

Scottsdale Insurance Company
 Home Office: One Nationwide Plaza
 Columbus, Ohio 43215
 Adm. Office: 8877 North Gainey Center Drive
 Scottsdale, Arizona 85258

Scottsdale Surplus Lines Insurance Company
 Adm. Office: 8877 North Gainey Center Drive
 Scottsdale, Arizona 85258

Scottsdale Indemnity Company
 Home Office: One Nationwide Plaza
 Columbus, Ohio 43215
 Adm. Office: 8877 North Gainey Center Drive
 Scottsdale, Arizona 85258

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 www.scottsdaleins.com

HOME HEALTH CARE GENERAL LIABILITY APPLICATION

Applicant's Name _____

 Mailing Address _____

 Location _____

 Web site Address _____

Agency Name _____
 Agent _____
 Address _____

 E-Mail _____
 Phone _____

PROPOSED EFFECTIVE DATE: From _____ To _____ 12:01 A.M., Standard Time at the address of the Applicant

Applicant is: Individual Corporation Partnership Joint Venture
 Limited Liability Company Other (Specify) _____

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

Limits Of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)	\$
Products & Completed Operations Aggregate	\$
Personal & Advertising Injury (any one person or organization)	\$
Each Occurrence	\$
Damage To Premises Rented To You (any one premise)	\$
Medical Expense (any one person)	\$
Errors and Omissions (Included up to General Liability Limits)	Each Claim \$ Aggregate \$
Sexual and/or Physical Abuse	<input type="checkbox"/> \$50,000/\$100,000 (included) <input type="checkbox"/> \$100,000/\$300,000
Other Coverages, Restrictions, and/or Endorsements:	\$
Deductible	\$

1. **Number of years in operation:** _____

2. How long under present management? _____

(If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the Director of Nursing or the individual responsible for hiring, screening and monitoring the work activities of your employees.)

3. Operations conducted in the following states:

State: _____ Licensed with state? Yes No License No.: _____
 State: _____ Licensed with state? Yes No License No.: _____
 State: _____ Licensed with state? Yes No License No.: _____

4. Employees and independent contractors are placed (by percentage) at the following locations:

Assisted Living Facilities	%	Laboratories	%
Clinics	%	Owned Facility Describe services: _____ _____	%
Convalescent/Nursing/ACLF Homes	%		
Home Health—Private Homes	%		
Hospice Facilities	%	Physician's Office	%
Hospitals	%	Schools	%
Infusion Therapy Centers	%	Other (describe): _____ _____	%
Jails/Prisons/Detention Centers	%		

(Please attach any brochures, literature or descriptive materials provided to the client.)

5. If employees or independent contractors are placed in hospitals, clinics, physician's offices, hospice, convalescent/nursing/ACFL homes, jails, prisons or detention centers, advise if hired by: facility patient patient's guardian

6. Services provided by percentage of total operations (must total 100%):

Assisted Living Facilities	%	Nanny/Au Pair	%
Clinical Trials	%	Nurse—General (LPN, LVN)	%
Clinics Owned/Operated	%	Nurse—Practitioner	%
Convalescent/Nursing Home	%	Nurse—Registered (RN)	%
Dietician/Nutritionist	%	Nurse—Student	%
Doula	%	Nurses Aides (CNA, STNA, NA/R)	%
Homemaker Health Aides	%	Occupational Therapy	%
Hospice	%	Patient Care Assistants	%
Hospital	%	Personal and Home Care Aides (AKA—Caregivers, Companions, Personal Attendants, and Sitters)	%
Infant/Pediatric Care	%		
Infusion Therapy Centers	%	Personal Trainers	%
Infusion Therapy:	%	Pharmacist	%
Antibiotic Therapy	%	Pharmacy	%
Antiviral Therapy	%	Physical Therapy	%
Blood Transfusion	%	Physician	%
Chemotherapy	%	Physician Assistant	%
Dialysis	%	Radiation Therapy	%
Home Enteral Nutrition (HEN)	%	Rehabilitation	%

Hydration Therapy	%	Respiratory Therapy	%
Pain Management	%	Respite Care	%
Total Parenteral Nutrition (TPN)	%	Social Worker	%
Other (describe): _____ _____	%	Speech Therapy	%
		Ventilator	%
Laboratory Services	%	Other (describe): _____ _____	%
Licensed Counselors	%		
Meals on Wheels	%	Other (describe): _____ _____	%
Medical Equipment Supplier	%		

7. Employees and Independent Contractors—Annual Staffing:

Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS
	Number of Employees		Number of Subcontracted Workers
	Full Time	Part Time	
Dietician/Nutritionist			
Infant/ Pediatric Care			
Licensed Counselors			
Medical Director			
Nurse—Practitioner			
Nurse—Registered (RN)			
Nurse—General (LPN, LVN)			
Occupational Therapist			
Pharmacist			
Physical Therapist			
Physician			
Physician Assistant			
Psychologist			
Rehabilitation Therapist			
Respiratory Therapist			
Social Worker			
Speech Therapist			
X-Ray Technicians			
Other (describe):			

Non-Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS
	Number of Employees		Number of Subcontracted Workers
	Full Time	Part Time	
Certified Nursing Assistants (CNA)			
Doula			
Homemaker Health Aides			
Midwives			
Nanny/Au Pair			
Nurse Aides			
Nursing Assistants—Registered (NA/R)			
Patient Care Assistants			
Personal and Home Care Aides			
Social Worker			
Student Nurses			
Other (describe):			

8. Schedule of Hazards:

Operations—Payroll and Sales Information	PROFESSIONAL		NON-PROFESSIONAL	
	Annual Payroll/Cost	Annual Sales/Receipts	Annual Payroll/Cost	Annual Sales/Receipts
Employees providing services away from owned or operated health care facilities:				
Employees providing services at owned or operated health care facilities:				
Independent Contractors providing services away from owned or operated health care facilities:				
Independent Contractors providing services at owned or operated health care facilities:				
Medical Equipment Sales and Rental				
Pharmacy owned or operated by the insured				
Other (describe):				
Total:				

9. Has applicants' license ever been revoked, suspended, voluntarily surrendered, or had enforcement action?..... Yes No

If yes, provide details and corrective action taken: _____

10. Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):

11. **Has the applicant sold, acquired or discontinued any operations in the last five years or have plans to change operations within the next year?** Yes No
 If yes, explain: _____
12. **Is at least one of the principals or an Administrator/Director of Nursing involved in the operation on a full time basis?** Yes No
13. **Does applicant provide foster care placement?** Yes No
14. **Applicant's workforce is comprised of:**
 Employees% Independent Contractors%
15. **As part of hiring/screening of new employees or independent contractors, does applicant:**
- a. Verify certifications and/or professional licenses and confirm status? Yes No
 - b. Contact applicants' references before they are hired/placed? Yes No
 - c. Require, if hired/placed, that they sign a formal confidentiality statement? Yes No
 - d. Obtain criminal background checks? Yes No
 - e. Review sexual abuse registry? Yes No
 - f. Conduct a personal interview? Yes No
 - g. Validate education? Yes No
 - h. Validate work history? Yes No
 - i. Have a formalized disease, drug or alcohol screening process? Yes No
 - j. Validate driver's license? Yes No
 - k. Ask applicant if any previous involvement as a defendant in professional malpractice litigation? Yes No
 - l. Ask applicant if they ever had their license revoked or suspended, or had disciplinary action taken against them? Yes No
16. **When using independent contractors, does the applicant require the following information from them:**
- a. Professional Liability Certificate of Insurance? Yes No
 If yes, specify minimum limits required: \$ _____
 - b. Historical Loss Information? Yes No
 - c. Hold Harmless and indemnification clauses favorable to the applicant? Yes No
17. **Are job descriptions, detailing job duties and responsibilities, given to all employees and independent contractors?** Yes No
18. **Does the applicant have formal documented training in place for the following:**
- a. Crisis Management? Yes No
 - b. Disposal of medical waste, controlled substances, contaminated supplies or equipment? Yes No
 - c. First Aid, CPR, and AED Training? Yes No
 - d. Infusion Therapy? Yes No
 - e. Safe lifting, transferring, and client handling? Yes No
 - f. Blood borne Pathogen? Yes No
 - g. Safe use and operation of equipment? Yes No
19. **What is the applicant's average staff turnover rate in a calendar year for:**
 Professional Staff% Non-Professional Staff%

- 20. Does applicant have written protocols that govern the medical treatment of patients for the following policies and procedures?**
- a. Complete treatment plan prescribed by the physician, including follow-up plans? Yes No
 - b. Assessments of clients prior to and after accepting the clients? Yes No
 - c. Client care and home visits documented? Yes No
 - d. Documentation of all homecare training? Yes No
 - e. All changes in the condition of the client are documented in the records and reported to the family and physician? Yes No
 - f. Client incident report procedure is in place with notification also given to family and physician? Yes No
 - g. Medications and dosage, including documentation of administering medications? Yes No
 - h. A copy of all literature given to clients explaining services and fees? Yes No
 - i. Termination of services and discharge criteria? Yes No
- 21. Are medications ordered by a licensed physician and administered, discarded and documented by or under the close supervision of a qualified medical professional in accordance with legal requirements for controlled substances?** Yes No
- 22. If the applicant provides advanced skilled care (i.e., infusion therapy, ventilator, chemotherapy, radiation therapy, etc.), what are the clinical expertise requirements and/or professional training for the staff that provide these services?** _____

- 23. Does applicant have Workers' Compensation coverage in force?** Yes No
- 24. Does applicant have any contractual agreements wherein applicant assumes the liability of others?** Yes No
 If yes, please attach a list of each entity and the type of service(s) applicant provides.
- 25. Are any professional services provided on applicants premises (doctor's office, clinic, infusion therapy center, etc.)?** Yes No
 If yes, explain: _____

- 26. Does applicant provide bed and board facilities (convalescent home, hospice, assisted living facility, etc.)?** Yes No
 If yes, explain: _____

- 27. Does the applicant sell, rent or lease any medical supplies and/or equipment?** Yes No
 If yes, provide details: _____

- 28. Does the applicant own/operate a pharmacy or provide pharmaceutical products?** Yes No
- 29. Does the applicant manufacture any products?** Yes No
 If yes, advise: _____

- 30. Has the applicant ever distributed directly imported products from a foreign manufacturer?** Yes No
 If yes, advise: _____

31. Does the applicant modify any product or repackage/relabel any items obtained from suppliers?..... Yes No
If yes, advise: _____
32. Is all equipment checked and its condition documented prior to release? Yes No
33. Are employees authorized to use their personal vehicles to transport patients? Yes No
If yes, please provide details (i.e., under what circumstances, if applicant obtains a waiver of liability from the patients, etc.): _____
34. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangement with hospital, etc.):

35. Is staff informed of all patients with AIDS/HIV? Yes No
36. Copy of the applicant's State(s) Home Health Care License and most recent State Licensure survey attached (if any): Yes No
37. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies?..... Yes No
If yes, describe: _____
38. Does applicant have other business ventures for which coverage is not requested?..... Yes No
If yes, explain and advise where insured: _____
39. Does applicant have any other premises, operations or exposures not stated in this application?..... Yes No
If yes, explain: _____
40. Is the applicant a member of any:
- a. State Association?..... Yes No
If yes, name of association(s): _____
 - b. Industry Association? Yes No
If yes, name of association(s): _____
 - c. Health Care accrediting organization? Yes No
If yes, name of organization(s): _____
41. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation? Yes No
If yes, date: _____ Please explain: _____
42. During the past three years, has any company ever canceled, declined or refused similar insurance to the applicant (not applicable in Missouri)?..... Yes No
If yes, explain: _____

43. Prior Carrier Information:

	Year:	Year:	Year:	Year:	Year:
Carrier					
Policy No.					
Coverage					
Occurrence or Claims Made					
Total Premium					

44. Loss History—Five Year Period:

<p>Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior five years. <input type="checkbox"/> Check if no losses last five years.</p>				
Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING: 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. **Not applicable in Nebraska, Oregon and Vermont.**

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: 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. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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.

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

NOTICE TO OHIO APPLICANTS: Any person who knowingly and with intent to defraud any insurance company 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: 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.

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

FRAUD WARNING (Applicable in 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 include imprisonment, fines and denial of insurance benefits.

NOTICE TO NEW YORK APPLICANTS (Other than automobile): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation..

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer)

PRODUCER'S SIGNATURE: _____ DATE: _____

IOWA LICENSED AGENT: _____
(Applicable in Iowa Only)

AGENT NAME: _____ AGENT LICENSED NO.: _____
(Applicable to Florida Agents Only)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.