



## HOME HEALTHCARE AGENCY PROFESSIONAL LIABILITY INSURANCE SHORT FORM APPLICATION

Return Applications to:  
**Rockwood Programs, Inc**  
 3001 Philadelphia Pike  
 Claymont, DE 19703  
 Tel: 800-365-0816  
 Fax: 302-764-9125  
 www.rockwoodinsurance.com

1. Complete legal name and D/B/A of the Applicant:			
2. Principal Business Address:			
3. Other location addresses:			
4. Years in operation:	Phone:	Email:	Website:
5. Number of Employees/Contractors:	Full Time:	Part Time:	
6. If current Professional Liability & General Liability coverage is in force for these activities please specify:			
Carrier:	Expiration Date:	Expiring Premium:	
Limits:	Retroactive Date:	Expiring Deductible:	
7. Projected Annual Gross Revenue:	\$1-\$250,000 \$500,001 - \$750,000	\$250,001 - \$500,000 \$750,001 - \$1,000,000	\$1,000,000+

<b>PROFESSIONAL LIABILITY</b>	TRUE	FALSE
8. We are seeking professional liability insurance for home healthcare services.		
9. Do you provide infusion therapy?	YES	NO
10. Do you have physicians on staff other than a medical director that does not perform any direct patient care?	YES	NO
11. Do you provide overnight services (beds for overnight occupancy at your facility)?	YES	NO
12. Do you provide services in nursing homes, hospitals, clinics or correctional facilities? If Yes:   %Home       % Hospice       %Nursing Home       %Assisted Living Facility %Hospital        %Clinic/Doctor's Office       % Adult Day Care %Other Facility (specify)                                  Total percentages must equal 100%	YES	NO
13. Our professional employees and/or independent contractors are each properly licensed or certified in accordance with applicable state and federal regulations.	TRUE	FALSE
14. Less than 10% of our services are provided to patients under the age of 18.	TRUE	FALSE
<b>GENERAL LIABILITY</b>		
15. We do not own or rent any properties other than those listed in questions 2 & 3 above.	TRUE	FALSE
16. We do not manage or operate any inpatient or residential facility and we have no common ownership with any such facility.	TRUE	FALSE
17. Medical equipment or other product sales make up less than 25% of our gross revenue.	TRUE	FALSE
<b>HIRED &amp; NON-OWNED AUTO</b>		
18. We require all employed or contracted licensed drivers to maintain personal auto liability insurance with liability limits of at least the state required minimum and verify their compliance.	TRUE	FALSE
19. We check the motor vehicle records (MVR) of all staff prior to employment and annually.	TRUE	FALSE
<b>PRIOR HISTORY</b>		
20. We do NOT have current knowledge of any incident or circumstance that could reasonably be expected to give rise to a claim for the proposed insurance coverage.	TRUE	FALSE
21. We have NOT had any prior professional, general or hired & non-owned auto liability claims made against us or our professional employees or independent contractors.	TRUE	FALSE
<b>WARRANTY</b>		
22. We warrant that all statements in this application have been truthfully answered and we have not misstated any material fact and understand that this application shall be the basis of the contract with the insurance carrier.	TRUE	FALSE

Additional Comments:	
Title:	Print Name:
Date:	Signature: