



CID Insurance Services

THE BROKERS PREFERRED WHOLESALE SOLUTION

Home Health Care

For a complete submission, please include the following information:

- Home Health Program Application
- Sexual Misconduct Supplemental Application
- State License
- Most Recent Inspection Report
- ACORD Applications 125 & 126 (if needing GL coverage)

If you don't see what you need or have any questions,
please email your underwriter: lexi@cidinsurance.com

Section One – Applicant Information

Name of Applicant: _____
(As it should appear on the policy)

Physical Address: _____ Phone: _____

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

Additional Locations: _____

1. Number of Years in Business: _____

2. Total Staff Count: _____

For question 3.b), if the answer is “No”, coverage cannot be bound under the terms of the Home Health Program.

3. a) Does the Applicant have any providers/employees that are physicians, chiropractors, acupuncturists, CRNAs, Nurse Practitioners, or Physician’s Assistants? Yes No
- b) If “Yes” to question 2.a) above, do all such individuals carry their own coverage? Yes No N/A

For questions 4 through 6, if the answer is “No”, coverage cannot be bound under the terms conditions of the Home Health program.

4. Are all providers/employees licensed in accordance with applicable state and federal regulations? Yes No
5. a) Are criminal background checks conducted on all employees? Yes No
- b) Does the Applicant conduct pre-employment screenings and/or any other necessary investigations and credentialing prior to hiring any staff? Yes No
6. a) Does the Applicant have a written/formalized risk management/quality assurance program? Yes No
- b) Does the Applicant have written procedures in place for the reporting of incidents? Yes No
- If “No”, please explain:
- _____
- _____

For questions 7 through 13, if the answer is “Yes”, coverage cannot be bound under the terms of the Home Health program.

7. Has the Applicant or any of its providers/employees ever:
- a) Been the subject in disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
- b) Been convicted of an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- c) Been treated for alcoholism or drug addiction? Yes No
- d) Had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered? Yes No
- If “Yes”, please explain:
- _____
- _____

8. Are greater than 15% of the Applicant's services rendered at, or involve, any of the following:
- a) Hospitals? Yes No
 - b) Pediatric care? Yes No
 - c) Skilled nursing? Yes No

If "Yes", what percentage? _____%

9. Does the Applicant perform or provide the following:
- a) Services to correctional facilities? Yes No
10. Is the Applicant's estimated gross revenue for the next 12 months expected to exceed \$2 million? Yes No

Total Gross Revenue:

Amount Last Policy Year: \$ _____

Estimated next 12 Months: \$ _____

11. Has any application for Professional Liability Insurance made on behalf of the Applicant, any predecessors in business or present Partners EVER been declined or has similar insurance ever been cancelled or non-renewed? Yes No
 If "Yes", please explain:

12. Has any claim EVER been made against the Applicant or any of its employees? Yes No
13. Is the Applicant aware of ANY circumstances which may result in ANY claim against it, its predecessors in business, or any of its past or present directors, officers, or partners? Yes No
14. a) Does the Applicant have expiring coverage in place? (If retroactive coverage is desired, please submit expiring declaration page and a five-year loss run.) Yes No
 b) If the expiring policy is claims-made, what is the retroactive date? _____
15. a) Is the Applicant interested in Hired and Non-Owned Auto Liability coverage? Yes No
 b) If "Yes" to the above, does the Applicant warrant that all providers/employees with driving responsibilities maintain automobile insurance that meets the minimum state requirements, AND does the Applicant access and review Motor Vehicle Reports on all such individuals as a condition of employment? Yes No N/A

Section Two – Warranties and Representations

- A. The Applicant warrants and represents that the statements set forth herein are true and complete, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this application.
- B. The Applicant agrees that this application, and any materials submitted herewith, are the basis of the proposed insurance and will be attached to, and made part of the policy, should a policy be issued.
- C. The Applicant agrees that, if the information supplied on this application changes between the date of the application and the inception date of the policy period, the Applicant will immediately notify the underwriter of such a change, and the underwriter may modify or withdraw coverage.
- D. As respects Hired and Non-Owned Auto Liability coverage, the Applicant warrants by the signing of this application that only those drivers that meet the following conditions will be allowed to drive on company business:
 - a. No more than two (2) moving violations within the past three (3) years.

- b. No At-fault accidents within the past 3 years.
- c. No convictions of Driving Under the Influence (DUI), Reckless Driving, Driving While Intoxicated (DWI), Vehicular Manslaughter, Driving Dangerously, or other similar type of offense.

Signed: _____ Date: _____

Authorized signature of a Principal or Officer
(Must be signed and dated no more than 45 days prior to binding)

Print Name: _____ Title: _____

Section Three – Payment Instructions

Premium:	\$ _____
Taxes & Fees <i>(if applicable)</i> :	\$ _____
Policy Issuance Fee*:	\$ _____
Broker fee:	\$ _____
TOTAL PAYMENT	\$ _____

***Policy issuance fees vary by state, with \$175 being the maximum. Underwriters will confirm the policy issuance fee at the time of binding.**

If this risk is subject to surplus lines tax, you must arrange for filing the affidavit and for payment of the applicable state tax/fees, in addition to the premium.

- **Policy Issuance Fee is fully earned.**
- **Written Policies are subject to a minimum earned premium of 25%.**
- **No Flat Cancellations.**

CID Insurance Programs Inc. DBA CID Insurance Services

Sexual Misconduct and Molestation Liability Insurance Supplemental Application

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

This Application must be completed in type or ink by the Applicant. All questions must be answered for a quotation to be given. Blank answers or "N/A" will not be accepted. Please answer "No" or "None" to any such questions. Use separate sheet if needed.

If a material change occurs to any of the answers given below prior to the inception of any insurance, the Applicant must notify the insurer, and at the sole discretion of the insurer, any outstanding questions may be modified or withdrawn.

The particulars, representations and statements contained in this Application, and any other information submitted, are the basis for the proposed insurance and will be considered as incorporated into and constituting part of the proposed certificate and/or policy.

The completion and signing of the Application does not bind the Applicant or the Insurer to a policy or certificate of insurance.

1. Name of Applicant: _____

2. Staff Breakdown:

Total staff count: _____

Total number with direct client contact: _____

3. Annual Turnover Rate: _____

Loss Prevention Efforts

4. Check which of the following methods are used in the screening and hiring process for employees and volunteers. Please attach a copy of any items in bold.

Loss Prevention Methods	Employees	Independent Contractors
a) Standard Application	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Code of Conduct	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Interview	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Reference Checks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Standard questions for references		
e) Criminal background check	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Abuse registry check (**Required upon binding)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Checklist of indicators that may indicate increased risk to abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Loss History

5. Is the Applicant aware of any facts, incidents, circumstances or allegations that may result in claims being made against you? Yes No
(If "Yes", please provide details on a separate sheet of paper.)

6. Has the Applicant, any employee or any volunteer currently seeking coverage been involved in an allegation or claim relating to abuse (sexual or other) or molestation? Yes No
(If "Yes", please provide details on a separate sheet of paper.)

7. Are accused employees removed from client care responsibilities pending the outcome of an investigation? Yes No
If "No", please advise what occurs: _____

8. Does the organization have a written policy prohibiting all those listed in question #7 above from working alone with a single client? Yes No

9. Do staff members ever have clients at their home? Yes No

10. Do staff members ever spend time at the home of clients? Yes No

11. If transportation is provided, is there more than one adult present at all times? Yes No

12. Are staff members required to complete annual abuse prevention training? Yes No

13. Does central administration establish, monitor, and enforce policies and procedures across all locations? Yes No
If "No", please explain: _____

14. Are items below included in the operations handbook for all staff members listed in question #6 above?

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A zero tolerance statement for sexual abuse perpetrated on children or other vulnerable persons in the Applicant's care. |
| <input type="checkbox"/> | <input type="checkbox"/> | A written policy that defines appropriate and inappropriate displays of affection. |
| <input type="checkbox"/> | <input type="checkbox"/> | A written procedure for governing the interactions between employees/independent contractors and children or other vulnerable persons in your care outside of regular program activities. |
| <input type="checkbox"/> | <input type="checkbox"/> | A written procedure for managing the risk when one employee/volunteer is a lone child or other vulnerable person. |

Historical Activity

15. Have any of the individuals been transferred in or out of your business because they were involved, suspected, or a complaint was made regarding an allegation of sexual misconduct? Yes No
(If "Yes", please provide details on a separate sheet of paper.)

16. In the past 10 years, have any individuals been terminated for cause related to abuse (sexual or not) behavior? Yes No
(If "Yes", please provide details on a separate sheet of paper.)

Claims Handling

17. Does the Applicant have a written procedure to allow victims to report abuse? Yes No
If "Yes", please explain: _____
-
18. Does the Applicant have a written procedure for responding to reports of suspicious or inappropriate behaviors? Allegations of abuse? Yes No
19. Does the Applicant have a designated investigator with specialized training who is in charge of handling all internal sexual misconduct investigations? Yes No
20. Does the Applicant use a standardized incident reporting form across all locations and programs? Yes No
21. Reason Coverage is desired: _____
22. Has any insurance company, including Lloyds, ever canceled or non-renewed this type of coverage? Yes No
(If "Yes", please identify the provider and explain the reason for non-renewal on a separate sheet of paper)

Signature Page

The undersigned warrants and represents that, to the best of his or her knowledge, the statements herein are true and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the insurer and shall be deemed attached, as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the insurer, any insurance issued shall be void in its entirety.

The undersigned agrees that if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the undersigned shall notify the insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the insurer.

The insurer is hereby authorized to make any investigation and inquiry in connection with this Application as it may deem necessary.

Signature of Applicant: _____ Title: _____ Date: _____

NAS insurance

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