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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME HEALTH CARE APPROVED FRANCHISE SUPPLEMENTAL APPLICATION

Firm Name:_____ Effective Date:_____
(If more than one entity/subsidiary, please attach description and % owned for each)
☐For Profit ☐Non Profit ☐Partnership ☐Other:_____
Is the Applicant's organization more than 25% owned by a private equity fund structure? ☐Yes ☐No
If yes, provide name of private equity firm:_____
Web site address:_____
Billing Address:_____
Date business established:_____(Attach current financial statement and principal's resumes if in business less than three years.)
Employer Federal Tax I.D. Number:_____
Risk Management Contact:_____Cell Phone:_____Email:_____

This application is to be used for non-skilled Home Health Care Approved Franchise Agencies only. If there is any skilled nursing involved with the Agency, please complete the Home Health Care Supplemental in lieu of this application.

SUBMISSION REQUIREMENTS

- ACORD Application including drivers list
- Franchise employee handbook
- Currently valued loss for the current year plus prior three years
- Brochure and/or Newsletter, if available
- Franchise quality control program
- Resume of owner/principle if less than 3 years in business
- Client contract

SECTION I – ACCOUNT INFORMATION

1. Number of clients / customers per year:_____
2. Applicant's total annual gross receipts: $_____
3. Type of firm: (Please check all those that apply.)
   ☐Companionship ☐Home Helper ☐Personal Care
   ☐Medical Equipment Supplier ☐Other:_____
4. Description of operations:

   _____
5. Any locations / square footage leased to others? ☐Yes ☐No
   If yes, number of locations:_____ Square footage of each:_____
6. Are employee / contractor references contacted before hired / placed? ☐Yes ☐No
7. How are references checked? ☐Written ☐Verbal ☐Both
   If verbal only, please explain:

   _____
8. Does Applicant conduct criminal background checks on prospective employees? ☐Yes ☐No
9. Has Applicant's organization ever had an incident which resulted in an allegation of sexual abuse? ☐Yes ☐No
   If yes, please explain:

   _____
10. Does the Applicant perform background checks on hired independent contractors? ☐Yes ☐No
    Will any independent contractors have access to children or perform operations where they will be physically touching another person? ☐Yes ☐No
    If yes, please explain:

    _____
11. Does Applicant's current insurance program exclude Abuse and Molestation coverage? ☐Yes ☐No
    If no, please indicate the limit of liability provided: $_____
12. Previous Professional Liability Insurance:

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence	Retroactive Date (claims made only)
			$		
			$		
			$		

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13. Are the Applicant's independent contractors required to carry their own professional liability coverage? ☐Yes ☐No
    If yes, are minimum limits of liability required? ☐Yes ☐No
14. Are certificates of insurance maintained on file for all independent contractors? ☐Yes ☐No
15. Does Applicant obtain updated certificates of insurance on an annual basis? ☐Yes ☐No
16. Location where services are provided? (Total must equal 100%)
    Private Home _____% Nursing Home _____% Hospitals _____%
    Hospice _____% Other Locations: _____ _____%
17. Types of services provided:

Skilled Care Services			
Cardiac care	_____%	Dietician / Nutritionist	_____%
Case management	_____%	Gastronomy (GT) care	_____%
Chemotherapy	_____%	Hospice services	_____%
Clinical trials	_____%	Palliative care	_____%
Dialysis	_____%	Respite care	_____%
Infusion therapy	_____%	Special care (Alzheimer's / Dementia)	_____%
Obstetrical /doula	_____%	Trach / Ventilator	_____%
Radiation therapy	_____%	Other (specify): _____	_____%
Rehabilitation: Physical, Occupational, Speech therapy	_____%	**Total Skilled Care Services**	_____**%**

Non-Skilled Services			
Companion / Sitter / Personal Care	_____%	Mid-Wife	_____%
Dietician / Nutritionist	_____%	Palliative care	_____%
Gastronomy (GT) care	_____%	Respite care	_____%
Hospice	_____%	Other (specify): _____	_____%
		Total Non-Skilled Services	_____**%**

Miscellaneous Services			
Child daycare	_____%	Pharmacy	_____%
Clergy	_____%	Social services	_____%
Consumer Directed Personal Assistance Program Intermediary	_____%	Supplemental staffing	_____%
		Training/Certification	_____%
Handyman	_____%	Telehealth	_____%
Meals on Wheels	_____%	Thrift shops	_____%
Medical equipment supplier	_____%	Wet nurse	_____%
Pet therapy	_____%	Other (specify): _____	_____%
		Total Miscellaneous Services	_____**%**

18. Does the Applicant provide pediatric care? ☐Yes ☐No
    If "yes" what is the percentage of total patients: _____%
    If yes, describe the types of pediatric services provided: _____
    Are any of the patients deemed medically fragile (i.e.: feeding tube, breathing ventilator)? ☐Yes ☐No
19. Does the Applicant provide live-in* Home Health Care Service? ☐Yes ☐No
    *Live-in care is considered to be greater than 48 hours of continuous medical attention provided by the same caregiver.
    If yes, what is the percentage? _____%
20. Location of Services Provided (total must equal100%)

Adult day care facilities	_____%	Outpatient facilities	_____%
Assisted living facilities	_____%	Owned facility	_____%
Clinics	_____%	Prisons	_____%
Doctor's offices	_____%	Private homes	_____%
Hospitals	_____%	Schools	_____%
Laboratories	_____%	Other: _____	_____%
Nursing homes	_____%	**Total:**	_____%

21. Describe any changes in operations planned within the next year: ☐N/A

_____

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22. Staffing:
Total number of: Employees:_____ Independent Contractors:_____ Volunteers:_____

Staffing	Total # of Annual Hours Worked	Total # of Employee		Total # of Independent Contractors		Total # of Volunteers	Annual Payroll (Or 1099 Amount)	
		FT	PT	FT	PT		Employees	Independent Contractors
Counselors								
Social Workers								
Occupational Therapists								
Speech Therapists								
Teachers								
Nutritionists								
Resident Managers								
Home Health Aides								
Licensed Social Workers								
Sociologists								
RN's								
LPN's								
Physical Therapists								
Psychiatrists								
Physicians Hospice								
Pediatricians								
Physicians								
Dentists								
Opticians								
Optometrists/Ophthalmologist								
Psychologists								
Medical Directors (Admin. Only)								
Nurse Practitioners								
Physicians Assistants								
Pharmacists								
Paramedic EMTs								
*Other (describe):_____								
*Other (describe):_____								

F/T = Full Time – over 20 hours per week / P/T = Part Time – up to 20 hours per week

*Please describe "other" staff positions not listed in the above chart in the provided area.

23. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**

24. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

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SECTION II - AUTOMOBILE

1. Are there any company-owned vehicles? ☐Yes ☐No
   **Please note that we will not write the non-owned auto without the scheduled vehicles.
   If yes:
   a. Does the Applicant allow personal use of a company-owned vehicle? ☐Yes ☐No
   b. Is there a formal, written Fleet Safety Program in place? ☐Yes ☐No
   c. Are family members allowed to use the company owned vehicles? ☐Yes ☐No
2. Does the Applicant run MVR's on all homecare providers? ☐Yes ☐No
   If yes:
   a. How often: ☐ At time of hire ☐ Annually ☐ Randomly
   b. What action is taken if an "unacceptable" driver is identified?

   _____
3. Does the Applicant have a driver safety training program? ☐Yes ☐No
4. Estimated total number of homecare providers that use their own vehicle in course of business:
   Employees:_____ Volunteers:_____ Independent Contractors:_____
   a. How often do the homecare providers use their own vehicle for company business rather than use a company owned vehicle:
      ☐Always ☐Regularly ☐Occasionally ☐Rarely Never
   b. Does the Applicant require all homecare providers who use their own vehicles for company business to carry personal auto insurance? ☐Yes ☐No
      If yes, what limits are required? $_____
   c. Does the Applicant confirm all homecare providers' personal auto policies do not exclude claims arising out of the course of driving if part of their profession? ☐Yes ☐No
   d. Does the Applicant obtain certificates of insurance or a copy of the declarations page from the homecare providers automobile insurer? ☐Yes ☐No
      If yes, who maintains these records?_____
   e. Does the Applicant require all independent contractors to list the Applicant as an additional insured? ☐Yes ☐No
5. Does the Applicant transport clients? ☐Yes ☐No
   If yes:
   a. How often is transportation required: ☐ Frequently ☐Occasionally ☐Rarely
   b. Does the Applicant require evidence of regular preventative vehicle maintenance? ☐Yes ☐No
   c. Are the clients non-ambulatory? ☐Yes ☐No
   d. Are all drivers trained on wheelchair securement protocols & procedures? ☐Yes ☐No
6. Does the Applicant allow employees to operate a patient or client's vehicle? ☐Yes ☐No
   If yes:
   a. How does Applicant verify patient and/or client owned automobile liability coverage is in force?

      _____
   b. Does the Applicant require evidence of regular preventative maintenance? ☐Yes ☐No
7. Does the Applicant contract with an ambulance or livery service to transport clients? ☐Yes ☐No
   If yes, please provide a copy of the contract.
8. Are all drivers at least twenty-one (21) years of age? ☐Yes ☐No
   How many homecare providers aged twenty-one (21) to twenty-five (25) transport clients?_____
9. Does the Applicant make sure travel logs are kept for all drivers? ☐Yes ☐No

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SECTION III – CLAIMS MADE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

☐ N/A (Please proceed to signature section)

Policy Effective Date: _____

Line of Business: _____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No
   If yes, please provide details:

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐ Yes ☐ No
   If yes, please provide details:

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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

Underwritten by:
Philadelphia Indemnity Insurance Company

CYBER SECURITY LIABILITY ENDORSEMENT – SUPPLEMENTAL QUESTIONNAIRE

Name of Applicant:_____
Address of Applicant:_____
City:_____ State:_____ Zip:_____
Website: www:_____
Nature of Operations:_____

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1. Annual sales or revenue: $_____

2. Does the Applicant collect, store or otherwise handle any Personally Identifiable Information (PII) belonging to customers, clients, or other third parties, other than employees? ☐ Yes ☐ No
   If yes, please indicate the types of Personally Identifiable Information held (check all that apply):
   - ☐ a. Social Security Numbers, Bank or Other Financial Account Details, Driver's License or other State Identification Numbers
   - ☐ b. Non-public Medical or Healthcare Data, including Protected Health Information (PHI)
   - ☐ c. Credit or Debit Card Information

3. a. During the last three (3) years, has anyone alleged that the Applicant was responsible for damage to their computer system(s) arising out of the operation of the Applicant's computer system(s)? ☐ Yes ☐ No
   b. During the last three (3) years, has anyone made a demand, claim, complaint, or filed a lawsuit against the Applicant alleging invasion or interference of rights of privacy or the inappropriate disclosure of Personally Identifiable Information (PII)? ☐ Yes ☐ No
   c. During the last three (3) years, has the Applicant been the subject of an investigation or action by any regulatory or administrative agency for privacy-related violations? ☐ Yes ☐ No
   d. Is the Applicant aware of any circumstance that could reasonably be anticipated to result in a claim being made against them for the coverage being applied for? ☐ Yes ☐ No

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

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 SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDLENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO: 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.

APPLICABLE IN DISTRICT OF COLUMBIA: 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.

APPLICABLE IN FLORIDA 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.

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS 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.

APPLICABLE IN MAINE: 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.

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APPLICABLE IN NEW JERSEY: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW MEXICO: 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.

APPLICABLE IN OHIO: 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.

APPLICABLE IN OKLAHOMA: 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.

APPLICABLE IN PENNSYLVANIA: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON: 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.

APPLICABLE IN VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

APPLICABLE IN 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 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. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)