IMACO UNDERWRITERS

HEALTH CARE SUPPLEMENTAL

NAMED INSURED	DBA	EFFECTIVE DATE	
ADDRESS	STATE	CITY	ZIP
WEBSITE ADDRESS	YEARS IN BUSINESS?	ANNUAL REVENUE $	
ANY ADDITIONAL LOCATIONS? ◯ YES ◯ NO	IF YES, DESCRIBE		

STATES OPERATED IN

EXPERIENCE

YEARS EXPERIENCE	OWNER	ADMINISTRATOR	DIRECTOR
YEARS AT FACILITY	OWNER	ADMINISTRATOR	DIRECTOR

DESCRIPTION OF OPERATIONS (CHECK ALL THAT APPLY):

◯ ASSISTED LIVING FACILITY	◯ HOME HEALTH CARE	◯ NURSING HOME	◯ MEDICAL STAFFING AGENCY
◯ PROGRESSIVE LIVING HOME	◯ VETERAN'S HOME	◯ CHILDREN'S HOME	◯ DEVELOPMENT DISABLED HOME
◯ SOCIAL SERVICES	◯ GROUP HOME	◯ ABUSE CENTER	◯ OTHER
% OF RECEIPTS	PRIVATE PAY %	MEDICAID %	MEDICARE %

% OF PATIENTS WITH	HEPATITIS %	HIV %	ALZHEIMER/DEMENTIA %	MENTAL ILLNESS %	CHEMICAL DEPENDENCY %

PAY YOUR EMPLOYEES BY: W2: ◯ YES ◯ NO ____ % OF EMPLOYEES 1099: ◯ YES ◯ NO ____ % OF EMPLOYEES CASH: ◯ YES ◯ NO ____ % OF EMPLOYEES

EMPLOYEE PROFILE

OCCUPATION	# FULL TIME	# PART TIME	AVERAGE ANNUAL PAYROLL
REGISTERED NURSES			$
LICENSED PRACTICAL NURSES			$
CERTIFIED NURSING ASSISTANT			$
HOUSEKEEPING/MAINTENANCE/LAUNDRY			$
DIETRY			$
OFFICE			$
OTHER (DESCRIBE)			$
VOLUNTEERS			ESTIMATED $

EMPLOYEE SELECTION PROCEDURES

WRITTEN APPLICATION ◯ YES ◯ NO	PRE/POST-HIRE PHYSICAL ◯ YES ◯ NO		
INTERVIEW ◯ YES ◯ NO	REFERENCE CHECKS ◯ YES ◯ NO		
DRUG TEST ◯ YES ◯ NO	MVR REVIEW ◯ YES ◯ NO		
IS SICK TIME PROVIDED? ◯ YES ◯ NO	IS VACATION TIME PROVIDED? ◯ YES ◯ NO		
ARE MEDICAL BENEFITS PROVIDED? ◯ YES ◯ NO	% ANNUAL EMPLOYEE TURNOVER? %		
BACKGROUND CHECK ◯ YES ◯ NO			

COMPANY VEHICLES (PLEASE PROVIDE COMPANY OWNED VEHICLE LIST.)

# OF COMPANY VEHICLES	# OF DRIVERS	RADIUS OF OPERATIONS	
COMMERCIAL AUTO INSURANCE CARRIER	LIABILITY LIMITS $	# OF EMPLOYEES TRAVELLING IN THE SAME VEHICLE?	
ANY PERSONAL VEHICLES USED FOR COMPANY BUSINESS? ◯ YES ◯ NO	PROOF OF INSURANCE OBTAINED?	LIABILITY LIMITS $	

PLEASE PROVIDE A COPY OF YOUR DECLARATION PAGE AND A VEHICLE SCHEDULE FROM YOUR AUTO POLICY.

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PLEASE COMPLETE ALL OF THE FOLLOWING	
DO YOU HAVE A FORMAL SAFETY PROGRAM?	◯ YES ◯ NO
IS THE INSURED COMMITTED TO AN EARLY RETURN TO WORK PROGRAM?	◯ YES ◯ NO
IS THE APPLICANT ASSOCIATED WITH A RELIGIOUS ORGANIZATION?	◯ YES ◯ NO
ANY DRUG, ALCOHOL, ADDICTION COUNSELING OR SERVICES TO: JAILS, CORRECTIONAL, OR DETENTION CENTERS?	◯ YES ◯ NO
IN REVIEWING LOSS HISTORY OF THE APPLICANT, IS THERE ANY EVIDENCE OF VIOLENCE TOWARDS STAFF OR RESIDENTS?	◯ YES ◯ NO
ARE SERVICES PROVIDED IN CITIES WITH A POPULATION GREATER THAN 200,000?	◯ YES ◯ NO
IS THE APPLICANT A NEW VENTURE OR AN ACQUISITION OF AN EXISTING OPERATION?	◯ YES ◯ NO
DOES THE APPLICANT HAVE A CORPORATE BROCHURE? (PLEASE INCLUDE A COPY)	◯ YES ◯ NO
DOES THE APPLICANT HAVE A SEPARATE VOLUNTEER POLICY?	◯ YES ◯ NO

HOME HEALTH/ASSISTED LIVING SECTION (IF APPLICABLE)		
ANY SKILLED NURSING CARE (NOT INCLUDING: BLOOD PRESSURE, TEMPERATURE, DISPENSING MEDICATIONS?)		◯ YES ◯ NO
IF YES, PLEASE DESCRIBE WHAT IS PERFORMED?		
% OF CLIENTS: AMBULATORY? %	WHEELCHAIRS? %	REQUIRES ASSISTANCE GETTING IN/OUT OF BED, TUB, ETC.? %
DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? (DOCTOR APPOINTMENTS, SHOPPING, ETC.)		◯ YES ◯ NO
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?		◯ YES ◯ NO
ANY "LIVE IN" CARE OR 24 HOUR CARE? ◯ YES ◯ NO	IF YES, HOW MANY HOURS ARE THE SHIFTS?	HOURS
FOR ASSISTED LIVING	# OF BEDS	OCCUPANCY RATE % %

NURSING HOME SECTION (IF APPLICABLE)			
TOTAL # OF BEDS	# SKILLED NURSING BEDS		#INTERMEDIATE BEDS
#ASSISTED LIVING BEDS	#RESIDENTIAL CARE BEDS		OCCUPANCY RATE
NURSE TO PATIENT RATIO	1ST SHIFT	2ND SHIFT	3RD SHIFT
IS THIS FACILITY: ◯ UNION ◯ NON-UNION	STATE LICENSED? ◯ YES ◯ NO	SURVEY DATE?	
DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? (DOCTOR APPOINTMENTS, SHOPPING, ETC.)			
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?			

LIST ALL RESIDENT TRANSFER AIDS:			
TYPE OF DEVICE	**#**	**TYPE OF DEVICE**	**#**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, or VT. In DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

INSURED SIGNATURE:	AGENT SIGNATURE:
DATE:	DATE: