PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME HEALTH CARE AND HOSPICE RENEWAL SUPPLEMENTAL APPLICATION

Applicant Name:

SUBMISSION REQUIREMENTS

- PHLY Home Health Care Renewal Supplemental Application
- Copy of State(s) Home Health Care License(s) and most recent State Licensure survey
- Copy of all Federal and State complaint investigation reports in the last twelve (12) months
- (If contracted with Nursing Homes, Assisted Living and Hospitals); Provide copies of any new Indemnification Agreement, Hold Harmless Agreement, Additional Insured Provisions
- Physician's Application required for each insured physician

APPLICANT INFORMATION

1. Total Annual Gross Receipts: $ Total receipts from Medicaid: $
   Total receipts from Medicare: $ Total receipts from Private Pay: $
2. Describe any changes in operations during the last year:
3. 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:
4. How many drivers use personal vehicles for business?
5. 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		Supplemental staffing	%
Program Intermediary	%	Training/Certification	%
Handyman	%	Telehealth	%
Meals on Wheels	%	Thrift shops	%
Medical equipment supplier	%	Wet nurse	%
Pet therapy	%	Other (specify):	%

6. **Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here:**

Private Homes	%	Hospitals	%	Clinics	%
Doctor's Offices	%	Nursing Homes	%	Owned Facility	%
Assisted Living Facilities	%	Other:	%	Other:	%
				Above must total 100%	**%**

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7. Does Applicant provide advanced skilled care (i.e. ventilator, chemotherapy, radiation therapy etc.)? Yes No
If yes, what are the clinical expertise requirements and/or professional training for staff that will provide these services?

8. 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

9. Does the Applicant provide live-in Home Health Care Service? Yes No
If yes, what is the percentage? %

10. Location of Services Provided (total must equal100%)

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

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

12. Professional Liability Employees / Independent Contractors – Annual Staffing:
Total number of: Employees: Independent Contractors: Volunteers:

Staffing	**Total # of Annual Hours Worked**	**Total # of Employees**		**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.

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13. **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.**

If the Physician, Psychiatrist, Dentist or Optician currently has medical professional coverage with the company, the Applicant will not need to submit a newly completed medical professional application. Please confirm names of medical professionals that are currently insured with company.

Name	Specialty

14. **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.**
15. Does the Applicant transport clients/consumers for other private or government agencies? Yes No
If yes, please explain:
If yes, for a fee? Yes No
16. Please advise if the Applicant's hospice model (i.e. freestanding, hospital-based, home health care agency based) has changed in the last 12 months or is expected to change in the coming 12 months Yes No
17. Please advise if the Applicant's hospice type (i.e. routing home care, crisis care, inpatient respite care, general inpatient care) has changed in the last 12 months or is expected to change in the coming 12 months? Yes No

AUTOMOBILE

1. Does the Applicant have a formal driving policy in place with MVR standards? Yes No
If yes:
   a. How often does the Applicant check MVR reports?
   b. Is driving policy communicated in writing to all employees? Yes No
   c. Is a signed acknowledgement form kept on file? Yes No
   If yes, please provide a copy.
   d. Do driving standards include the following:
      i. No major violations including DUI, racing, hit and run, speeding in excess of 20 mph over posted speed limit, manslaughter? Yes No
      ii. No more than 2 moving violations within past 3 years? Yes No
      iii. No more than 1 at fault accident within past 3 years? Yes No
2. Does the Applicant allow employees to drive personal vehicles for company purposes? Yes No
If yes:
   a. How many drivers use personal vehicles for business?
   b. Are the driving policy and standard for these drivers the same as in questions 1? Yes No
   c. 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? $

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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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