HOME HEALTH CARE / HOSPICE / DME RENEWAL APPLICATION

Instructions:

1. Review your application completed last year in conjunction with this renewal application.
2. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
3. This application must be completed, signed and dated by an authorized officer of the entity.
4. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

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1. Name of Applicant: _____
   (Provide names of all legal entities past and present that are intended for coverage. This would include any additional entities acquired this past year).

2. Do you want to change your current insurance structure? ☐ Yes ☐ No

3. Has the applicant had any change to their business operations over the past 12 months? ☐ Yes ☐ No
   If "Yes" have the exposures and losses been included with this application? ☐ Yes ☐ No

4. Are there any plans to acquire other facilities within the next 12 months? ☐ Yes ☐ No

5. Has there been any change in where services are provided? ☐ Yes ☐ No

6. Has there been a change in patient population? ☐ Yes ☐ No

If the answer is yes to any of the above provide details on a separate sheet of your letterhead.

7. Is the applicant Accredited? ☐ Yes ☐ No.
   If Yes, by whom? _____

8. Indicate % of Gross Receipts by Type of Care and Visits. "Visits" are defined as the number of patients entering the facility for health related services per year.

Services	% of Gross Receipts	Projected Annual Number of Visits	Revenue	Type of Provider	Number of Providers
Activities of Daily Living	%		$		
Apnea Monitor	%		$		
Behavioral Health	%		$		
Dialysis	%		$		
Handy Man Services	%		$		
Home Dialysis	%		$		
Hospice Care – Homebound	%		$		
Hospice Care –Institutional	%	# of Beds	$		
Infusion Therapy	%		$		
Medical Equipment Suppliers	%	$ Receipts	$		
Nurse Registry/Staffing Agency	%		$		
Oxygen Supplier	%		$		
Prenatal	%		$		
Pediatric	%		$		
Postpartum	%		$		
Prenatal Care	%		$		
Prosthetic/Orthotic	%		$		
Rehabilitation	%		$		

Services	% of Gross Receipts	Projected Annual Number of Visits	Revenue	Type of Provider	Number of Providers
Respiratory Therapy, including trach care and ventilator dependent patients	%		$		
Skilled Medical Care	%		$		
Telemonitoring	%		$		
Transportation personal/patient	%	N/A	N/A	N/A	N/A
Medical Equipment Suppliers	%	$ Receipts	$		
Other (_____)	%		$		
Other _____)	%		$		

9. What is the typical daily visit load for a full-time nurse (e.g. number of patients seen per day): _____

10. Do you transport patients? ☐ Yes ☐ No
    If "yes" how do you transport patients? ☐ Agency Vehicle ☐ Employee Vehicle ☐ Other: _____
    How many patients on average do you transport monthly? _____

11. Do you operate a Pharmacy? ☐ Yes ☐ No
    If yes, what are the expected annual receipts? Annual Receipts $ _____

12.. MEDICAL EQUIPMENT/SUPPLIES SALES AND LEASING OPERATIONS (if applicable)

Category I: EXPENDABLE ITEMS - Intended for one-time usage and disposed (e.g. adhesive tape, bandages, hypodermic needles, etc.)

Annual Sales $_____

Category II: NON-EXPENDABLE ITEMS - Excluding diagnostic or treatment equipment or devices. Includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts/hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, prosthetic devices, IV stands, medical and surgical instruments, etc.

Annual Sales $_____
Annual Lease/Rental Receipts $_____

Category III: DIAGNOSTIC OR TREATMENT DEVICES - Includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, and transmitting devices.

Annual Sales $_____
Annual Lease/Rental Receipts $_____

Category IV: LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES - This category includes dialysis or heart/lung machines, apnea monitors or any other life dependent monitors or any other equipment or devices where malfunction/failure or improper function could result in death or serious deterioration in health condition.

Annual Sales $_____
Annual Lease/Rental Receipts $_____

13. Are you involved in the designing or renovating of patients homes? ☐ Yes ☐ No
    If yes, please describe: _____

14. General Liability - Has there been a change in the number of locations you own or lease? ☐ Yes ☐ No
    If yes, explain: _____

15. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

_____ _____

Signature in full Date

_____

Name - please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.