

GLATFELTER UNDERWRITING SERVICES, INC.
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HOSPICE AND COMMUNITY CARE INSURANCE SERVICES APPLICATION

- | | | |
|----------------------------------|------------------------------|-------------------|
| ◆ Professional/General Liability | ◆ Directors & Officers | ◆ Inland Marine |
| ◆ Buildings/Personal Property | ◆ Commercial Crime Insurance | ◆ ERISA Bond |
| ◆ Non-Owned/Hired Auto | ◆ Owned/Leased Auto | ◆ Excess/Umbrella |

A response is required for all questions.

I. GENERAL INFORMATION

A. Policy effective date: ____/____/____ Current Professional Liability Retro Date: ____/____/____
Current General Liability Retro Date: ____/____/____

(Please attach a copy of your current policy Declarations page.)

B. Name of organization: _____

Mailing address: _____
(street) (county) (city) (state) (zip code)

C. Phone: _____ Fax: _____ FEIN No.: _____

E-mail address: _____ Web site address: _____

D. Administrator or CEO: _____

Insurance contact person: _____

E. Date first accepted patients/clients: _____

F. What best describes your operation? Check one. Hospice (only) Home Health Care (only)

Combined Hospice/Home Health Care Home Health Care Aides (non-skilled)

State Association Foundation Other (describe): _____

G. Is your organization: nonprofit corporation for-profit corporation unincorporated organization

partnership or joint venture Other (describe): _____

H. 1. Are there subsidiaries that are to be included in this coverage? Yes No

(If "yes," please list the name of each subsidiary, and attach a current organizational chart.)

2. Please provide a brief description of the operations of each subsidiary listed above.

II. EXPOSURE INFORMATION

A. Please check only those blocks which apply to the services your agency provides and furnish the corresponding information required with your selection.

1. Hospice; annual number of hospice "patient days on service" _____; Annual number of hospice patients _____
2. "In-house" residential hospice care facility; number of "in-patient" beds _____; Does the facility meet local or state fire protection codes? Yes No
3. Palliative care for non-hospice patients; annual revenue generated \$ _____; Number of palliative care visits _____ Describe services and location where provided: _____

4. Home health care; number of annual patient visits _____; Annual number of patients treated _____
5. 24-hour "live-in" nurses or aides; number of assigned personnel _____; Annual number of patients _____
6. Home care aides (non-skilled companion care domestic services); number of annual clients _____; Number of employed aides providing services _____
7. State or regional hospice association; number of member organizations represented _____
8. Hospice or home health care foundation; list annual funds generated \$ _____
9. Hospice / Home Health Care agency ancillary operations (Please check those that apply and complete the referenced supplement(s))
 - Special events or fund-raisers (**Complete Supplement No. 1**)
 - In-house pharmacy (**Complete Supplement No. 2**)
 - Bereavement camps (**Complete Supplement No. 3**)
 - Sales, lease or rental of durable medical equipment (**Complete Supplement No. 4**)
 - Day care services (**For child day care, complete Supplement No. 5; for adult day care, complete Supplement No. 6**)
10. Thrift shop; annual gross sales/receipts \$ _____
11. Infusion therapy; percentage of patients receiving infusion therapy as compared to your overall operations _____ %
12. Pediatric care services; percentage of pediatric care provided as compared to your overall operations ____%. Annual number of pediatric care patients: _____
13. Professional personnel staffing services for other institutions or organizations; provide the number of assigned personnel and identify the institutions or agencies to whom the assignments are made:
 Number of personnel _____
 Number of personnel _____
 Number of personnel _____
 Number of personnel _____

14. Community immunization or vaccination programs; identify programs and provide an estimate of how often the programs are conducted and estimated number of annual immunizations or vaccinations provided:

15. Health care "emergency clinic" facilities; describe: _____

16. Mental health, special needs services; describe: _____

17. AIDS services; describe: _____

18. Family counseling or family crisis center

19. Pet therapy; identify the breed and whether the animal has been specially trained or certified for use in the therapy program by Therapy Dogs International, Inc. or the American Kennel Club:

20. Clinical trials, pharmaceutical testing, research, training and consulting services; describe:

Is this FDA approved? Yes No

21. Do you provide other services under contract other than hospice or home health care? Yes No

If "yes," please describe. _____

22. Describe any changes in services planned within the next year:

23. Organization gross annual budget: \$_____; **NOTE: If budget exceeds \$5,000,000, attach copy of latest audited financial statement.** Total annual payroll \$_____

B. Certification

1. Are you Medicare certified? Yes No

2. Are you licensed by state, local or county agencies? Yes No (If "yes," please attach a copy of your latest inspection report, along with a copy of your documented remedial actions taken to correct any deficiencies cited in the report.) (If "no," indicate status of state licensure.) _____

3. Are you accredited by:

JCAHO Yes No

Community Health Assessment Yes No

Accreditation Commission for Health Care Yes No

Please provide copy of most recent report.

C. List separately the name and title/position of all senior management, including directors and officers, of your organization and any wholly-owned subsidiary corporations on the following schedule:

DIRECTORS, OFFICERS OF THE ORGANIZATION

NAME	TITLE/POSITION

1. Does the board of directors have at least 51% participation by directors not employed by your organization?

Yes No

2. Have your executive director and/or majority stockholders previously managed a similar organization under another corporate name within the last five years?

Yes No (If "yes," list the names and dates of the organizations which were managed.)

3. Have there been any changes in senior management during the past three years? Yes No (If "yes," please explain on a separate sheet of paper and attach to this application.)

4. Has your organization merged with any facilities or business enterprises within the past ten years? Yes No (If "yes," list the names and dates of the organization with which your operations have merged.)

5. Within the last three years has your organization or any of its senior management, officers or other proposed "insureds" been a part of any civil or criminal litigation or arbitration proceeding related to the applicant's activities?

Yes No (If "yes," please provide complete details on a separate sheet of paper and attach to this application.)

6. Within the last three years has your organization or any of its officers, directors or other proposed "insureds" been advised that he, she or it is the subject of a complaint, suit, inquiry, investigation or other proceeding by any governmental or self-regulatory entity? Yes No (If "yes," please provide complete details on a separate sheet of paper and attach to this application.)

- D. For each location not listed in the Property Supplement #9, list full addresses, including county, with a description of operations (i.e., inpatient, office):

III. EMPLOYEE SELECTION AND TRAINING

- A. List number of personnel by class: _____ Full Time _____ Part Time _____ Volunteers

- B. Employee Type – Please indicate the number of employees by type:

Registered Nurses	Counselors	Home Care Aides
LPN/LVN	Pharmacists	Housekeepers
Therapists	Mngmt/Supervisors	Sitters
Nursing Aides		Other
		Total Number of Employees _____

- C. Which of the following background check methods do you use?
- | | <u>Employees</u> | <u>Volunteers</u> |
|--|--|--|
| 1. Social security number verification and search | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Home telephone verification | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Residency information | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Present employment and two previous employers' verification | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Education and professional licensing verification | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Driver's license information (MVR) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. County, state (if possible) and federal criminal search | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Drug screening | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Public records information | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Credit search | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

D. Employment Practices

1. Does your organization have written policies and procedures covering the following areas?
 - a. Hiring personnel and/or selecting volunteers Yes No
 - b. Dismissal Yes No
 - c. Discrimination Yes No
 - d. Sexual harassment Yes No
 - e. Disciplinary activities Yes No
 - f. Promotions Yes No
 - g. New employee/volunteer orientation Yes No
 - h. Performance evaluation/salary administration Yes No
2. Do you seek counsel from a human resource person or attorney prior to terminating an employee?

Yes No
3. Do you have a written grievance program? Yes No (If "yes," please provide a copy.)

4. Do you have a separate human resources or personnel department? Yes No (If "no," how is this function handled?) _____
5. Annual employee turnover for each of the last three years: _____ Latest Yr. _____ 2nd Yr. _____ 3rd Yr.
6. How many employees have been terminated or laid off during the past three years? _____ Latest Yr. _____ 2nd Yr. _____ 3rd Yr.
- E. What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies? _____%

F. Training

1. Is mandatory training conducted for all employees and volunteers Yes No, and is documentation maintained on attendees? Yes No
2. Describe in-service training programs for employees and volunteers, including frequency of training sessions:

3. Describe your safety procedures and risk management training for employees and volunteers:

G. Screening

1. Does your employment application include questions about whether the prospective employee has ever been convicted of a felony? Yes No
2. Does admission of a felony automatically eliminate the prospective employee from employment consideration? Yes No If "no," explain: _____

3. Does your organization have a written "zero tolerance" sexual abuse and molestation policy? Yes No

a. Does your written policy include:

- i. Definition of sexual abuse/molestation Yes No
- ii. Reporting and investigation procedures Yes No
- iii. Disciplinary procedures Yes No
- iv. Retaliation warning Yes No

- b. Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy? Yes No

- c. Have procedures been established to monitor the implementation of the program? Yes No

- d. Is training conducted for all employees and volunteers on the program and is documentation maintained on attendees? Yes No
- e. Are all records and documentation maintained for any incidents or allegations reported? Yes No
- f. Have any allegations or incidents been reported or are known to have occurred? Yes No (If "yes," provide complete details): _____

4. **Attach a copy of your current sexual abuse and molestation prevention policy.** (If you would like to view a copy of a standardized version of an acceptable sexual abuse and molestation prevention policy, for reference in developing your own, contact our web site, www.hccis.com.)

- H. Do you have a signed confidentiality agreement addressing conflict of interest, ethics and required code of conduct on file for each employee? Yes No

IV. RISK MANAGEMENT AND LOSS CONTROL

- A. Do you have a Safety Committee? Yes No. (If "yes," how often does it meet?) _____
 Do you have a Corporate Compliance Plan? Yes No
 Do you have a Compliance Officer? Yes No
 Do you have a Privacy Officer? Yes No
 Do you have electronic security access and transmission of data policies? Yes No

- B. Does your organization have a written "Quality Assurance" or "Risk Management" program? Yes No (If "yes," what is the name of the designated risk manager?) _____

- C. Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? Yes No

- D. Please identify anyone or any organization that will require a Certificate of Insurance from your organization in the forthcoming year. List the name and address and specify the reason for the certificate, i.e., landlord, owner of equipment leased to you, etc. (You may include a separate listing if additional space is required.)

<u>Name and Address of Certificate Holder</u>	<u>Purpose</u>
_____	_____
_____	_____

- E. Is there a designated individual within your operations who is responsible for recording all incidents that may result in litigation against your organization and for coordinating the reporting of all such incidents or property losses to your insurance carrier? Yes No

- F. Does your organization have knowledge of any incidents, which would cause a reasonable person to conclude that a claim or suit might result? Yes No (If "yes," please provide complete details on the incident(s), along with the date(s) of occurrence below. You may include a separate narrative if the space provided is insufficient.)

- G. Has any insurer ever refused to renew or cancelled any insurance coverages during the past three years? Yes No
 (If "yes," please provide the reason given for their actions.) _____
- H. A copy of a currently valued prior three-year loss exhibit from your current insurance company must accompany this application.

V. PHYSICIAN SERVICES

- A. Do you have any employed, volunteer or contracted physicians serving your organization? Yes No;
 Number of Physicians _____
 Do you engage in a credentialing process of all professional health care providers prior to their hire or when contracting for their services? Yes No; If "yes," describe process. _____

Complete Supplement No. 7 for each employed or volunteer physician serving your agency. Note: Physicians must be specifically endorsed onto your policy as additional insureds for coverage to apply.

- B. Indicate the number of each of the following types of medical professionals, whether volunteer or employed, if insurance is to be provided on our policy. *Each must be named as an additional insured on our policy, or no coverage is provided for that medical professional.

Physician's Assistant	Dentist	Psychiatrist
Resident Intern	Extern	Chiropractor
Acupuncturist	Nurse-Midwife	Certified Nurse Anesthetist

Please identify the respective individuals below, along with their title or position:

Name Title or Position

VI. NURSE PRACTITIONERS

- A. Do you have any employed, volunteer or contracted nurse practitioners serving your organization? Yes No
 If "yes," please indicate the number of nurse practitioners and combined total hours worked per month:
 _____ Number of nurse practitioners; _____ Hours worked per month

- B. Do your nurse practitioners carry individual medical malpractice insurance? Yes No
 If "yes," please identify the name of their insurance provider and limits of coverage provided for each individual:

<u>Nurse Practitioner</u>	<u>Insurance Company</u>	<u>Limits of Liability</u>

VII. AUTOMOBILE

(Please note: If company-owned/leased vehicles are insured by another carrier, Nonowned Auto Liability coverage will be excluded from this policy and must be secured under your owned automobile policy.)

- A. Do your employees and volunteers utilize their personal vehicles to provide services on behalf of your organization?
 Yes No
- B. Do you annually order MVR's on each employee and volunteer with driving responsibilities? Yes No
- C. Do you agree to extend driving privileges only to employees and volunteers with acceptable driving records? Yes No

Note: Acceptable driving records are:

1. No more than three moving violations or more than one chargeable accident during the past 36 months, AND
2. No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven years, AND
3. No license suspensions or revocations within the past seven years.

- D. Do you require that all employees and volunteers who operate their personal autos on behalf of your organization maintain minimum state financial responsibility limits?
 Yes No
- E. Do your employees and volunteers transport patients or clients in their personal autos? Yes No
If "yes," does your employee or volunteer maintain auto liability limits of at least \$100,000 Combined Single Limit?
 Yes No
- F. Do you allow your employees and volunteers to operate a patient's or client's vehicle? Yes No
If "yes," do you:
1. Restrict use to business use? Yes No
 2. Secure written permission from each client regarding use of their vehicle? Yes No
 3. Secure written verification that each client maintains current in-force limits of at least \$100,000 Combined Single Limit? Yes No
 4. Include driver safety education to your staff? Yes No

If you have owned or leased vehicles titled or contracted under your organization's name, please contact us for an automobile application.

VIII. OPTIONAL LIABILITY COVERAGE

- A. Employee Benefits Liability – The standard limit of \$25,000 each employee/\$50,000 aggregate will automatically be included as an endorsement to the Professional/General Liability policy. If you prefer, you may select higher limits, as indicated:
- \$50,000 each employee; \$50,000 aggregate
 \$100,000 each employee; \$100,000 aggregate
- B. Excess Liability Insurance – If you would like us to offer a quotation for Following Form Excess Liability coverage, please indicate the limit of liability to be quoted: **(This will not extend over D&O coverage.)**
- \$1,000,000 \$2,000,000 \$3,000,000 \$4,000,000 \$5,000,000
- C. Directors and Officers Liability Coverage – If your organization is chartered as a nonprofit organization under the Internal Revenue Code, and you desire a proposal for Directors and Officers Liability coverage, please complete and sign the Directors and Officers Liability application.

- D. Employee Retirement Income Security Act Insurance (ERISA) – We can offer you a proposal for a bond to insure your organization’s liability in the proper administration of employer-administered employee benefit plans. The act is designed to protect the rights of employees and beneficiaries covered under the benefit plans your organization administers. If a quote is desired, please indicate Yes and complete Supplement No. 8.

IX. OTHER OPTIONAL COVERAGE

- A. Property Insurance – If you have any owned or leased property and desire a quote, please indicate Yes and complete Supplement No. 9.
- B. Commercial Crime Coverage – This coverage is only offered if we also provide Property Insurance coverage. The basic policy provides a \$25,000 commercial crime limit. Please indicate if a higher limit is desired.
- \$50,000 \$100,000 \$250,000 \$400,000 \$_____ Other

ANY SIGNIFICANT CHANGES TO YOUR ORGANIZATION DURING THE POLICY YEAR MUST BE REPORTED TO GLATFELTER UNDERWRITING SERVICES, INC. TO ENSURE COVERAGE.

PLEASE READ CAREFULLY

GENERAL FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

Your signature acknowledges that you have read the state-specific fraud warning that applies to your state of domicile. See list.*

Authorized Signature of Applicant: _____ **Date:** _____

Print Name and Title: _____

***Arkansas Fraud Warning**

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.

California Fraud Warning

Any person who knowingly makes an application for motor vehicle insurance coverage containing any statement that the applicant resides or is domiciled in this state when, in fact, that applicant resides or is domiciled in a state other than this state, is subject to criminal and civil penalties.

Colorado Fraud Warning

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.

District of Columbia Fraud Warning

WARNING: 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.

Florida Fraud Warning

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.

Hawaii Fraud Warning

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 imprisonment.

Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Fraud Warning

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.

Maine Fraud Warning

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.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am a resident of the State of New Hampshire. I understand that if I falsely claim to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year and a fine of \$2,000.

New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Fraud Warning

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 civil fines and criminal penalties.

New York 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 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.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Warning

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.

Oregon Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents materially false information in an application for insurance, may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania Fraud Warning

Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

Tennessee Fraud Warning

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.

Virginia Fraud Warning

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.

Washington Fraud Warning

All applications for insurance must contain a statement, permanently affixed to the application, that clearly states in substance: 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.

THIS APPLICATION MUST BE SIGNED BEFORE WE CAN PROCESS.

INSURANCE AGENT INFORMATION:

Agency name: _____

Contact person: _____

Agency address: _____

Telephone number: _____ Fax number: _____

E-mail address: _____