. Description of operations:

   _____
5. Any locations / square footage leased to others? ☐Yes ☐No
   If yes, number of locations:_____ Square footage of each:_____
6. Are employee / contractor references contacted before hired / placed? ☐Yes ☐No
7. How are references checked? ☐Written ☐Verbal ☐Both
   If verbal only, please explain:

   _____
8. Does Applicant conduct criminal background checks on prospective employees? ☐Yes ☐No
9. Has Applicant's organization ever had an incident which resulted in an allegation of sexual abuse? ☐Yes ☐No
   If yes, please explain:

   _____
10. Does Applicant's current insurance program exclude Abuse and Molestation coverage? ☐Yes ☐No
    If no, please indicate the limit of liability provided: $_____
11. Previous Professional Liability Insurance:

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence	Retroactive Date (claims made only)
			$		
			$		
			$		

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12. Are the Applicant's independent contractors required to carry their own professional liability coverage? ☐Yes ☐No
    If yes, are minimum limits of liability required? ☐Yes ☐No
13. Are certificates of insurance maintained on file for all independent contractors? ☐Yes ☐No
14. Does Applicant obtain updated certificates of insurance on an annual basis? ☐Yes ☐No
15. Location where services are provided? (Total must equal 100%)
    Private Home _____% Nursing Home _____% Hospitals _____%
    Hospice _____% Other Locations: _____ _____%
16. Types of services provided:

Skilled Care Services			
Cardiac care	_____%	Dietician / Nutritionist	_____%
Case management	_____%	Gastronomy (GT) care	_____%
Chemotherapy	_____%	Hospice services	_____%
Clinical trials	_____%	Palliative care	_____%
Dialysis	_____%	Respite care	_____%
Infusion therapy	_____%	Special care (Alzheimer's / Dementia)	_____%
Obstetrical /doula	_____%	Trach / Ventilator	_____%
Radiation therapy	_____%	Other (specify): _____	_____%
Rehabilitation: Physical, Occupational, Speech therapy	_____%	**Total Skilled Care Services**	_____**%**

Non-Skilled Services			
Companion / Sitter / Personal Care	_____%	Mid-Wife	_____%
Dietician / Nutritionist	_____%	Palliative care	_____%
Gastronomy (GT) care	_____%	Respite care	_____%
Hospice	_____%	Other (specify): _____	_____%
		Total Non-Skilled Services	_____**%**

Miscellaneous Services			
Child daycare	_____%	Social services	_____%
Clergy	_____%	Supplemental staffing	_____%
Handyman	_____%	Training/Certification	_____%
Meals on Wheels	_____%	Telehealth	_____%
Medical equipment supplier	_____%	Thrift shops	_____%
Pet therapy	_____%	Wet nurse	_____%
Pharmacy	_____%	Other (specify): _____	_____%
		Total Miscellaneous Services	_____**%**

17. Does the Applicant provide pediatric care? ☐Yes ☐No
    If "yes" what is the percentage of total patients: _____%
    If yes, describe the types of pediatric services provided: _____
    Are any of the patients deemed medically fragile (i.e.: feeding tube, breathing ventilator)? ☐Yes ☐No
18. Does the Applicant provide live-in Home Health Care Service? ☐Yes ☐No
    If yes, what is the percentage? _____%
19. Location of Services Provided (total must equal100%)

Adult day care facilities	_____%	Outpatient facilities	_____%
Assisted living facilities	_____%	Owned facility	_____%
Clinics	_____%	Prisons	_____%
Doctor's offices	_____%	Private homes	_____%
Hospitals	_____%	Schools	_____%
Laboratories	_____%	Other: _____	_____%
Nursing homes	_____%	**Total:**	_____%

20. Describe any changes in operations planned within the next year: ☐N/A

21. Staffing:
Total number of: Full time employees:_____ Part Time Employees:_____ Volunteers:_____

Staffing	Total # of Annual Hours Worked	Employee		Contracted		Volunteers	Annual Payroll (Or 1099 Amount)	
		FT	PT	FT	PT		Employees	Independent Contractors
Counselors								
Social Workers								
Occupational Therapists								
Speech Therapists								
Teachers								
Nutritionists								
Resident Managers								
Home Health Aids								
Licensed Social Workers								
Sociologists								
RN's								
LPN's								
Physical Therapists								
Psychiatrists								
Physicians Hospice								
Pediatricians								
Physicians								
Dentists								
Opticians								
Psychologists								
Medical Directors (Admin. Only)								
Nurse Practitioners								
Physicians Assistants								
Pharmacists								
Paramedic EMTs								
*Other (describe):								
*Other (describe):								

F/T = Full Time – over 20 hours per week / P/T = Part Time – up to 20 hours per week
*Please describe "other" staff positions not listed in the above chart in the provided area.

22. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**
23. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

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SECTION II - AUTOMOBILE

1. Are there any company-owned vehicles? ☐Yes ☐No
   If yes, please note that we will not write the non-owned auto without the scheduled vehicles.
2. What is Applicant's total number of:
   Employees:_____ Volunteers:_____ Independent Contractors:_____
3. Does Applicant run abuse and background checks on all drivers? ☐Yes ☐No
4. Does the Applicant have a driver safety training program? ☐Yes ☐No
5. During the most recent year, how many of the Applicant's employees provided at home care?_____
6. Does Applicant have a visiting nurse program? ☐Yes ☐No
7. Does the Applicant transport clients? ☐Yes ☐No
   If yes, in employee vehicles? ☐Yes ☐No _____%
   If yes, in clients vehicles? ☐Yes ☐No _____%
   If yes, does the Applicant provide or require completion of medical emergency training for transportation of clients? ☐Yes ☐No
   If yes, does the Applicant require evidence of regular preventative maintenance? ☐Yes ☐No
8. Does the Applicant transport non-ambulatory clients? ☐Yes ☐No
9. Does the Applicant contract with an ambulance or livery service to transport clients? ☐Yes ☐No
10. What is the maximum and minimum age of drivers allowed to drive clients? Max:_____ Min:_____
11. Total amount expensed in the previous fiscal period, as reported to the I.R.S. for employee mileage reimbursement:_____
12. If Applicant has visiting nurses or home care providers, is there a minimum age requirement? ☐Yes ☐No
13. Estimated total number of employees/volunteers/independent contractors that use their own vehicle for company business, not home care. (i.e. sales, delivery, mail pickup, bank deposits)
    Employees:_____ Volunteers:_____ Independent Contractors:_____
14. How often and for what purpose do employees/volunteers/independent contractors use their own vehicle for company business? (i.e. daily, occasionally, never)
    Employees:_____ Volunteers:_____ Independent Contractors:_____
15. Does Applicant run MVRs on all employees:
    At the time of hire? ☐Yes ☐No Annually? ☐Yes ☐No Randomly? ☐Yes ☐No
16. What action is taken if an "unacceptable" drive is identified?

    _____
17. Are Motor Vehicle Reports ordered on all non-employee drivers who may use a company vehicle? ☐Yes ☐No
18. Does Applicant require all employees who use their own vehicles for company business to carry personal auto insurance? ☐Yes ☐No
    If yes, what limits are required? $_____
19. Does Applicant obtain certificates of insurance or a copy of the declarations page from the employees' automobile insurer? ☐Yes ☐No
    If yes, who maintains these records?_____
20. Does Applicant confirm that the employee's personal auto policy does not include an exclusion for claims arising out of the course of driving if part of your profession? ☐Yes ☐No
21. Does Applicant receive confirmation from employees that a preventative regular maintenance plan is in place? ☐Yes ☐No
22. Is there a process or procedure in place that requires an employee to notify the company if their personal automobile policy has lapsed or been cancelled? ☐Yes ☐No
23. Does Applicant require employees to complete a Defensive Driver Training Course? ☐Yes ☐No
24. Does Applicant allow employees to operate a patient or client's vehicle? ☐Yes ☐No
    If yes, how does Applicant verify patient and/or client owned automobile liability coverage is in force?

    _____
    If yes, does the Applicant require evidence of regular preventative maintenance? ☐Yes ☐No
25. How many vehicles (cars, vans, trucks, or tractors) are hired, rented or borrowed each year?
    Short-term leases (less than 6 months):_____ Short-term rentals (include airport rentals):_____

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26. Other than airport rentals, for what purpose are the hired vehicles used?

27. Other than airport rentals, what is the total estimated cost for all hired vehicles for the most recent fiscal period? $_____
28. Does the Applicant make sure travel logs are kept for all drivers? ☐Yes ☐No
29. Who is providing primary automobile liability and automobile physical damage for the hired/borrowed vehicles? (i.e. rental company, leasing firm, employee, insured, credit card)

30. Does Applicant hire independent contractors to provide home care or other patient services? ☐N/A ☐Yes ☐No
31. If home caregivers or visiting nurses are considered independent contractors, is there a signed contract in place? ☐N/A ☐Yes ☐No
    If yes, please provide a copy of the sample contract.
32. Does the contract require the independent contractors to provide a certificate of insurance? ☐Yes ☐No
33. Does the contract require the independent contractors to carry a minimum of Automobile Liability limit? ☐Yes ☐No
    If yes, what is the limit? $_____
34. Does the contract require the independent contractors to name our insured as an additional insured? ☐Yes ☐No
35. Is there a formal, written Fleet Safety Program in place? ☐Yes ☐No
36. Are random drug tests conducted on employees? ☐Yes ☐No
37. Is there a company policy on underage drivers using company vehicles? ☐Yes ☐No
38. Are family members allowed to use the company owned vehicles? ☐Yes ☐No
39. Does the Applicant allow personal use of a company-owned vehicle? ☐Yes ☐No
40. Does the agent or the Applicant include non-employee operators on the drivers list? ☐Yes ☐No
41. Does the Applicant transport clients/consumers for other private or government agencies? ☐Yes ☐No
    If yes, please explain:

    If yes, for a fee? ☐Yes ☐No

SECTION III – CLAIMS MADE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

☐N/A (Please proceed to signature section)

Policy Effective Date:_____
Line of Business:_____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐Yes ☐No
   If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐Yes ☐No
   If yes, please provide details:

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FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.
APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY 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 WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: 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 FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company.

NAME
(PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

Produced By: (Section to be completed by Producer/Broker)

PRODUCER

AGENCY

PRODUCER LICENSE NUMBER

AGENCY TAXPAYER ID OR SS NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)

HOMECARE & HOSPICE
National Association for Home Care & Hospice
MEMBER 2012