

Percentage of Types of Services Provided (total must equal 100%)

| | | | |
|----------------------------------|--------|--|--------|
| Personal Care Chore or Companion | _____% | Respiratory Therapy (trach care?/ventilator care?) | _____% |
| Rehabilitation | _____% | Radiation Therapy | _____% |
| Infusion Therapy | _____% | Skilled Nursing Care | _____% |
| Hospice | _____% | Social Services | _____% |
| Supplemental Staffing | _____% | Infant Care | _____% |
| Obstetrical Services | _____% | Pediatric Care | _____% |
| Adult Day Care* | _____% | Retail Pharmacy | _____% |
| Child Day Care* | _____% | Closed Pharmacy | _____% |
| Medical Equipment Supplier | _____% | Clinics Owned/Operated | _____% |
| Meals on Wheels | _____% | Other Services (please specify) | _____% |
| Skin Care or Bedsore Wound Care | _____% | | |

*Firms providing day care may be required to complete a supplemental application

9. Are employees/contractors references contacted before hired/placed? No Yes
 How are references checked? _____Written _____Verbal _____Both
 If "Verbal only," please explain: _____
- Do you perform criminal background checks on prospective employees/contractors? No Yes
 If "No," please explain: _____
- Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? No Yes
 If "No," please explain: _____
- Is certification and/or professional licensure status of employees & independent contractors verified? No Yes
- Are employees screened to rule out drug, alcohol and/or sexual abuse? No Yes
- Are job descriptions provided for all professional and nonprofessional employees? No Yes
10. Describe services performed by your LPN's/RN's: _____

11. Do you supply medical equipment or are your personnel responsible for monitoring equipment? No Yes
 If "Yes," describe all such equipment: _____
12. Do you sell or lease any equipment? No Yes
 If "Yes," please explain: _____
13. Do you repair or maintain any medical equipment? No Yes
 If "Yes," please explain: _____
14. Receipts from equipment sales, leasing or repair: \$ _____
15. Provide details for licensing or certification needed for this operation: _____
16. How long have you been licensed/certified? _____

17. Has your license ever been suspended or revoked? No Yes
If "Yes," please explain: _____

18. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number: _____

If this information is kept by you, provide the telephone number and address where the records are kept.

19. Physical abuse/sexual molestation coverage for protection of alleged acts of your employees? No Yes

SUPPLEMENTAL STAFFING:

20. Do you provide temporary workers to other businesses or institutions? No Yes

21. Do you acknowledge that the Colony Insurance policy does not cover liability you assume in any contract or agreement? No Yes

SUPPLEMENTAL STAFFING (continued):

No Yes

22. Do contracts you sign make your company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions?

23. Do you require those temporary workers to maintain their own professional liability policies? No Yes

Do you verify coverage?

No Yes

How often? _____

24. Do you staff any hospitals? No Yes

If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions?

No Yes

If "Yes," estimated annual revenue from these placements: \$ _____

25. Do you staff any correctional facilities? No Yes

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.