Northland INSURANCE

HOME COMPANION CARE (BASIC NON-NURSING) APPLICATION

BUSINESS INFORMATION

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address — Street — City — County — State — ZIP Code

3. Telephone: | Fax:

Website:

4. Contact Person/Phone #: | Inspection:

Accounting/Records:

5. Business Type: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Trust
☐ Other (specify):

6. Operating as: ☐ For Profit ☐ Nonprofit ☐ Other

7. Date Business Established:

8. Indicate states licensed and certified in:

Provide details of what your license/certification allows you to do:

9. Has your license ever been suspended or revoked? ☐ Yes ☐ No
If yes, provide details:

10. Have you ever been investigated by the State Health Dept., State Licensing Board or other governmental body?
☐ Yes ☐ No
If yes, provide details:

11. Are you Medicare approved? ☐ Yes ☐ No Medicare sales: $

12. Are you accredited by any of the following?

	Yes	No
a. National Home Caring Council	☐	☐
b. Joint Commission on Accreditation of Healthcare Organizations	☐	☐
c. National Association for Home Care	☐	☐
d. Community Health Accreditation Program	☐	☐

OPERATIONS

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

Companionship	%	Cooking/Light Housekeeping/Errands	%
Sleep Over Service	%	Bathing/Grooming/Incontinence Care	%
Bookkeeping/Accounting	%	Transportation	%
24 Hour Service	%	Medical Equipment Monitoring	%
Other	%	Describe:	

2. If 24 hour service, is this: ☐ Live-in ☐ Shift work
Provide full description:

3. If monitoring medical equipment, provide full description:

	Yes	No
4. Are all duties performed non-medical?	☐	☐
5. Do any duties include diagnosis, prescribing and/or dispensing of medications?	☐	☐
If yes, describe:		
6. Do any duties include the provision of financial related activities?	☐	☐
If yes, describe:		
7. Are all duties performed in private homes?	☐	☐

8. Total Annual Revenues/Sales $

Sales from Employees $

Sales from Independent Contractors $

Sales from Non-Nursing Operations $

9. Provide details of Employed or Contracted Personnel:

	No. Employed	No. Contracted	Contractors Ins. Limits Required
Aides/Homemaker Health Aides			
LPNs			
RNs			
Home Companions			
Certified Nursing Assistants			
Others (specify):			

		Yes	No
10.	Do you have a contract outlining scope of duties?	☐	☐
11.	Do you have recordkeeping procedures?	☐	☐
12.	Do care providers complete daily work reports?	☐	☐
13.	Is there an informed consent process in place?	☐	☐
14.	Do you care for children under the age of 18 years old?	☐	☐
	If yes, provide details:		

15. Are there written policies in place for:

	Yes	No		Yes	No
a. Emergencies in the field	☐	☐	g. Patient rights	☐	☐
b. Employee training	☐	☐	h. Physician orders	☐	☐
c. Food preparation	☐	☐	i. Proper lifting	☐	☐
d. Handling of complaints	☐	☐	j. Reporting suspected physical/sexual abuse	☐	☐
e. Medical equipment training	☐	☐			
f. Patient acceptance	☐	☐	k. Termination of care	☐	☐

		Yes	No
16.	Do you conduct background checks of all new hires/subcontracted personnel?	☐	☐

17. Do background checks include the following:

	Yes	No		Yes	No
a. All prior employers	☐	☐	f. Home telephone verification	☐	☐
b. All educational institutions	☐	☐	g. Professional licensing verification	☐	☐
c. Drivers license information	☐	☐			
d. Drug screening required	☐	☐	h. Residency information	☐	☐
e. Federal, State (if possible) and County criminal record search	☐	☐	i. Sex offender registry search	☐	☐
			j. Social security number verification	☐	☐

		Yes	No
18.	Are all staff/subcontractors over the age of 18 years?	☐	☐
19.	Are certificates of insurance maintained on file for all independent contractors?	☐	☐
20.	Are certificates of insurance updated on an annual basis?	☐	☐
21.	Are you in compliance with all applicable laws and ordinances pertaining to licensing and safety codes?	☐	☐
22.	If self-employed, does your employer carry insurance limits in an amount equal to or greater than the limit of this policy? ☐ N/A	☐	☐
23.	Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?	☐	☐
	If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?	☐	☐
24.	Do you enter into any contractual agreements?	☐	☐
	If yes, is legal advice sought to write and approve?	☐	☐
	If yes, does the agreement require you to hold any third party harmless?	☐	☐

25. Describe your hiring practices:

26. Are there written guidelines regarding sexual misconduct? ☐ Yes ☐ No
If yes, provide details:

27. Describe steps taken to prevent or avoid a sexual misconduct incident. (e.g. same gender caregiver/client)

28. Has the facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, provide details:

29. Have you or any employee, volunteer, or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, provide details:

30. Has any facility applicant, in the past year, been associated with, ever had any incidents occur, or claims brought against it while applicant was there? ☐ Yes ☐ No
If yes, provide details:

DESIRED TERMS AND CONDITIONS

Effective Date Desired:	Term Desired:	
Limit of Liability Desired:	General Aggregate Limit	$
	Products-Completed Operations Aggregate Limit	$
	Personal and Advertising Injury Limit	$
	Damage to Premises Rented to You (any one premises)	$
	Medical Expenses Limit (any one person)	$

Missouri Applicants: **DO NOT** answer this question.
Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
☐ No ☐ Yes - If Yes, give name of company, date, and reason:

Prior carrier information for the past three years:

Policy Dates	Carrier	Policy Number	Coverage	Check if Claims Made	Premium
				☐	
				☐	
				☐	

Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. Attach separate sheet if necessary.

Dates (Month/Year)	Allegations	Amount	Paid	Reserve

HIRED & NON-OWNED AUTO COVERAGE – Complete only if requesting coverage

1. Number of drivers using personal vehicles for business: (Full-time = over 20 hrs/week; Part-time = up to 20 hrs/week)

Full-time:	Part-time:	Volunteer:

Describe use:

	Yes	No
2. Do you require employees to carry and show evidence of personal insurance? If yes, limits required: $	☐	☐
3. Do you run MVRs on employees? If yes, how often:	☐	☐

			Yes	No
4.	Do you have a driver safety training program?		☐	☐
5.	Are employees trained on wheelchair tie-down procedures?		☐	☐
6.	Does your agency transport clients?		☐	☐
	If yes, in employee vehicles?	%	☐	☐
	If yes, in client's vehicle?	%	☐	☐

For information about how Northland compensates its agents, brokers and program managers, please visit this website:

http://www.northlandins.com/Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northland Insurance Companies, c/o Law Department, 385 Washington St., St. Paul, MN 55102.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Northland. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

FRAUD STATEMENTS

ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

FLORIDA: 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 of the third degree.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: 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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, 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 may include imprisonment, fines, and denial of insurance benefits.

IMPORTANT NOTICE
DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

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

SIGNATURES

Applicant Signature	Title	Date

Producer Signature	Date

Producer Name and Address