BRICELAND BA AGENCY, INC.
INSURANCE

Application For Insurance Coverages For Health Care Organizations

General Information

☐ New Application
☐ Renewal Application

1. Firm Name: _____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐For Profit ☐Not for Profit ☐Partnership ☐Other (specify)_____

2. Address:_____
Street PO Box

_____
City State Zip County

Phone:_____ Fax:_____

Website:_____ Email:_____

3. Total Annual Gross Receipts: $_____ Federal ID Number:_____

1. Date Business Established: _____ (Required: Attach current annual financial statement and principal's resumes if in business less than three years)
2. Type of Firm (check all that apply):

☐ Home Health Care Provider ☐ Visiting Nurse Agency ☐ Supplemental Staffing
☐ Infusion Therapy Provider ☐ Nurse Registry ☐ Medical Equipment Supplier
☐ Retail Pharmacy ☐ Closed Pharmacy ☐ Hospice
☐ Other(specify)_____

3. Description of operations: _____

_____

_____

Hiring/Screening and Employment Procedures

1. Are employees/contractors references contacted before hired/placed? ☐Yes ☐No
2. How are references checked? ☐ Written ☐ Verbal ☐ Both
3. Does the applicant utilize criminal background checks? ☐Yes ☐No
If yes, at what level are criminal searches conducted? ☐County ☐State ☐Federal ☐Felony ☐Misdemeanor Convictions
4. Do you verify certification and/or professional licensure status of employees and independent contractors? ☐Yes ☐No
5. Are employees screened to rule out drug and alcohol abuse? ☐Yes ☐No
6. Are job descriptions provided for all professional and nonprofessional employees? ☐Yes ☐No

Accreditation and Membership in Professional Associations

Is the applicant a member of, or accredited by, any of the following organizations:

☐ The National Association for Home Care (NAHC) Member #_____

☐ Community Health Accreditation Program (CHAP) ☐ Joint Commission on Accreditation of Healthcare Organizations(JCAHO)

Risk Management/Quality Assurance

1. Is the applicant licensed in all states in which it is operating? ☐Yes ☐No
   List states of operation: _____
2. Has the applicant's license ever been suspended, revoked, voluntarily surrendered, or subject to probate in any state? ☐Yes ☐No
   If yes, please explain:_____
   _____
3. Does the applicant utilize a formal written Quality Assurance and Risk Management Program? ☐Yes ☐No
   If no, please explain: _____
4. 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: _____
   _____
5. Does the applicant conduct patient/client surveys? (If yes, please attach sample) ☐Yes ☐No
6. Are the results of patient/client surveys used to improve day to day operations? ☐Yes ☐No
7. Briefly describe educational training and certification programs utilized by your firm: _____
   _____
   _____
8. Is the applicant currently being investigated by state or federal regulatory agencies? ☐Yes ☐No
   If yes, please explain:_____
   _____

Claims/Coverage History

1. Have any claims/suits been made within the last five 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.)
2. 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:_____
   _____
3. Has any insurance company or Lloyd's declined, canceled or refused to renew any of the applicant's insurance? ☐Yes ☐No
   If yes, please explain: _____
   _____

A. Previous Professional Liability Insurance (Past Five Years)

Company	Limits of Liability	Effective Dates	Annual Premium	Claim Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

B. Previous General Liability Insurance (Past Five Years)

Company	Limits of Liability	Effective Dates	Annual Premium	Claim Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

C. Previous Products Liability Insurance (Past Five Years)

Company	Limits of Liability	Effective Dates	Annual Premium	Claim Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

Professional Liability Section

(All applicants must complete this section)

A. Employees – Annual Staffing

Employee Type	Number Full Time	Number Part Time	Annual Hours	Annual Payroll*
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide				
Homemaker				
Sitter/Companion				
Clerical Placements				
X-ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Other (specify)				
Total				

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

B. Independent Contractors – Annual Staffing

Contractors Type	Number of 1099's	Annual Hours	Total Amount Paid Per 1099's **
Nurse (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Home Health Aide			
Homemaker			
Sitter/Companion			
Clerical Placements			
Other (specify)			
Total			

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

1. Are applicant's 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: $_____

2. Are certificates of insurance maintained on file for all independent contractors? ☐Yes ☐No

3. Do you obtain updated certificates of insurance on an annual basis? ☐Yes ☐No

C. Locations Where Services are Provided % (Total Must Equal 100%)

☐Private Homes	_____%	☐Clinics	_____%
☐Nursing Homes/ACLF/ILF	_____%	☐Doctor's Offices	_____%
☐Hospitals	_____%	☐Other Locations	_____%
☐Prison Facilities	_____%	(please specify)	
☐Schools	_____%	_____	

D. Types of Services Provided % (Total Must Equal 100%)

☐Personal Care Chore or Companion	_____%	☐Training/Certification Program Open to General Public	_____%
☐Rehabilitation	_____%		
☐Infusion Therapy	_____%	☐Respiratory Therapy (trach care / ventilator care)(please circle)	_____%
☐Hospice	_____%		
☐Supplemental Staffing – Medical (please complete section E)	_____%	☐Clinics Owned/Operated	_____%
		☐Social Services	_____%
☐Supplemental Staffing – Non-medical	_____%	☐Infant Care	_____%
☐Obstetrical Services	_____%	☐Pediatric Care	_____%
☐Adult Day Care*	_____%	☐Retail Pharmacy	_____%
☐Child Day Care*	_____%	☐Closed Pharmacy	_____%
☐Medical Equipment Supplier	_____%	☐Mail Order Pharmacy	_____%
☐Clinical Trials	_____%	☐Radiation Therapy	_____%
☐Meals on Wheels	_____%	☐Laboratory Services	_____%
Do you prepare the food? ☐Yes ☐No		☐Surgical Nursing/Operation Techs Describe services:_____	_____%

* Firms providing day care may be required to complete a supplemental application.

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

E. Supplemental Staffing % (Total Must Equal 100%)
(Supplying health care providers to other facilities for a fee)

If no supplemental staffing provided, please check here ☐

☐Nursing Homes _____% ☐Doctor's Offices _____% ☐Hospitals _____%

☐Clinics _____% ☐Prisons _____% ☐Schools _____%

☐Other Facilities (please specify) _____ _____%

General Underwriting Section

(Please complete for all lines of coverage)

Owned or Leased Premises

(Please attach list of all other locations)

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

1. Are any professional services provided on your premises (i.e., clinics, day care, infusion)? ☐Yes ☐No
   If yes, please explain: _____
   _____
2. Does the applicant own or operate any bed and board facilities? ☐Yes ☐No
   If yes, please explain: _____
   _____
3. Do you provide any "high tech" services? (i.e., trach care, ventilator care, chemotherapy, etc.)? ☐Yes ☐No
   If yes, what are the expertise requirements for staff that will provide services? _____
   _____
4. Does the organization enter into any contractual agreements?
   (i.e., with hospitals, nursing homes or other health care facilities, etc.) ☐Yes ☐No
   If yes, please list and attach copies of all agreements:_____
5. List all entities to be named as Additional Insured's with names and insurable interest:
   (Please attach a copy of each contractual agreement, excluding landlords.)

NAME	NAME
ADDRESS	ADDRESS
INTEREST	INTEREST

6. Has applicant sold, acquired, or discontinued any operations in the past five years? ☐Yes ☐No
   If yes, please explain: _____
   _____
7. Is the applicant considering any changes in operations or products handled in the next 12 months? ☐Yes ☐No
   If yes, please explain: _____
   _____

Products Liability Section

A. Medical Equipment/Supplies

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

NOTE: If applicant has locations in more than one state, please provide information on a per state basis.

1. Does applicant SELL any medical supplies and/or equipment? ☐Yes ☐No Total Annual Sales $_____

2. Does applicant provide pharmaceutical products? ☐Yes ☐No Total Annual Sales $_____

3. Does applicant RENT or LEASE any medical supplies and/or equipment? ☐Yes ☐No
   Total Annual Lease/Rental Receipts: $_____

4. Does applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? ☐Yes ☐No
   a. Total Annual Repair/Maintenance RECEIPTS $_____
   b. Total Annual Repair/Maintenance PAYROLL $_____

If you answered "YES" to either 1. and 2. please complete the remainder of this section. If you answered "NO" to both 1. and 2. you may skip this section.

CATEGORY I. **EXPENDABLE ITEMS** – Intended for one time usage and disposed (i.e., adhesive tape, bandages, hypodermic Needles, etc.) – DO NOT INCLUDE PHARMACEUTICAL SALES.

Annual Sales $_____

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.

Annual Sales $_____ Annual Lease/Rental Receipts $_____

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, I.V. pumps, portable EKG machines, or sending devices.

Annual Sales $_____ Annual Lease/Rental Receipts $_____

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. (Please attach list of Category IV equipment or devices).

Annual Sales $_____ Annual Lease/Rental Receipts $_____

NOTE: Total amount of Annual Sales in Categories I_IV must equal amount in Section A.,1. above;
Total amount of Annual Lease/Rental Receipts in Categories II_IV must equal amount in Section A., 2. above.
Total amount of Annual Sales, Lease/Rental Receipts, and Pharmaceuticals must equal the amount on page 1 – Total Gross Receipts.

5. Does the applicant manufacture any products? ☐Yes ☐No

6. Is the applicant named as an additional insured – vendor on the manufacturer's policy for any/all products? (Note- required for any category IV products) ☐Yes ☐No
   Provide copies of Certificates for Category IV.

7. Does the applicant obtain certificates of insurance form their products suppliers? ☐Yes ☐No

8. Do you or have you ever distributed or directly imported products from a foreign manufacturer? ☐Yes ☐No
   If yes, please explain:_____
   If yes, does the foreign manufacturer have a U.S. location? ☐Yes ☐No

9. Do you modify any product in any way from its intended use? ☐Yes ☐No
If yes, please explain: _____

_____

10. Do you do any repackaging or relabeling of items obtained from suppliers? ☐Yes ☐No
If yes, please explain: _____

_____

11. Does the manufacturer's label remain on the equipment? ☐Yes ☐No

12. Do you maintain a written quality control program? ☐Yes ☐No

13. Do you perform preventive maintenance on all equipment according to a written schedule? ☐Yes ☐No

14. Is all equipment checked and their condition documented prior to their release? ☐Yes ☐No

15. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments? ☐Yes ☐No

16. Do you use the services of an EPA approved contractor for the disposal of hazardous waste materials? ☐Yes ☐No
If yes, what materials? _____

17. Does applicant have any exposure to nuclear or radioactive materials? ☐Yes ☐No
If yes, please explain: _____

18. On oxygen, oxygen related equipment, life sustaining or critical life monitoring equipment or devices, describe the 24 hour service, 365 day/year program that exists: _____

_____

_____

19. Do you distribute oxygen cylinders? ☐Yes ☐No
If yes, are they pre-filled or do you fill them at your premises?_____

20. Do you follow F.D.A. and D.O.T regulations for the sterilization and transportation or oxygen? ☐Yes ☐No

When the applicant has oxygen filling exposure:

The insured has indicated an exposure with filling oxygen on premises. For this exposure, please confirm the following:

a. Confirm the insured is FDA approved for transfilling oxygen tanks. ☐Yes ☐No

b. Certificates of Analysis are required and purity test is conducted upon every delivery At risk's site. ☐Yes ☐No

c. Lot numbers are received and created for both the received product and during filling so that it can be traced back to supplier at any time? ☐Yes ☐No

d. Are the employees performing oxygen transfilling properly trained and certified? ☐Yes ☐No

e. Do oxygen operations take place in a separate room? ☐Yes ☐No
If yes, is this room restricted only to the insured's employees and not in the general public? ☐Yes ☐No
Is this room clearly marked as restricted to only employees and also marked "No Smoking"? ☐Yes ☐No

When applicant has an oxygen exposure but tanks are prefilled:

The insured has indicated an exposure with pre-filled oxygen on premises. For this exposure, please confirm the following:

a. Do oxygen operations take place in a separate room? ☐Yes ☐No
If yes, is this room restricted only to the insured's employees and not in the general public? ☐Yes ☐No
Is this room clearly marked as restricted to only employees and also marked "No Smoking"? ☐Yes ☐No

b. Is a home assessment conducted prior to delivery and set up of any oxygen and its related Equipment in a patient's home? ☐Yes ☐No

c. When oxygen is provided in the home, are "No Smoking" signs provided to the patient? ☐Yes ☐No

d. Is the proper use of oxygen reviewed with the patient and caregiver and sign-off required by all parties (patient, caregiver and employee)? ☐Yes ☐No

B. Maintenance and/or Repair of Equipment

1. Do you SELL other supplier's used equipment? ☐Yes ☐No
   If yes, please list gross revenue derived from this operation: $_____
2. Do you REPAIR other supplier's used equipment? ☐Yes ☐No
   If yes, please list gross revenue derived from this operation: $_____
3. Please list all types of equipment you repair: _____

   _____
4. Are manufacturer's recommendations followed for all repair of equipment? ☐Yes ☐No
5. Do you subcontract labor for any installation, services or repair? ☐Yes ☐No
   If yes, please explain: _____
6. Are certificates of insurance obtained from those subcontractors that provide installation service or repair? ☐Yes ☐No
7. Does applicant sell, install or maintain stair glides or vehicle lifts? ☐Yes ☐No
   If yes, provide a list of equipment you sell and/or lease or rent.

Fidelity Coverage Section

A. Limit Requested: $_____ (Note: minimum limit $10,000)

B. Internal Controls:

1. How many people routinely handle money and/or securities? _____
2. Is countersignature of checks required? ☐Yes ☐No
   If no, who signs the checks? (name and title)
   _____
3. Are bank accounts reconciled by someone who is not authorized to deposit or withdraw from the account? ☐Yes ☐No
   If no, is reconciliation of bank accounts done by the owner? ☐Yes ☐No
4. Is the applicant audited at least annually by an independent CPA? ☐Yes ☐No
5. Does the audit, if performed, include inventory? ☐Yes ☐No
6. If an audit is not conducted, is an annual review or compilation prepared by an outside party? ☐Yes ☐No
7. Total number of applicant's offices: _____

C. Previous Fidelity Insurance (Past Three Years):

Company	Limits of Liability	Effective Dates	Annual Premium	Third Party Liability Provided?

Business Auto Liability Section

(Owned, Non0owned, and Hired Auto)

1. Please attach the following information if applying for Owned Auto Coverage:
   a. ACORD APPLICATION (blank ACORD auto application available upon request).
   b. List of drivers including name, driver's license #'s, addresses, dates of birth and dates of hire, and MVR's if available.
   c. Schedule of owned vehicles.

2. Does the applicant own any vehicles used for business purposes? ☐Yes ☐No

3. Does the applicant require each employee/independent contractor to provide evidence of auto insurance? ☐Yes ☐No

4. Does the applicant request a Division of Motor Vehicle Report (MVR) prior to employment? ☐Yes ☐No

5. Does the applicant require employees to maintain minimum insurance limits of at least $100,000 per person/$300,000 per accident, or $300,000 combined single limit? ☐Yes ☐No

   Does the applicant require independent contractors to maintain minimum Insurance limits of at least $100,000 per person/$300,000 per accident, or $300,000 combined single limit? ☐Yes ☐No

   (NOTE: Minimum $100,000/300,000 limits required for non-owned and hired auto coverage)

6. Does the applicant or any employee/independent contractor regularly transport clients? ☐Yes ☐No
   If yes, please explain: _____

7. Are any of the applicant's vehicles used for transport? (i.e., emergency, errands, etc.) ☐Yes ☐No
   If yes, please explain: _____

8. Does applicant modify, convert or fit vehicles for special equipment? ☐Yes ☐No