COMPLETE THIS FORM TO GET A QUICK PREMIUM INDICATION FOR HOME HEALTHCARE INSURANCE

ROCKWOOD PROGRAMS, INC.
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Return form by fax to 302-764-9125 or by email to medmal@rockwoodinsurance.com.

Name of Applicant/Entity _____

Physical Address _____

City _____ State _____ ZIP _____ Website _____

Email _____ Phone (_____) _____ Year Established _____

Annual Revenues: Prior _____ Current _____ Projected Next Year _____

Insurance Coverage History (*if applicable*) **:**

	Company	Expiration Date	Retention	Limits	Premium	RetroDate
PL:						
GL:						

Locations where services are provided *(Total must equal **100%**)*:

Private Home ..... _____ Nursing Home ..... _____ Substance Abuse Facility.... _____

Assisted Living Facility ..... _____ Hospice..... _____ Correctional Facility..... _____

Physician's Office ..... _____ Physical Rehab Facility..... _____ Hospital..... _____

Psychiatric Facility..... _____ Other Facility (*specify):* _____ ..... _____

Types of Services *(Total must equal **100%**)*:

Skilled Nursing..... _____ Assisted Nursing..... _____ Labor & Delivery/Obstetrics _____

ICU (Intensive Care) ..... _____ Surgical / OR..... _____ Tracheostomy/Ventilator.... _____

Correctional .... _____ Pain Management ..... _____ Sitter / Companion Care..... _____

# of Annual Visits *(Current YR / Projected YR*:

Companion Care..... _____/_____ Rehabilitation (Occupational, Physical, Speech) ..... _____/_____

Specialized Care (to include dialysis, infusion, respitatory therapy, obstetrical, pediatric, trach/ventilator) ..... _____/_____

Skilled Care (including Alzheimber's / Dimentia, etc) _____/_____ Other Service_____ ..... _____/_____

I require all Nursing Homes/Assisted Living/Long Term Care facilities to carry Professional and General Liability Coverage ☐ Yes ☐ No

I annually check MVRs and require all drivers to carry a minimum of $100,000/$300,000 in personal auto insurance ..... ☐ Yes ☐ No

Loss Information:

Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf? ..... ☐ Yes ☐ No. If Yes - please provide details on a separate sheet

Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability, or products liability claim or suit? ..... ☐ Yes ☐ No.
If Yes - please provide details on a separate sheet

Has the applicant or any staff ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association?..... ☐ Yes ☐ No. If Yes - please provide details on a separate sheet

Applicant's Authorized Signature: _____ Date: _____

Print Name: _____ Print Title: _____