

Application for Premium Indication

Please note: filling out this application will generate a premium **indication** NOT a formal quote. To bind coverage we will need a complete application submission!

I. Applicant Information

Business or Corporate Name

Entity Type (Corporations, LLC, Sole Prop. , Etc)

Street Address

County

City

State

Zip

Daytime Phone

Fax

Contact Name

E-Mail

II. Operations

Type of Entity (check all that apply):

- Home Health Non-Medical Home Care Medical Staffing Outpatient Physical / Occupational Therapy Nurse Registry
 Other _____

Do you sell, rent, or service any products?: Yes No

If YES, please indicate total revenue attributable to products: \$ _____

Do you perform criminal background checks on all employees?: Yes No

Years in business under this name: _____ **Please feel free to attach any marketing material or brochures, which describe your operations.*

Gross Receipts for the last 12 months: \$ _____

Est. Gross Receipts for the next 12 months: \$ _____

Do you provide services in any of the following areas? If so, please note what % of total revenue is attributable to that service.

- | | | | |
|---|---------|--|---------|
| <input type="checkbox"/> Nursing Home, including Assisted or Independent Facilities | _____ % | <input type="checkbox"/> Prisons | _____ % |
| <input type="checkbox"/> I.V. | _____ % | <input type="checkbox"/> Pediatric | _____ % |
| <input type="checkbox"/> Trach | _____ % | <input type="checkbox"/> High-tech / Critical / Surgical | _____ % |
| <input type="checkbox"/> Ventilator | _____ % | <input type="checkbox"/> Hospitals | _____ % |
| <input type="checkbox"/> Clinics | _____ % | <input type="checkbox"/> Physician Office | _____ % |

III. General Underwriting Information

Desired effective date: _____

Are you currently insured for General & Professional Liability? YES NO

If YES, please complete the following five items:

- a) Name of Insurance Company _____
b) Claims-Made Form Occurrence Form
c) If Claims-Made Form – Retroactive Date: _____
d) Limits of Insurance: _____
e) Premium: \$ _____

*Note: This information can be found on your **current policy declarations page** – or attach a copy of your policy.*

Have any claims/suits been made within the last 5 years against the applicant? *YES NO
**If YES, please attach information specifying date, description, amount paid, and amount reserved for each claim.*

Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical records? *YES NO
**If YES, please attach information specifying date, description, amount paid, and amount reserved for each claim.*

Has any insurance company declined, cancelled, or refused to renew any of the applicant's insurance? *YES NO
**If YES, please attach information describing why coverage was denied or cancelled.*

IV. Desired Coverage Information

Professional Liability: YES NO Workers Comp: YES NO

General Liability: YES NO

Non-Owned Auto: YES NO

If YES:

Are all employees operating a personal auto on company business required to have their own personal auto insurance? YES NO

If YES – What is the minimum required limit of coverage? _____

Do you obtain MVRs on all drivers and verify that they carry personal auto insurance and carry the state minimum limits?: YES NO

Check the professional categories below that are applicable to your operation and provide head count and billed hours for each:

Profession	Full Time Equivalent (based on a 40 hr work week)		Billed Hours	
	Employed (W-2)	Contracted (W-1099)	Employed (W-2)	Contracted (W-1099)
Administrative / clerical				
Home Health Aide				
LPN / LVN				
Nurse Aide				
CNA				
Registered Nurse				
Occupational / Speech Therapist				
Social Worker				
Physical Therapist				
Respiratory Therapist				
Rehab Therapist				

Note: M.D.'s, D.D.'s, D.D.S.'s, Paramedics, PA.'s, EMT's, Nurse Midwives, and Nurse Anesthesiologists are not eligible for coverage.

List states of operation: _____

Are there any Medical Doctors on the premises? Yes No

If YES – are they operating in an administrative capacity? Yes No

If NO –please describe their duties:

Applicant's Affidavit and Signature: I hereby represent and warrant that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied professional liability coverage. I further understand that that the completion and signing of this application does not bind the applicant or the company to complete this insurance and supplemental information may be requested to produce a bind-able quote.

Signature _____

Date _____

Please return your completed application via fax or mail for a premium indication to:

David Dickie
The Solutions Group
2101 Lockhill-Selma Rd., Suite 210
San Antonio, TX 78213
Ph: 800-866-2682
Fax: 888-889-7101
Alternate Fax: 210-568-4904
E-Mail: david@solg.net