MEDICAL STAFFING AND NURSE REGISTRY PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Please email this completed application to the IGP Specialty underwriter you are working with.
For contact information, please visit our Healthcare Program webpage.

Desired effective date: _____

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   _____

   Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   Contact Name: _____ Title: _____
   Contact Email Address: _____ Phone: _____
   Website URL: _____
   List all other locations:

2. Applicant is:
   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____
   b. ☐ Not-for-profit ☐ For-profit ☐ Both
3. Date established: _____
4. a. Type of firm: ☐ Medical staffing ☐ Nurse registry ☐ Other (explain): _____
   b. Total annual gross revenues: $ _____
5. Is the firm engaged in, owned by or associated with or controlled by any other business? ☐ Yes ☐ No
   If yes, provide details (use an additional sheet of paper if necessary):
6. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? ☐ Yes ☐ No
   If yes, provide details:
7. List the individual partners or members of the applicant who provide professional services:
8. Are any services provided outside of the United States? ☐ Yes ☐ No
   If yes, explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services:
9. Do you provide any internet services? ☐ Yes ☐ No
   If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.

 | igpspecialty.com | Rev. 03.01.25

10. Does the applicant anticipate any expansions within the next year? ☐ Yes ☐ No
    If yes, please describe:

11. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory? ☐ Yes ☐ No
    If yes, please attach a copies of **all** advertisements.
12. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advise is offered to the public?
    ☐ Yes ☐ No
13. Hold Harmless (Indemnification) Agreements:
    a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

    b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? ☐ Yes ☐ No
       If yes, please submit a copy of the agreement.
14. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No
    If yes,
    a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No
    b. Name and title of the applicant's privacy officer: _____
15. Do you have any contracts with any of the following?
    a. Hospitals? ☐ Yes ☐ No
       If yes, what is the percentage of total revenues from this contract? _____ %
    b. Nursing Homes? ☐ Yes ☐ No
       If yes, what is the percentage of total revenues from this contract? _____ %
    c. Other Entities? ☐ Yes ☐ No
       If yes, what is the percentage of total revenues from this contract? _____ %
       Describe:

16. Location and percentage where services are provided **(total must equal 100%):**

Location	Percentage
Private home	%
Assisted living	%
Hospital	%
Clinic/physicians office	%
Nursing home	%
Hospice	%
Adult daycare	%
Other (specify):	%

 | igpspecialty.com | Rev. 03.01.25

17. Type of services provided along with the percentage **(total must equal 100%):**

Services	Percentage
Skilled Nursing Care	____ %
Emergency, Urgent Care or Surgery (if a percentage, provide details): ____	____ %
Personal Care Chore or Companion	____ %
Physical/Occupational/Speech Therapy	____ %
Infusion Therapy	____ %
Complete pediatric care (percentage of persons under age 18)	____ %

18. Schedule of all employees and independent contractors:

Discipline	**Employees**			**Independent Contractors**	
	Number of Full-Time	Number of Part-Time	Annual Hours Worked	Number of Contractors	Annual Hours Worked
Administrator					
Physician					
Psychiatrist					
Psychologist—Doctorate					
Psychologist—Bachelors/Masters					
Counselor—Other					
Social and Case Workers					
Occupational Therapist					
Respiratory Therapist					
Physical Therapist					
Speech Therapist					
Therapist Aide					
Nurse—RN					
Nurse—LPN/LVN					
Nurse Practitioner					
Nurse Aide					
Home Health Aide					
Pharmacist					
Pharmacy Assistant					
General Clerical or Maintenance					
Medical Technician					
Homemaker/Provider/Caregiver					
Other (specify): ____					

a. Do aides and/or homemakers have CPR or First Aid Training? ☐ Yes ☐ No
b. Are all the above individuals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If no, attach an explanation.
c. Is continuing education or staff development required for your employees? ☐ Yes ☐ No
d. If you use subcontractors, do subcontractors carry their own coverage? ☐ Yes ☐ No
If yes, are limits of coverage equal to or greater than your limits? ☐ Yes ☐ No

19. HIRING PRACTICES
a. Do you require signed applications on all prospective employees? ☐ Yes ☐ No
b. Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse-related offenses? ☐ Yes ☐ No
c. Do you verify all professional qualifications, licenses and certifications at time of employment? ☐ Yes ☐ No
d. Do you regularly check employees' licenses and certifications? ☐ Yes ☐ No
e. Do you conduct a personal interview with prospective employees and non-employees? ☐ Yes ☐ No
f. Do you require professional and personal references on each employee? ☐ Yes ☐ No
g. Do you conduct a criminal background check? ☐ Yes ☐ No
h. Do you require drug/alcohol screening? ☐ Yes ☐ No
i. Do you provide training and orientation for new employees? ☐ Yes ☐ No
j. Do you follow up on any pending license suspensions or revocations or any pending disciplinary actions? ☐ Yes ☐ No
k. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ☐ Yes ☐ No

20. RISK MANAGEMENT/LOSS CONTROL
a. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No
b. Is there a written, formalized Quality Assurance Program? ☐ Yes ☐ No
c. In case of an emergency, is management available 7 days a week, 24 hours a day? ☐ Yes ☐ No
d. Do you discuss at staff orientation elder and/or child abuse or sexual abuse? ☐ Yes ☐ No
e. Do you have a supervision plan in place that monitors staff in the daily relationships with clients? ☐ Yes ☐ No

21. GENERAL LIABILITY
Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

Location Address	Occupancy	Percentage
	☐ Owned ☐ Leased	%
	☐ Owned ☐ Leased	%

Are you required to name your landlord or any other business as an additional insured? ☐ Yes ☐ No
If yes, please list name and address of each and state interest. Use separate sheet if required:

Name	Address	Interest

 | igpspecialty.com | Rev. 03.01.25

22. DURABLE MEDICAL EQUIPMENT

a. Do you supply or sell any medical supplies or equipment to patients or clients? ☐ Yes ☐ No

b. Do you rent or lease or supply any medical or therapeutic equipment to patients or clients? ☐ Yes ☐ No

If yes, please complete the following:

Category I	Expendable Items (intended for one time use and then disposed of)	Annual Sales: $
Category II	Non-expendable Items (including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory aids; excludes diagnostic treatment equipment devices)	Annual Sales: $
		Annual Rental Receipts: $
Category III	Diagnostic or Treatment Devices (including oxygen and other medical gasses used in conjunction with respiratory therapy; excluding ventilators)	Annual Sales: $
		Annual Rental Receipts: $
Category IV	Life Sustaining or Critical Monitoring Equipment or Devices (including dialysis or heart/lung machines, all monitors)	Annual Sales: $

23. EXISTING INSURANCE

Do you currently carry the following:

a. Professional Liability Insurance? ☐ Yes ☐ No

If yes, list the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. Commercial General Liability Insurance? ☐ Yes ☐ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

24. CLAIMS HISTORY

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No

If yes, provide full details:

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ☐ Yes ☐ No

If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

