**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**

**175 Water Street, 18th Floor New York, NY 10083**

**(a capital stock company, herein called the Company)**

**Home Care - Renewal Application - Maine**

**NOTICE: This is a claims made policy. Except to such extent as may otherwise be provided herein, the coverage of this policy is limited to liability for only those claims that are first made against you and reported in writIng to us during the policy period. Please read the Policy Carefully and discuss the coverage thereunder with your insurance agent or broker**

INSTRUCTIONS:

1. Please type or print clearly in ink. Application must be signed by an owner or officer of the company.
2. **APPLICANT INFORMATION**
3. Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Renewal Date: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Has there been any change in the ownership structure of the agency? Yes No

1. **CLAIMS HISTORY**

Is the applicant aware of any circumstances which may result in any claim or suit being made against them (including requests for medical records)? Yes No

1. **RENEWAL RATING INFORMATION:**

Have your operations, staffing or services, changed since your last renewal with us? Yes No

**If your answer was NO, please skip Sections IV and V. Sign and date application and return to us for your renewal quotation.**

**If your answer was YES, please complete sections IV and V.**

1. **STAFFING**

**(To be completed if different than last renewal only):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Profession** | **Employee Annual Hours** | **Employee Annual Payrolls** | **Independent Contractor Hours** | **Independent Contractor Compensation** |
| Nurse (RN) |  |  |  |  |
| LPN/LVN |  |  |  |  |
| Nurse Practitioner |  |  |  |  |
| Physical Therapist |  |  |  |  |
| Respiratory Therapist |  |  |  |  |
| Speech Therapist |  |  |  |  |
| Occupational Therapist |  |  |  |  |
| Social Worker |  |  |  |  |
| Pharmacist |  |  |  |  |
| Home Health Aide/CNA |  |  |  |  |
| Medical Directors |  |  |  |  |
| Pharmacy Techs |  |  |  |  |
| Other (specify) |  |  |  |  |

1. **WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)**

**(To be completed if different than last renewal only):**

Private Homes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Clinics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Nursing Homes/Assisted/ Doctor’s Offices\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Independent Living\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Laboratories\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Hospitals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Prison Facilities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

Schools\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FRAUD WARNINGS**

**NOTicE to applicants:** 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 act, which is a crime and MAY subject such person to criminal and civil penalties.

**NOTICE TO MAINE APPLICANTS:** 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 OR A DENIAL OF INSURANCE BENEFITS.

FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE UNDERSIGNED DECLARES TO THE BEST OF HIS OR HER KNOWLEDGE THAT THE STATEMENTS SET FORTH HEREIN ARE ACCURATE, TRUE AND COMPLETE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS,

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

Signed

(**Applicant**)

Date

Title

(must be signed by authorized officer)

Agent/Producer

License Number

Address