Underwriting Company:
All products are underwritten by The Hanover Insurance Company or one of its insurance company subsidiaries or affiliates ("The Hanover"): The Hanover American Insurance Company, Massachusetts Bay Insurance Company, Citizens Insurance Company of America, Citizens Insurance Company of Illinois, or Citizens Insurance Company of Ohio.

Coverage may not be available in all jurisdictions and is subject to the company underwriting guidelines and the issued policy. This material is provided for informational purposes only and does not provide any coverage. For more information about The Hanover visit our website at www.hanover.com

Instructions: Provide the following for your submission to be considered complete.

- This application must be completed and signed.
- Submit Acord applications if requesting Auto, Property, Umbrella
- Provide 5-year current valued loss runs and/or a copy of the director's resume if in business less than three years.

THIS APPLICATION MAY BE USED FOR BOTH OCCURRENCE COVERAGES AND CLAIMS MADE COVERAGES.

CLAIMS-MADE NOTICE

FOR COVERAGE ON CLAIMS-MADE COVERAGES, SUBJECT TO ITS TERMS, CLAIMS-MADE COVERAGE APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD THAT MAY APPLY. PLEASE READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, COVERAGE AND COVERAGE RESTRICTIONS.

EFFECTIVE DATE REQUESTED: _____

I. GENERAL INFORMATION

A. Legal Name of Applicant (Primary Named Insured): _____

DBA(s): _____

Entity is: ☐ For Profit ☐ Non-Profit ☐ Franchise ☐ Government Entity

Business Description: _____

Corporate Address: _____

Mailing Address (if different): _____

Contact/Title: _____ Phone #: _____ Email: _____

Applicant Website (s): _____

How many years has the applicant been in operation? _____ And under present management? _____

Medicare Provider #: _____ FEIN #: _____

B. Additional Named Insured(s): Provide names and descriptions of all legal entities that are intended for coverage under the policy being applied for or provide in an attachment:

Name	Description of Ops	% Owned	Date Acquired
		%	
		%	
		%	

Is the applicant Medicare and/or Medicaid licensed and certified? ☐Yes ☐No

Accredited by? ☐ ACHC ☐ CARF ☐ CHAP ☐ The Joint Commission ☐ Other: _____

What states do you operate in

State of Operation		Licensure Required
1.		☐Yes ☐No
2.		☐Yes ☐No
3.		☐Yes ☐No

II. COVERAGES REQUESTED

Complete the coverages or send a copy of your expiring policy(s). If the coverage requested differs from your current policy, please indicate the difference. Proof of coverage limits and retro dates are required unless policy is new.

COVERAGE	Current Carrier	Limits Requested	Retro Date (if any)	Annual Premium
General				
Professional				
Abuse or Molestation				
Employee Benefits				
Hired/Non-Owned Auto				
Umbrella				
Other:				

1. Has the applicant or any staff member ever been disciplined by any local, state or federal authority, or has their license been revoked or suspended? ☐Yes ☐No
2. Is the applicant aware of ANY claims, facts, or circumstances which may give rise to a claim being made against any person or entity applying for this insurance? ☐Yes ☐No

   If Yes, has this been reported to the prior carrier? ☐Yes ☐No
3. Has the applicant had any claims or suits brought against them in the past 5 years? ☐Yes ☐No
4. Do you provide management services for others? ☐Yes ☐No
5. Does the applicant own any other business not shown on this application? ☐Yes ☐No
6. Within the next 12 months, does the applicant plan on making any changes to their operations? ☐Yes ☐No
7. Within the past five years, has the applicant acquired, sold, or discontinued any operations? ☐Yes ☐No

If you answer YES to any of the above, please provide additional details:

_____

_____

_____

_____

III. SERVICES PROVIDED

1. Does the applicant lease staff to any facility or third party including, but not limited, to hospitals, long-term care, nursing homes, rehab centers, or assisted living facilities? ☐Yes ☐No

   If Yes, please provide details: _____

2. Indicate the % breakout of where the applicant provides services. Total of all should equal 100%.

Location	% Of services	Location	% Of services
Applicant's Owned Facility	%	Hospital	%
Patient's Home	%	Long Term Care/Nursing Facility/ALF	%
Independent Living	%	Adult Day Care Facilities	%
Correctional Facilities	%	Other:	%

3. Gross Revenue:

Next 12 months Projection	Current Year Annual Projection	1 Year Prior Actual	2 Years Prior Actual
$	$	$	$

4. Total Visits/Patient Encounters:

Next 12 months Projection	Current Year Annual Projection	1 Year Prior Actual	2 Years Prior Actual
#	#	#	#

5. Provide breakout of projected series for the next 12 months: **both revenue and visits are required**.

Service	Projected Annual Revenue	Projected Annual Visits
Adult Day Care (licensed slots:)	$	#
Cardiac Care	$	#
Case Management	$	#
Companion/Personal Care	$	#
Consumer Directed Personal Assistance Program (CDPAP)	$	#
Dialysis	$	#
Dietician/Nutritionist	$	#
Hospice – In Facilities	$	#
Hospice – In Home	$	#
Infusion Therapy	$	#
Pediatric Care (ages 0-18)	$	#
Respiratory Therapy	$	#
Skilled Nursing	$	#
Therapy: Occupational	$	#
Therapy: Physical	$	#
Therapy: Speech	$	#
Special Care (Alzheimer's/Dementia)	$	#
Supplemental Staffing to Facilities	$	#
Trach/Ventilator Care	$	#
Telehealth (describe):	$	#
Handyman Services	$	N/A
Medical Equipment (describe):	$	N/A
Pharmacy	$	N/A
Thrift Store	$	Sq. ft:
Other (describe):	$	#

6. Total # of clients: _____

   a. Indicate percentage of clients by age: 0-18 _____% 19-55 _____% 56+ _____%

   b. What percentage of all services are live in care provided by one caregiver? _____%

7. Indicate number and types of staff:

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS	
	F/T	P/T	F/T	P/T	F/T	P/T
Administrator						
Clergy						
Clerical/Office Staff						
Companion, Attendants, Homemakers, Aides						
Nurse – LPN, LVN						
Nurse - RN						
Nutritionist						
Respiratory Therapist						
Social Worker						
Nutritionist						
Respiratory Therapist						
Social Worker						
Therapist - Occupational						
Therapist – Physical						
Therapist – Speech						
Other:						
Medical Director (Administrative only)						
Nurse Practitioner						
Physician Assistant						
Physician						

8. Does your Medical Director provide direct patient care? ☐Yes ☐No ☐NA

9. What is your staff turnover ratio? _____%

10. Are contracted professionals required to carry individual professional liability coverage? ☐Yes ☐No

    If Yes, what limits of liability: _____

11. Does the applicant require all contracted professionals to sign a hold harmless or indemnification agreement? ☐Yes ☐No

IV. RISK MANAGEMENT

1. Does the applicant utilize a formal Risk Management Program? ☐Yes ☐No

2. Do you have a dedicated Risk Manager? ☐Yes ☐No

   Risk Manager contact: _____

3. Does your Risk Management address:

   a. HIPAA compliance procedures ☐Yes ☐No

   b. Policies on use of portable device and social media ☐Yes ☐No

   c. Theft prevention of client property ☐Yes ☐No

d. Infectious disease prevention policies ☐Yes ☐No

1) Are materials frequently reviewed to ensure federal, state, and CDC recommendations are included when applicable? ☐Yes ☐No

2) Are employees advised to stay home if any flu-like symptoms are present? ☐Yes ☐No

3) Are there back-up plans in place to provide care to clients when an employee is out sick. ☐Yes ☐No

4) Are staff encouraged to get immunizations that include Flu and COVID? ☐Yes ☐No

4. Is there a formal incident reporting and grievance procedure in place? ☐Yes ☐No
5. Are all incidents and grievances reviewed and considered for further investigation ☐Yes ☐No

   If Yes, by whom? _____
6. Do you survey your clients to measure satisfaction to improve day to day operations? ☐Yes ☐No
7. Do you document details of all patient care visits? ☐Yes ☐No

V. HIRING AND TRAINING

1. Are formal written procedures in place for all staff hiring? ☐Yes ☐No
2. The employment process includes (check all that apply): ☐ employment application, ☐ personal interviews, ☐ reference checks, ☐ verification of licenses/certifications
3. Do you perform criminal background checks on all prospective staff? ☐Yes ☐No

   If yes, check all that apply: ☐ National ☐ State ☐ County ☐ National Sex Offender Public Registry

   How often are criminal background checks reverified? _____
4. Do you require drug tests on all staff and drivers? ☐Yes ☐No ☐NA

   a. If Yes, with what frequency? _____

   b. What actions are taken if any reports are unfavorable? _____
5. Do all staff members complete a formal orientation? ☐Yes ☐No
6. Does applicant document within each staff file, formal training provided in:

Infection Control?	☐Yes ☐No
Cardiopulmonary Resuscitation “CPR”?	☐Yes ☐No
Safe lifting and transfers including assistance with ambulation?	☐Yes ☐No
Incident Reporting?	☐Yes ☐No
Policies and Procedures for all care and treatments performed?	☐Yes ☐No

7. Is there a standardized format for patient records? ☐Yes ☐No
8. Who has authority to dispense medication? _____

   a. Can over the counter medications be dispensed without written permission from a doctor? ☐Yes ☐No

   b. Are formal records kept as to time, type of medication, and dosage? ☐Yes ☐No
9. When necessary, do you provide interpretive services for non-English speaking clients? ☐Yes ☐No
10. When necessary, do you provide alternative language options for training materials? ☐Yes ☐No
11. Is there an established protocol to address level of care changes? ☐Yes ☐No
12. Do you verify that staff reports to clients on time and care has been provided? ☐Yes ☐No
13. Do you inform clients who to contact if their scheduled care provider does not arrive? ☐Yes ☐No

VI. ABUSE & MOLESTATION PREVENTION

1. Does the applicant have written "zero tolerance" sexual abuse and molestation policy? ☐Yes ☐No
2. Does the applicant's written policy include:

Definition of sexual abuse/molestation?	☐Yes ☐No
Incident reporting procedures?	☐Yes ☐No
Investigation procedures?	☐Yes ☐No
Incident Reporting?	☐Yes ☐No
Disciplinary procedures?	☐Yes ☐No
Non Retaliation procedures?	☐Yes ☐No

3. Is the policy consistently enforced, requiring periodic review with individual sign-off by each employee and/or volunteer? ☐Yes ☐No
4. Does the applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child abuse related offenses, before an offer of employment is made? ☐Yes ☐No
5. Are there written procedures that govern staff in day-to-day relationships with clients, both on and off premises? ☐Yes ☐No
6. Is there formal staff training on abuse prevention, including how to recognize signs of abuse? ☐Yes ☐No
7. Is there more than one person responsible for the welfare of any single patient? ☐Yes ☐No

VII. HIRED AND NON-OWNED AUTO – if you would like HNOA coverage, complete the below:

1. Do you have a Commercial Business Auto Policy in place for owned auto(s)? ☐Yes ☐No

   If Yes, are they titled in applicant's name? ☐Yes ☐No
2. How often do you rent or lease vehicles for business? _____
3. Total number of employees that drive on behalf of the insured (includes going to multiple locations per day, running errands, and transport of clients): _____
4. Is proof of personal insurance obtained annually from all drivers and kept on file? ☐Yes ☐No
   What coverage limits to you require: _____
   Do you confirm policies do not exclude claims arising out of the course of driving if part of their profession? ☐Yes ☐No
5. Do staff transport clients to appointments and running errands? ☐Yes ☐No
   a. Do you verify evidence of preventative maintenance on all vehicles used to transport clients? ☐Yes ☐No
   b. Are all clients that are transported ambulatory? ☐Yes ☐No

      If No, are drivers trained on wheelchair securement protocols? ☐Yes ☐No ☐NA
6. Do you reimburse employees for mileage on their personal vehicles? ☐Yes ☐No

   If Yes, total annual miles that are reimbursed: _____
7. Does staff drive client's vehicles? ☐Yes ☐No
   a. Is auto liability coverage confirmed for the vehicle prior to driving? ☐Yes ☐No
   b. Is general maintenance on the vehicle confirmed? ☐Yes ☐No
8. MVRs are reviewed (check all that apply) ☐prior to hire ☐annually

9. Does your MVR policy restrict driving duties for employees or contractors with major violations within the past 3 years (DUI/DWI, driving without a license, reckless/aggressive driving, etc) ☐Yes ☐No

10. Do you have a driver safety program? ☐Yes ☐No

If Yes, does it include:

☐	Restricted cell phone use
☐	Seat belt requirements
☐	Distracted driving
☐	CPR/First Aid/Emergency training
☐	Protocol if an accident occurs

11. Are travel logs kept for all drivers? ☐Yes ☐No

12. Do you contract with a transport service to transport clients? ☐Yes ☐No

If Yes, is the applicant listed on the policy as an additional insured? ☐Yes ☐No

13. Do you provide Medicaid non-emergency medical transport (NEMT)? ☐Yes ☐No

AUTHORIZATION

I have answered the questions in this 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.

It is further agreed that:

- If any of you discover or become aware of any material change which would render the Application inaccurate or incomplete between the date of this application and the policy inception date, notice of such change will be reported in writing to us as soon as practicable.

GENERAL FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly provides false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or 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 confinement in prison.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent 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.

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.

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 (of the third degree in FL).

KANSAS: 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 commits a fraudulent insurance act.

KENTUCKY, OHIO AND 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.

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 and denial of insurance benefits. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT FRAUD NOTICE: 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.

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 subjects such person to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF APPLICANT'S AUTHORIZED REPRESENTATIVE

SIGNATURE IN FULL: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

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

Produced By: Producer:_____ Agency:_____

Taxpayer ID:_____ License Number:_____ Email:_____

Address (Street, City, State, Zip):_____