

BUNKER HILL INSURANCE AGENCY
 Home Health Application

Name of Applicant: _____
 Agency: _____
 Agency Address: _____
 Producer: _____ Phone: _____
 Fax: _____ Email: _____
 Expiration: _____ Quote Needed By: _____

<u>REQUIRED ITEMS TO BE COMPLETED & ENCLOSED:</u>	(✓)
1. Bunker Hill Home Health Application	<input type="checkbox"/>
2. ACORD Applications: (✓) <input type="checkbox"/> Umbrella <input type="checkbox"/> Auto <input type="checkbox"/> Crime <input type="checkbox"/> Inland Marine	<input type="checkbox"/>
3. Financial Statements (Income, Balance Sheet, Cash Flow)	<input type="checkbox"/>
4. Copy of Company Loss Reports (5 years, Company Generated, Currently Valued)	<input type="checkbox"/>
5. Resumes for Principals – for new operations only	<input type="checkbox"/>
6. Copy of State License – if applicable	<input type="checkbox"/>
7. Company Brochures or Website Address: _____	<input type="checkbox"/>

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Home Health Application

HOME HEALTH & HOSPICE APPLICATION
GENERAL INFORMATION – ALL LOCATIONS

1) Applicant: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

2) Requested Policy Period: ____ / ____ / ____ 12:01 a.m. to ____ / ____ / ____ 12:01 a.m.

3) a. Applicant is: Individual Partnership Corporation Non-Profit For-Profit

b. Type of Operation: (✓) _____ Home Health Care %

- 1. Home Health Care _____
- 2. Adult Day Care _____
- 3. In-Patient Hospice _____
- 4. Medical Equipment Supplier _____
- 5. Supplemental Staffing _____
- 6. Nurse Registry _____
- 7. Other: _____

c. Date business was started: ____ / ____ / ____

d. Officers of Operating Company or General Partners:

Name:	Title:	# Years Health Exp.	Active	Inactive
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

e. Does common ownership (over 50%) exist with any other operation? Yes No

If yes, give names, locations and type:

f. Does Operating Company manage any other operations? Yes No

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PRESENT CARRIER INFORMATION

	Name of Carrier	Limits	Expiration Date	Years Insured	Annual Premium
Property/Crime/IM			/ /		\$
General Liability			/ /		\$
Professional Liability			/ /		\$
Automobile			/ /		\$
Hired/Non-Owned Automobile			/ /		\$
EDP & Machinery			/ /		\$
Umbrella			/ /		\$
Workers' Compensation			/ /		\$

- 1) Has the applicant been Insured with the Producer? Yes No
 If yes, what coverages? _____ When: _____
- 2) Is present General Liability policy claims-made? Retro Date: _____ Yes No
 Is present Professional Liability policy claims- made? Retro Date: _____ Yes No
- 3) Does present liability policy have per location aggregate? Aggregate amount? _____ Yes No
- 4) Does present liability policy exclude sexual/physical abuse? Sublimit: \$ _____ Yes No
- 5) Does present liability policy exclude punitive damages? Yes No
- 6) Does present liability policy have a deductible? Amount: \$ _____ Yes No
- 7) Are General Liability and Professional Liability limits separate? Yes No

FIVE YEAR HISTORY

- 1) Has the Applicant (including owners, managers, partners or administrators) ever:
 (If yes, attach complete explanation)
 - a. Been involved in any personal or business bankruptcy? Yes No
 - b. Been arrested, charged or convicted of any civil or criminal violations? Yes No
 - c. Had insurance cancelled or renewed? Yes No
- 2) Is applicant aware of any circumstances which may result in any claim or suit made
 (including requests for medical records) ? Yes No
 If yes, describe:

- 3) Has applicant had any losses (exclude W. C.) in the last FIVE years, insured or not? Yes No

Year:	Description of Loss or Circumstance Potentially Leading to Loss:	Paid or Reserved Amount:
		\$
		\$
		\$
		\$
		\$
		\$

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Home Health Application

LOCATIONS

Loc. #: _____ DBA Name: _____ No. & Street: _____
 City: _____ County: _____ State: _____ Zip: _____
 Administrator: _____ Years Experience: _____ Years at Location: _____

Loc. #: _____ DBA Name: _____ No. & Street: _____
 City: _____ County: _____ State: _____ Zip: _____
 Administrator: _____ Years Experience: _____ Years at Location: _____

Loc. #: _____ DBA Name: _____ No. & Street: _____
 City: _____ County: _____ State: _____ Zip: _____
 Administrator: _____ Years Experience: _____ Years at Location: _____

Loc. #: _____ DBA Name: _____ No. & Street: _____
 City: _____ County: _____ State: _____ Zip: _____
 Administrator: _____ Years Experience: _____ Years at Location: _____

(If necessary, submit additional sheet.)

PROPERTY LIMITS & COVERAGES

	Location # ___ Bldg # ___	Location # ___ Bldg # ___	Location # ___ Bldg # ___
A. Describe Occupancy			
1. Total Building Value	\$ _____	\$ _____	\$ _____
2. Business Personal Property	\$ _____	\$ _____	\$ _____
3. Time Element (See Below)	\$ _____	\$ _____	\$ _____
Total Values (add 1 + 2 + 3)	\$ _____	\$ _____	\$ _____
Property Rating Bureau File #			

a. Coverages:

Coinsurance: _____ % Building and Contents

Deductible: \$ _____ All Risk

b. Time Element:

\$ _____ Business Income and Extra Expense:

_____ % Coinsurance _____ Monthly Limitation: 33 1/3%

Are duplicate records kept? Yes No If yes, location? _____

c. Other Coverages:

Inland Marine / Fine Arts (Attach ACORD App.)

Crime / Fidelity (Attach ACORD App.)

EDP (Attach ACORD App.)

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Home Health Application

PROPERTY UNDERWRITING DATA

	Loc. # _____ Bldg. # _____ Stories # _____	Loc. # _____ Bldg. # _____ Stories # _____	Loc. # _____ Bldg. # _____ Stories # _____
1) Year of Construction:			
2) Construction Type: (Brick, Veneer, Masonry, etc.)			
3) Protection Class Code or Description:			
4) Was Building Built for Intended Purpose?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5) Distance to Fire Department:	Miles	Miles	Miles
Distance to Fire Hydrants:	Feet	Feet	Feet
6) % of Building Sprinklered:	%	%	%
7) Type Wiring (Copper or Aluminum):			
8) Central Burglar Alarm?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Central Fire Alarm?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9) Type Heating System: (Electric, Gas, Steam)			
Type Cooling System (Central, Window):			
10) Type of Roof / Age	/	/	/
11) Describe other occupants on premises:			
12) Describe Adjacent Buildings, Other Exposures Distances (ft.):	North: South: East: West:	North: South: East: West:	North: South: East: West:
13) Miles from Coast (Hurricane Areas Only):	Miles	Miles	Miles
14) Is New Construction Planned Within 12 Months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, Cost:	\$	\$	\$
Start Date / End Date:	/	/	/
15) Has any building had broken pipes around vicinity of foundation?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, describe the damage and explain when and how it was corrected:			
16) Property Certificates Required: (List Name, Address, and Interest)			
	Name	Address	Interest
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____

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LIABILITY UNDERWRITING DATA

1) License

Is operation licensed by the state? Yes No Date: _____
 Licensed Medicare? Yes No Receipts: _____ %
 Licensed Medicaid? Yes No Receipts: _____ %
 Licensed Private Pay? Yes No Receipts: _____ %

2) Receipts – For the *last four* ____ fiscal or ____ policy years, please indicate:

Total Receipts:	Projected Receipts		Prior Years Receipts		
	Next Policy Period Ending 20()		20 ()	20 ()	20 ()
Receipts	\$		\$	\$	\$
Payroll	\$		\$	\$	\$

3) Services Provided – (✓) and indicate approximate percentage of receipts:

✓ SERVICE %	✓ SERVICE %	✓ SERVICE %
<input type="checkbox"/> Skilled Nursing (RN) _____ %	<input type="checkbox"/> Occupational Therapy _____ %	<input type="checkbox"/> Housekeeping _____ %
<input type="checkbox"/> General Nursing (LPN) _____ %	<input type="checkbox"/> Physical Therapy _____ %	<input type="checkbox"/> Personal Care / HHA _____ %
<input type="checkbox"/> Chemotherapy _____ %	<input type="checkbox"/> Respiratory Therapy _____ %	<input type="checkbox"/> Adult Day Care/ Sitters _____ %
<input type="checkbox"/> Dialysis _____ %	<input type="checkbox"/> Speech Therapy _____ %	<input type="checkbox"/> Meals – on – Wheels _____ %
<input type="checkbox"/> Hospice _____ %		<input type="checkbox"/> Pharmacy _____ %
<input type="checkbox"/> Infusion Therapy _____ %		<input type="checkbox"/> Durable Medical Equip. _____ %
<input type="checkbox"/> Radiation Therapy _____ %		<input type="checkbox"/> Medical Supplies _____ %
<input type="checkbox"/> Infants _____ %		
<input type="checkbox"/> Pediatrics _____ %		
<input type="checkbox"/> Obstetrics _____ %		
<input type="checkbox"/> Ventilator _____ %		
Above Must Total 100 %: _____		

4) Client Type - (✓) and indicate percentage of receipts by type of client:

✓ TYPE %	✓ TYPE %	✓ TYPE %
<input type="checkbox"/> Private Homes _____ %	<input type="checkbox"/> Hospital _____ %	<input type="checkbox"/> Clinics _____ %
<input type="checkbox"/> Doctor's Offices _____ %	<input type="checkbox"/> Nursing Homes _____ %	<input type="checkbox"/> Others _____ %
_____ %	_____ %	_____ %
Above Must Total 100 %: _____		

5) Employee Type - (✓) and indicate number of employees by type:

✓ TYPE #	✓ TYPE #	✓ TYPE #
<input type="checkbox"/> Registered Nurse _____	<input type="checkbox"/> Counselors _____	<input type="checkbox"/> Sitters / Companion _____
<input type="checkbox"/> LPN / LVN _____	<input type="checkbox"/> Pharmacies _____	<input type="checkbox"/> Housekeepers _____
<input type="checkbox"/> Therapies _____	<input type="checkbox"/> Nurse Practitioners _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Nursing Aides _____	<input type="checkbox"/> Physicians _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Mgmt. / Supervisors _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
Total # of Employees: _____		

Do you use independent contractors in lieu of employees? Yes No

If so, what percentage of visits? _____ %

How many visits per week does your average employee make? _____

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Home Health Application

6) Hiring Procedures

a. How are workers recruited?

b. Describe benefits offered to employees:

1. Health Insurance # Participating _____ Carrier _____
2. Payroll Deduction Life Insurance
3. 401K Vesting Period _____ yrs. Prior Year Contribution _____ %
4. Section 125 Cafeteria Plan
5. Other (List): _____

c. Describe background verification checks on new employees:

1. Work History:

2. Education:

3. Criminal Record:

4. Driving Record (MVR):

5. Drug Testing:

6. Is written documentation maintained in employee file?

Yes No

d. Employees reimbursed on what basis?

e. Are nurses required to carry own professional liability insurance?

Yes No

If yes, do you obtain Certificates of Insurance?

Yes No

f. Do you have written procedures in place to provide employee benefits?

Yes No

NOTE: Employee benefits liability, if available, requires written procedures.

7) Prescriptions

a. Will you dispense your own prescriptions?

Yes No

If yes, receipts: \$ _____ # Pharmacists: _____

b. Do you store controlled substances?

Yes No

If yes, describe how:

Is daily inventory kept?

Yes No

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MEDICAL SUPPLIES SUPPLEMENT

1) Will you provide any durable medical equipment? Yes No
(If yes, complete this page. If no, go to page 9)

If yes, Sale Only Rental Sales & Rental

2) Receipts broken down by category:

<p>Category I: EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e., adhesive tape, bandages, or hypodermic needles, etc.)</p> <p>a. Annual Sales: \$ _____</p>							
<p>Category II: 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.</p> <p>b. Annual Sales: \$ _____ c. Annual Lease / Rental Receipts: \$ _____</p>							
<p>Category III: DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.</p> <p>d. Annual Sales: \$ _____ e. Annual Lease / Rental Receipts: \$ _____</p> <p>Do you distribute oxygen tanks? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, are they: Pre-Filled <input type="checkbox"/> Self-Filled <input type="checkbox"/></p> <p>If yes, does storage meet NFDA standards? Yes <input type="checkbox"/> No <input type="checkbox"/></p>							
<p>Category IV: 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.</p> <p>f. Annual Sales: \$ _____ g. Annual Lease / Rental Receipts: \$ _____</p>							
<p>Category V: DURABLE MEDICAL EQUIPMENT – Does the account sell or rent any of the following types of durable medical equipment? (If yes, please check type below)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Surgical Implant Devices</td> <td><input type="checkbox"/> Anesthesia Equipment</td> </tr> <tr> <td><input type="checkbox"/> Radiology Equipment</td> <td><input type="checkbox"/> Laboratory Equipment</td> </tr> <tr> <td><input type="checkbox"/> Blood Cleansing Equipment</td> <td><input type="checkbox"/> Laser Equipment</td> </tr> </table> <p>h. Annual Sales: \$ _____ i. Annual Lease / Rental Receipts: \$ _____</p>		<input type="checkbox"/> Surgical Implant Devices	<input type="checkbox"/> Anesthesia Equipment	<input type="checkbox"/> Radiology Equipment	<input type="checkbox"/> Laboratory Equipment	<input type="checkbox"/> Blood Cleansing Equipment	<input type="checkbox"/> Laser Equipment
<input type="checkbox"/> Surgical Implant Devices	<input type="checkbox"/> Anesthesia Equipment						
<input type="checkbox"/> Radiology Equipment	<input type="checkbox"/> Laboratory Equipment						
<input type="checkbox"/> Blood Cleansing Equipment	<input type="checkbox"/> Laser Equipment						

TOTAL ANNUAL RECEIPTS OF MEDICAL SUPPLIES AND / OR EQUIPMENT (ADD A – I) \$ _____

3) Does applicant rent, lease, repair or do maintenance on any medical or therapeutic supplies or equipment? Yes No

If yes, total annual rental receipts of such medical supplies and or equipment: \$ _____

List type of equipment rented or attached schedule:

Are service records kept on rentals? Yes No

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OWNED AUTOMOBILE

1) Do you own or lease any vehicles?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you desire coverage for owned automobiles?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, you will need to contact another market for the owned auto. WE CAN QUOTE HIRED AND NON-OWNED ONLY.	

HIRED / NON – OWNED AUTOMOBILE

1) Do you desire coverage for non-owned automobiles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2) Do you currently have coverage for non-owned automobiles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, Carrier _____		
Premium: \$ _____ Limit: \$ _____		
3) Do you desire coverage for hired automobiles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cost of hire: \$ _____		
4) Do you have a program to monitor employees' auto liability insurance coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, describe: _____		
If no, will you implement?		Yes <input type="checkbox"/> No <input type="checkbox"/>
5) Do you run MVRs ("Motor Vehicle Reports") on all employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
At time of hire?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Annually?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, would you be willing to begin a MVR program?		Yes <input type="checkbox"/> No <input type="checkbox"/>
6) What percentage of employees uses mass transit to make visits to clients?	_____ %	
7) Do employees transport clients in their own auto or the client's auto?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Estimated number of client transports (client's auto or employee's auto) annually: _____		

Applicant's Signature: _____

Date: _____