- DEERFIELD INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency _____ Nurse Registry _____ Other Medical Staffing (specify) _____

3. Date Established: _____

4. Location(s) where services are provided (total must equal 100%):
   _____%Home _____%Hospice _____%Nursing Home _____%Assisted Living Facility _____%Hospital _____%Clinic/Doctor's Office _____%Adult Day Care _____% Other Facility (specify)_____

5. Employees/Independent Contractors – Annual Staffing:

Type of Employee/Independent Contractor	No. Full-Time	No. Part-Time	Billable Hours Per Year
Employed Registered Nurse			
Contracted Registered Nurse			
Employed Licensed Practical Nurse			
Contracted Licensed Practical Nurse			
Employed Certified Nurse Assistant			
Contracted Certified Nurse Assistant			
Employed Nurse Practitioner/Physician Assistant			
Contracted Nurse Practitioner/Physician Assistant			
Employed Companion/Home Health Aide			
Contracted Companion/Home Health Aide			
Employed Social Worker			
Contracted Social Worker			
Employed Physical Therapist			
Contracted Physical Therapist			
Employed Other Medical (specify) _____			
Contracted Other Medical (specify) _____			

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____

Name of Applicant Title

_____ _____

Signature of Applicant Date