



Professional Liability/Medical Malpractice Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a 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.

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

- 1. Full name of Applicant:
2. Type of Firm (check all that apply): Home Health Care Infusion Therapy Visiting Nurse Agency Nurse Registry Other Medical Staffing (specify)
3. Date Established:
4. Location(s) where services are provided (total must equal 100%): %Home %Hospice %Nursing Home %Assisted Living Facility %Hospital %Clinic/Doctor's Office %Adult Day Care % Other Facility (specify)

5. Employees/Independent Contractors – Annual Staffing:

Table with 4 columns: Type of Employee/Independent Contractor, No. Full-Time, No. Part-Time, Billable Hours Per Year. Rows include various medical and support roles like Registered Nurse, Licensed Practical Nurse, etc.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Applicant

Title

Signature of Applicant

Date