Ace American Insurance Company
Allied Health Care Professionals and Organizations

Application for Health Care Organizations

Instructions: Please type or print clearly. Answer all questions, if any questions do not apply – please indicate with "N/A". If you need more space, continue on a separate sheet of your firm's letterhead and indicate the question number. This form must be completed by a Principal or Owner of the firm. Please attach any brochures or literature or descriptive materials provided to clients.

Applicant Information

Applicant / Firm Name				
Mailing Address	City	State	Zip Code	County
Practice Address (if different from mailing)	City	State	Zip Code	County
Business Phone	Fax Number			E-mail Address

☐ For Profit ☐ Not For Profit ☐ Individual ☐ Partnership ☐ Corporation ☐ Other (Specify)

Please indicate coverages you are applying for:

☐ Professional Liability ☐ General Liability

Please indicate limits desired:

☐ $1,000,000 / $3,000,000 ☐ $1,000,000 / $6,000,000
☐ $2,000,000 / $4,000,000 ☐ Other: ____________________

Date Business Established:____________________ Employer Federal Tax ID #: ____________________

Applicant's Total Annual Gross Receipts: ____________ Proposed Effective Date: ____________________

Type of Firm: (check all that apply)

☐ Home Health Care Firm ☐ Visiting Nurse Agency ☐ Supplemental Staffing
☐ Infusion Therapy Firm ☐ Nurse Registry ☐ Medical Equipment Supplier
☐ Retail Pharmacy ☐ Closed Pharmacy ☐ Hospice
☐ Imaging Center ☐ Physical Therapy ☐ Surgical Technicians / Assistants
☐ School / Students ☐ Other (specify): ______________________________

Description of Operations:____

____

____

____

Employment Procedures

Are employees/contractors references contacted before hired or 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 perform/obtain criminal background checks on prospective employees? ☐ Yes ☐ No

Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? (may not be applicable in all states) ☐ 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

Risk Management

Does the applicant utilize a formal written Quality Assurance and Risk Management Program? ☐ Yes ☐ No
If no, please explain: ____

Is the overall responsibility for Risk Management assigned to one individual in your firm? ☐ Yes ☐ No
If yes, please list name and title: ____
If no, please describe 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, please attach sample) ☐ Yes ☐ No

Are the results of patient/client surveys used to improve day-to-day operations? ☐ Yes ☐ No

Accreditation and Membership in Professional Associations

Is the applicant a member of The National Association for Home Care (NAHC)? ☐ Yes ☐ No
NAHC Membership number: ____________________________

Is the applicant a member of The Health Industry Distributors Association (HIDA)? ☐ Yes ☐ No
HDA Membership number: ____________________________

Are you a member of any state association? ☐ Yes ☐ No
Name of state association: ____

Are you a member of any other industry association(s)? ☐ Yes ☐ No
Please specify: ____

Is the applicant accredited by:

1. Community Health Accreditation Program (CHAP)? ☐ Yes ☐ No
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? ☐ Yes ☐ No
3. Any other accrediting organization? ☐ Yes ☐ No
   Please specify: ____

Is the applicant licensed in all states in which it is operating? ☐ Yes ☐ No
List states of operation: ____

Professional Liability Section

1. Employees - Annual Staffing:

Type of Employee	# Full-Time	# Part-Time	Annual Hours of Service	Annual Payroll*
Nurses (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Homemaker/Home Health Aide				
Clerical				
Other (Specify)				
TOTAL:				

*If applicant has locations in more than one state, please provide total annual payroll by state.

2. Independent Contractors – Annual Staffing:

Type of Employee	Number of 1099s	Annual Hours of Service	Total Amt. Paid per 1099s**
Nurses (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Homemaker/Home Health Aide			
Clerical			
Other (Specify)			
TOTAL:			

**Total amount paid to independent contractors per 1099's. Please provide breakdown by state.

Are applicants independent contractors required to carry their own professional liability coverage? ☐ Yes ☐ No
If yes, are minimum limits of liability required? ☐ Yes ☐ No
Please specify limits required: $________________________

Are certificates of insurance maintained on file for all independent contractors? ☐ Yes ☐ No
Do you obtain updated certificates of insurance on an annual basis?

Do you employ or contract with any physicians to provide professional services other than in a management or administrative capacity? If yes, please explain.____ ☐ Yes ☐ No

3. Types of services provided% (Total must equal 100%)

☐ Personal Care Chore or Companion ________%
☐ Rehabilitation ________%
☐ Infusion Therapy ________%
☐ Hospice ________%
☐ Supplemental Staffing ________%
(please complete section 4 below)
☐ Obstetrical Services ________%
☐ Adult Day Care ________%
☐ Child Day Care ________%
☐ Medical Equipment Supplier ________%
☐ Meals on Wheels ________%

☐ Respiratory Therapy ________%
(trach. care?/ventilator care?) (Please circle)
☐ Radiation Therapy ________%
☐ Skilled Care in Nursing Homes ________%
☐ Training Consultants ________%
☐ Infant Care ________%
☐ Pediatric Care ________%
☐ Retail Pharmacy ________%
☐ Closed Pharmacy ________%
☐ Other Services (please specify) ________%

REQUIRED: Please attach any brochures, literature or descriptive materials provided to clients.

4. Supplemental Staffing (Supplying health care providers to other facilities for a fee) % (Total must equal 100%):

(If no supplemental staffing provided, please check here _______)

☐ Nursing Homes ________%
☐ Hospitals ________%
☐ Clinics ________%
☐ Doctor's Offices ________%

☐ Other Facilities (please specify) ________%
____
☐ Other Facilities (please specify) ________%
____

General Underwriting Section

Owned or Leased Premises: (Please attach list of all other locations)

Loc.	Address	Own or Lease?	Describe Occupancy of Building
#1.			
#2.			

Are any professional services provided on your premises? ☐ Yes ☐ No
If yes, please explain: ______________________________________
____

Are any bed or board or overnight services provided? ☐ Yes ☐ No
If yes, please explain: ______________________________________
____

Do you provide any "high tech" services? ☐ Yes ☐ No
(i.e. trach care, ventilator care, chemotherapy, etc.)?
If yes, please explain: ______________________________________
____

Does the organization enter into any contractual agreement?
(i.e. with hospitals, nursing homes or other health care facilities, etc.) ☐ Yes ☐ No

1. If yes, please list and attach copies of all agreements:
____
2. If yes, do these agreements contain hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No

Are certificates of insurance obtained from all subcontractors? ☐ Yes ☐ No

List all entities to be named as Additional Insureds with names and insurable interest.

Please attach a copy of each contractual agreement other than landlord agreements.

1. Name:	2. Name:
Address:	Address:
Interest:	Interest:

Has applicant sold, acquired, or discontinued any operations in the past five years? ☐ Yes ☐ No
If yes, please explain: ______________________________________

Is the applicant considering any changes in operations or products handled in the next 12 months? ☐ Yes ☐ No
If yes, please explain: ______________________________________

Do you have owned vehicles? ☐ Yes ☐ No Auto coverage in place? ☐ Yes ☐ No
If yes, please advise carrier and limits: ____________________
Do you need Non-Owned Automobile Liability Coverage? ☐ Yes ☐ No
If yes, total # of employees, including clerical: ______________

Products Liability Section

Medical Equipment Supplies (Attach product listing for all products sold, leased or rented)

Does applicant SELL any medical supplies and/or equipment? ☐ Yes ☐ No
If so, please advise total annual sales: $______________________
Of the amount indicated as "Total Annual Sales", what portion, if any, applies to pharmaceutical products?
$______________________

Does applicant RENT, or LEASE, any medical supplies and/or equipment? ☐ Yes ☐ No
Is yes, please advise Total Annual Lease/Rental Receipts: $______________________

Does applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? ☐ Yes ☐ No
If yes, please advise Total Annual Repair/Maintenance Receipts: $______________________

If you answered yes to any of the above questions in this section, please complete the remainder of this section.

EXPENDABLE ITEMS – intended for one time usage and disposed (i.e., adhesive tape, bandages, hypodermic needles, etc.)
Annual Sales: $______________________

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.
Annual Sales: $______________________ Annual Lease/Rental Receipts: $______________________

DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory there\apy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.
Annual Sales: $______________________ Annual Lease/Rental Receipts: $______________________

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. (Please attach list of these devices).
Annual Sales: $______________________ Annual Lease/Rental Receipts: $______________________

Note: Total amount of Annual Sales in this section must equal amount on the top of this page.

Warranty Questions (All Applicants MUST ANSWER)

1. Have any of the following ever been revoked, suspended, refused, cancelled or voluntarily surrendered? (If yes, please explain on a separate sheet of paper.)
   State License or Certification ☐ Yes ☐ No
   Malpractice Insurance ☐ Yes ☐ No

2. Are you currently licensed, certified and/or registered where required by the state of jurisdiction where you provided services covered by this insurance? ☐ Yes ☐ No

3. Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any incident that might reasonably lead to a claim or suit? ☐ Yes ☐ No (If yes, please explain on a separate sheet)

4. Have you completed a continuing education course or other instructional seminar or course in the past 24 months relative to any of the following or related risk management topics: patient communication, informed consent, confidentiality of records, litigation and related issues? ☐Yes ☐No (If yes, please provide documentation)

5. How many years/months have you been practicing in the profession being applied for? ________________

6. Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any incident that might reasonably lead to a claim or suit? ☐ Yes ☐ No

7. Do you hold any other professional degrees, licenses, or certifications, under which you practice, other than those for which you are applying? ☐ Yes ☐ No (If yes, please describe: ________________________________)

Prior Insurance

Please list your previous insurance company names and other requested information for the past five years:

Insurer	Limits of Liability	Effective Dates	Premium	Claims Made or Occurrence	Retroactive Date (if claims made)

Loss History

Have any claims/suits been made within the last 5 years against the applicant? ☐ Yes ☐ No
(If yes, please attach copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.)

Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical records?
☐ Yes ☐ No
(If yes, please explain):
____
____

Has any insurance company declined, cancelled or refused to renew any of the applicant's insurance? ☐ Yes ☐ No
(If yes, please explain):
____
____

Applicants Affidavit and Signature

I hereby represent and warrant 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 professional liability coverage. I further understand that the completion and signing of this application does not bind the applicant or the company to complete this insurance.

NOTICE: In some states, any person, who with intent to defraud any insurance company or other person files and application for insurance of statement of claim containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Signature ____ Date ____________________

Return this application to:

Fritz Seifert
Americana Program Underwriters
355 N. 21 ST.
Camp Hill, PA 17011

V: 717-214-7576
F: 717-920-0731
E: fseifert@americananet.com