



**SUPPLEMENTAL APPLICATION FOR
HOME HEALTH CARE & HOSPICE CARE**

**MISCELLANEOUS HEALTHCARE FACILITIES
PROGRAM**

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

Instructions to the Applicant.

- A. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- C. The application must be signed and dated by an owner, partner, officer or director of your facility.

I. GENERAL INFORMATION

Applicant's / Entity Name: _____

II. OPERATIONS:

1. Type of Services Provided and Exposures (check all that apply):

Name/Type of Service	Annual Visits		
	Projected	Current	Past Year
<input type="checkbox"/> Home Care – Personal Care	_____	_____	_____
<input type="checkbox"/> Home Care – Skilled Care	_____	_____	_____
<input type="checkbox"/> Home Care – Rehabilitation	_____	_____	_____
<input type="checkbox"/> Home Care – Intravenous Therapy	_____	_____	_____
<input type="checkbox"/> Home Care – Kidney Dialysis	_____	_____	_____
<input type="checkbox"/> Home Care – Respiratory Therapy	_____	_____	_____
<input type="checkbox"/> Hospice Care	_____	_____	_____
<input type="checkbox"/> Hospital Care	_____	_____	_____
<input type="checkbox"/> Nursing Home Care	_____	_____	_____
<input type="checkbox"/> Obstetrical Care	_____	_____	_____
<input type="checkbox"/> Infant Day Care	_____	_____	_____
<input type="checkbox"/> Adult Day Care	_____	_____	_____
<input type="checkbox"/> Nurse Registry, Visiting Nurse, Other Staffing Agency	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

Name/Type of Service	Annual Receipts		
	\$	\$	\$
<input type="checkbox"/> Home Care – Durable Medical Equipment	_____	_____	_____
<input type="checkbox"/> Retail Pharmacy	_____	_____	_____
<input type="checkbox"/> Closed Pharmacy	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature of Owner, Officer or Partner

Print or Type Name and Title

Date (month-day-year)