ALL INSURANCE UNDERWRITERS

HEALTH CARE SUPPLEMENTAL APPLICATION

INSTRUCTIONS:
• PLEASE TYPE OR PRINT CLEARLY IN INK. ALL SECTIONS MUST BE COMPLETED FULLY.
• IF YOU NEED MORE SPACE, ATTACH ADDITIONAL SHEETS AS NEEDED USING COMPANY LETTERHEAD

1. APPLICANT OVERVIEW

Firm Name: _____

(If the insured has a DBA please list): _____

Date business established: _____ | Number of years under current ownership: _____

Website URL is: _____ | Total number of beds: _____

a) Are medical/health insurance benefits provided to employees? If so, please provide details of benefits and complete all that apply. ☐ Management Only ☐ Employee Participation _____ % ☐ Employers Contribution _____ %	☐ Yes	☐ No
b) What is the maximum number of employees at one location at any one time?	_____	
c) Indicate annual turnover rate: _____%	Avg. Weekly Hours: _____ Full Time _____ Part-Time	
d) Does the applicant have 24 hours exposure?	☐ Yes	☐ No
e) Do any employees work longer than a 12-hour shift? If yes, how many hours do they work? _____ If yes, how many days do they work in a row? _____	☐ Yes	☐ No
f) Do you have EE's over 60? If so how many? _____ What are their job duties? _____	☐ Yes	☐ No
g) Indicate percentage of volunteers in the workforce: _____%		
h) Does the applicant have ownership in any other healthcare related business? If yes, what is the percentage of ownership in related business? _____% If 50% or greater are the policies combinable? _____ What type of healthcare business? _____ Name of other business: _____ Website of other business: _____	☐ Yes	☐ No
i) Clerical EEs Where do the clerical EEs work? _____ What are the job duties for clerical EEs? _____		

2. NEW VENTURE QUESTIONS (only complete if this is a new venture)

a) Is this an existing business being purchased? If yes, what percentage of employees will be retained? _____% What percentage of management or supervisors will be retained? _____%	☐ Yes	☐ No
b) Is this a new business venture started by applicant? If yes, how many years of related industry experience? _____ **(Please attach resume)**	☐ Yes	☐ No
c) If applicant has no prior experience, is a manager being hired that does? **If yes, please attach the appropriate resume.**	☐ Yes	☐ No
d) How are you attaining Clientele? _____		

3. BUSINESS OPERATIONS (check all that apply)		
☐ Home Health - Skilled Nursing	☐ Substance Abuse Counseling	☐ Nursing Home
☐ Personal Care Provider	☐ Mental Health Counseling	☐ Assisted Living
☐ Hospice Provider	☐ Crisis Response Team	☐ Community Hospital
☐ Physical Therapy / Occ. Health	☐ Drug Treatment / Detox	☐ Clinic
a) What percentage of the operations are skilled vs non-skilled? % Skilled % non-skilled		
b) Excluding Medicare, what % of residents pay via Federal or State Medicaid? %		
c) What percentage of insured's clients are:		
Non-ambulatory _____ %	Alzhiemers/Dementia _____ %	Elderly %
Hospice Care _____ %	Developmentally Disabled _____ %	Short Term Care _____ %
Mentally Ill _____ %	Physically Disabled _____ %	Other _____ %
d) Please indicate where your employees perform their work:		
Private Homes/Apt. _____ %	Clinics _____ %	Nursing Homes _____ %
Doctor's offices _____ %	Hospitals _____ %	Corporate offices _____ %
Day Care Setting _____ %	Community Residences _____ %	Other Locations _____ %
e) Please explain Nursing Home or Hospital Exposures? _____		

4. RISK MANAGEMENT AND SAFETY PROGRAMS		
a) What is the average radius that employees drive during the workday? _____ miles		
b) Do more than 3 employees travel together in any one vehicle?	☐ Yes	☐ No
c) Are MVRs checked annually for all employees who drive as part of their job?	☐ Yes	☐ No
d) What standard are traveling employees held to regarding MVRs: ☐ No violations in the last 3 years and/or ☐ No more than _____ minor violations in the last 3 years and/or ☐ No more than _____ major violations in the last 3 years.		
e) Is a formal safety program in place?	☐ Yes	☐ No
If yes, is the safety program OSHA approved? ☐ Yes ☐ No ***PLEASE PROVIDE A COPY***		
f) Indicate the following safety practices the applicant has in place:		
☐ Driver Safety Programs	☐ Accident/Injury Investigation	☐ New Employee Orientation
☐ Safety Committee	☐ Patient Handling/Transfer Training	☐ Blood Borne Pathogen
☐ Safety Incentive Program	☐ Performance Evaluations include safety	☐ Combative Patient Training
☐ Regular Formal Safety Training Conducted	☐ Management involvement in safety	
g) Is there a full-time safety director on staff (not including the owner)? If yes, please provide the name: _____	☐ Yes	☐ No
h) Please provide details on your safe lifting procedures: _____		
i) How often do you implement safety meetings and training? _____		
j) If you do not follow all the above listed safety practices, please explain. _____		
k) Are you willing to implement all the above safety practices? _____		

5. HIRING PRACTICIES		
a) Check next to the below to indicate screening measures that are applied to prospective employees (note: some are post offer)		
☐ Reference Check	☐ Validate Work History	☐ Personal Interviews
☐ Drug Testing/Screening	☐ Criminal Background Check	☐ Verification of Certifications/licenses
☐ Post-Offer Physicals	☐ Child Abuse Clearance	☐ Psychological Testing
☐ Zero Tolerance Fraud Prog.	☐ New Employee Orientation	☐ Detailed Job Requirements
Please indicate frequency of Drug Testing. Please check all that apply: ☐ Upon Hire ☐ Random Testing ☐ Annual Testing		
b) Does the insured validate employee licenses & certifications? ☐ Yes ☐ No ☐ N/A		

6. CLAIMS MANAGEMENT		
a) Is there a designated person to manage workers' compensation claims?	☐ Yes	☐ No
b) Is there a formal Return to Work/Modified Duty Program in place?	☐ Yes	☐ No
c) Have detailed light duty job descriptions been developed	☐ Yes	☐ No
d) Has a relationship been established with a preferred medical provider?	☐ Yes	☐ No
e) Use of 3rd party claim triage and reporting vendor?	☐ Yes	☐ No

7. INSURANCE INFORMATION		
a) Has the applicant had continuous WC coverage for the past 2 years?	☐ Yes	☐ No
b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years?	☐ Yes	☐ No
c) Has the applicant's WC ever been cancelled for Underwriting Reasons? If Yes, what is the reason: _____	☐ Yes	☐ No
d) Is the applicant's current WC insurance provided through an Assigned Risk Plan?	☐ Yes	☐ No
e) Does the applicant supply any workers to other employers on a temporary or permanent basis?	☐ Yes	☐ No
f) Are all the applicant's operations (exclusive of monopolistic states) being submitted for WC?	☐ Yes	☐ No
g) Does the applicant have any 1099 exposure? If Yes, what is the # of 1099's _____ and what is the total cost of 1099's _____ Please provide a detailed description of 1099 duties: _____ Do the 1099's carry their own workers compensation? ☐ Yes ☐ No If yes, please provide Certificates of Insurance. ***If no, all 1099's must be included on the Acord as payroll.	☐ Yes	☐ No
h) What is the Employee to Patient Ratio?		
i) Please provide the previous payroll and premium history:		

Coverage Term	Payroll	Premium

To the best of my knowledge all the information I have given about my business is true and correct. If information is found to be different as the result of my knowingly attempting to defraud the insurance company, or information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the insurance company may send direct notice of cancellation.

_____ Applicant Signature	_____ Date
_____ Agent Signature	_____ Date