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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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her 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 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). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, 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 OR CONFINEMENT IN 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 FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON 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.

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APPLICABLE IN MAINE, 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, 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
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ADDRESS (STREET, CITY, STATE, ZIP)

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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

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DATE

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

AGENCY

PRODUCER LICENSE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP)