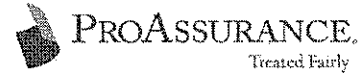


Professional Liability Application for Home Health Care Agencies & Medical Personnel Staffing

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC



Send submissions to midcsubmis@proassurance.com.

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Note: Application must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

Part I. General Information

- 1.1 Applicant Name (including DBAs): _____
- 1.2 Mailing Address: _____

- 1.3 Location Address(es): _____

- 1.4 County (parish) of Each Location: _____
- 1.5 Telephone Number: Office: _____ Fax: _____
- 1.6 Person to Contact for Survey: Name: _____ Title: _____
- 1.7 Year Entity Established: _____
- 1.8 Entity is: Individual Corporation Partnership Professional Association/Corporation
 Other; Describe: _____
- 1.9 Entity is: For Profit Non-Profit
Describe Source of Funds: _____
- 1.10 Entity is: Home Health Care Agency
 Medical Personnel Staffing (Home Health Care Services Only)
 Medical Personnel Staffing (All Other)
 Other; Describe: _____
- 1.11 Accreditation Information (check whichever applies):
Type: SAS Distinguished or Gold Standards SAS Full Accreditation
 Other; Describe: _____
- 1.12 Proposed Effective Date: _____
- 1.13 Requested Limits of Liability (if available):
Professional Liability \$ _____ /\$ _____
General Liability \$ _____ Each Occurrence
\$ _____ General Aggregate
- 1.14 Annual Gross Receipts: Estimated next 12 Months: \$ _____
Last 12 Months: \$ _____
- 1.15 Total premises square footage occupied by applicant: _____
- 1.16 List all memberships in professional organizations: _____

Part II. Exposures

2.1 Health care Staff: Indicate the next 12 months estimated figures for each of the following categories of staff, hours worked, and compensation.

2.1.1 **Employed Staff (W-2):**

| | Maximum No. | Annual Hours of Service | Annual Payroll |
|--------------------------|-------------|-------------------------|----------------|
| Registered Nurse | _____ | _____ | \$ _____ |
| Licensed Practical Nurse | _____ | _____ | \$ _____ |
| Physical Therapist | _____ | _____ | \$ _____ |
| Occupational Therapist | _____ | _____ | \$ _____ |
| Respiratory Therapist | _____ | _____ | \$ _____ |
| Psychotherapist | _____ | _____ | \$ _____ |
| Speech Therapist | _____ | _____ | \$ _____ |
| Social Worker | _____ | _____ | \$ _____ |
| Aide, Homemaker | _____ | _____ | \$ _____ |
| Physician* | _____ | _____ | \$ _____ |
| Other: _____ | _____ | _____ | \$ _____ |
| Employed Subtotal: | _____ | _____ | \$ _____ |

2.1.2 **Contracted Staff (1099):**

| | Maximum No. | Annual Hours of Service | Annual Payroll |
|--------------------------|-------------|-------------------------|----------------|
| Registered Nurse | _____ | _____ | \$ _____ |
| Licensed Practical Nurse | _____ | _____ | \$ _____ |
| Physical Therapist | _____ | _____ | \$ _____ |
| Occupational Therapist | _____ | _____ | \$ _____ |
| Respiratory Therapist | _____ | _____ | \$ _____ |
| Psychotherapist | _____ | _____ | \$ _____ |
| Speech Therapist | _____ | _____ | \$ _____ |
| Social Workers | _____ | _____ | \$ _____ |
| Aide, Homemaker | _____ | _____ | \$ _____ |
| Physician* | _____ | _____ | \$ _____ |
| Other: _____ | _____ | _____ | \$ _____ |
| Contracted Subtotal: | _____ | _____ | \$ _____ |
| Total: | _____ | _____ | \$ _____ |

*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete the Physician's Exposure Supplement.

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? Yes No

2.1.4 Enter percentage of services provided, by category, of staff including contracted staff:

RNs & LPNs

_____ % Hospitals
 _____ % Nursing Homes/Assisted Living
 _____ % Private Doctors
 _____ % Private Home Care
 _____ % Other; Describe: _____

Aides/Orderlies

_____ % Hospitals
 _____ % Nursing Homes/Assisted Living
 _____ % Private Doctors
 _____ % Private Home Care
 _____ % Other; Describe: _____

| | |
|---------------------------------------|---------------------------------------|
| Other: _____ | Other: _____ |
| _____ % Hospitals | _____ % Hospitals |
| _____ % Nursing Homes/Assisted Living | _____ % Nursing Homes/Assisted Living |
| _____ % Private Doctors | _____ % Private Doctors |
| _____ % Private Home Care | _____ % Private Home Care |
| _____ % Other; Describe: _____ | _____ % Other; Describe: _____ |

2.2 Of the total payroll for all home health care staff, indicate the percentage of payroll attributable to each of the following:

_____ % IV Therapy*
 _____ % AIDS Therapy*
 _____ % Chemotherapy*
 _____ % Infant Monitoring (SIDS, etc.)
 _____ % Pediatric/infant childcare including "babysitting"
 *If any, also complete supplement for IV Therapy.

2.3 Number of patients next 12 months: _____

2.4 Number of patients last 12 months: _____

2.5 Is your facility owned by an M.D.? Yes No
 If yes, owner name(s): _____

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients? Yes No
 To others? Yes No
 If yes, to either question, complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation? Yes No
 If yes, is applicant certified and/or accredited? Yes No
 If no, explain the reason: _____

2.8 Is applicant approved to receive Medicare and Medicaid payments? Yes No

Part III. Risk Management

3.1 Name, qualifications, and number or years of experience of the Medical Director:

| Name | Title | Experience/Training | Association Membership |
|------|-------|---------------------|------------------------|
|------|-------|---------------------|------------------------|

3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? Yes No

3.3 Do you conduct pre-employment screening and investigation? Yes No

3.4 Does the staff supervisor make regular audit visits of staff in the field? Yes No

3.5 Do you require contracted staff (if any) to carry their own Professional Liability Insurance? Yes No
 Do you secure Certificates of Insurance as evidence of such coverage? Yes No

3.6 Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience? _____

3.7 Who does the supervising of staff, and what is his/her experience? _____

3.8 Describe the referral source(s) by which patients are directed to the entity: _____

3.9 Are you equipped with an emergency 24-hour telephone call line for all staff and patients? Yes No

3.10 Do you enter into any contractual agreements (other than lease of premises agreements in which you hold others harmless)? If yes, please attach copies of all such contacts. Yes No

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. Yes No

3.12 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? Yes No

3.13 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? Yes No

Explain any exceptions: _____

3.14 Does your agency have a written incident/occurrence reporting policy and procedures? Yes No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. Yes No

3.16 Has the applicant or any of its employees:
a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? Yes No
b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? Yes No
c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

If the answer to any of 3.16 is yes, please attach a detailed explanation.

3.17 Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. None Description Attached

Part IV. Medical Staffing Services Only

If you do not provide staffing services, please initial here and proceed to Part V: _____

4.1 Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)? Yes No

If yes, enter percentage of services provided, by category, of staff including contracted staff:

_____ % OR

_____ % Labor/delivery

_____ % ICU/CCU

_____ % ER

_____ % Other; Describe: _____

4.2 Do you prepare job descriptions and instructional manuals for your staff? Yes No
If yes, enclose a copy of each.

4.3 Do you maintain records of specific areas of experience of each staff member? Yes No

4.4 Do you require staff to report all incidents (accidents) that might result in a liability claim AND are records of such reports kept on file by you? Yes No

Part V. History

5.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, state none.

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made | |
|----|---------|---------------|---------------------|---------|-----------|-------------|----|
| | | | | | | Yes | No |
| 1. | _____ | | | | | | |
| 2. | _____ | | | | | | |
| 3. | _____ | | | | | | |
| 4. | _____ | | | | | | |
| 5. | _____ | | | | | | |

If claims-made, what is the most recent retroactive date? _____

5.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, state none.

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made | |
|----|---------|---------------|---------------------|---------|-----------|-------------|----|
| | | | | | | Yes | No |
| 1. | _____ | | | | | | |
| 2. | _____ | | | | | | |
| 3. | _____ | | | | | | |
| 4. | _____ | | | | | | |
| 5. | _____ | | | | | | |

If claims-made, what is the most recent retroactive date? _____

5.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? Yes No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): _____

5.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 5.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? Yes No

If yes, describe the event and indicate the reason for anticipation of a claim:

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.

Date

Applicant Signature / Title