Application General & Professional Liability

Complete & FAX to: 832-426-5731

Your Rep: Mark Whitener 281-739-2448

Operation Type:

☐ Home Health Care	☐ Medical Staffing	☐ Adult Day Care
☐ Non-Medical Services (Non-Skilled)	☐ Durable Medical Equipment	☐ Other:

I. APPLICANT INFORMATION

Business Name:_____

Responsible Person:_____

Mailing Address:_____

City: _____ County:_____ State:_____ Zip:_____

Physical Address (if different): _____

City:_ _____ County:_ _____ State: _____ Zip: _____

Phone:_____ Fax:_____ Email:_____

Requested Policy Period: _____/_____/_____ 12:01 a.m. to _____/_____/_____ 12:01a.m.

Website:_____ Federal Tax ID: _____

II. OPERATIONS

Are you part of a franchise system or membership group: ☐ Yes ☐ No

If "Yes" what's the name:_____

Years in business under this business name:_____

Gross Receipts last 12 months:_____

Estimated Gross Receipts for the next 12 months:_____

Do you provide services in any of the following areas? If so, please note what % of total revenue comes from that service.

☐ Nursing Home, Assisted Living or Independent facilities	_____%	☐ Prisons	_____%
☐ Private Homes	_____%	☐ Hospitals	_____%
☐ Physicians Offices/Clinics	_____%	☐ Pediatrics	_____%

Do you use independent contractors in lieu of employees? ..... ☐ YES ☐ NO

Do employees provide incidental patient/client transportation in their personal vehicles? ..... ☐ YES ☐ NO

If YES, number of transports per year .....

Are MVRs checked annually for all employees driving for company business or transporting patients/clients?..... ☐ YES ☐ NO

Do you require your employees to carry at least minimum liability limits on their personal auto policy?..... ☐ YES ☐ NO

Do you keep a copy of evidence of insurance for your employees driving their vehicle for company business?..... ☐ YES ☐ NO

Name of business:_____

III. GENERAL UNDERWRITING INFORMATION

Are you currently insured for General & Professional Liability? ☐ YES ☐ NO

If YES, please complete the following items:

a) Name of Insurance Company _____

b) ❑ Claims Made Form ❑ Occurrence Form

c) If Claims-Made
   a. GL Retroactive Date: _____
   b. PL Retroactive Date: _____

d) Limits of Insurance: $

e) Premium: $

f) Liability Deductible: $

g) Physical Sexual Abuse sublimit: $ _____

NOTE: This information can be found on your current policy declarations page — or attach a copy of your policy.

Has the Applicant (including owners, managers, partners or administrators) ever:
(If yes, attach complete explanation)

a. Been involved in any personal or business bankruptcy?..... ☐ YES ☐ NO
b. Been arrested, charged or convicted of any civil or criminal violations?..... ☐ YES ☐ NO
c. Had insurance cancelled or non-renewed?..... ☐ YES ☐ NO

Have any claims/suits been made within the last 5 years against the applicant?..... ❑ *YES ❑ NO
**If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical info? ❑ *YES ❑ NO **If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Has any insurance company declined, cancelled or refused to renew any of the applicant's insurance? ❑ *YES ❑ NO
**If YES, please attach information describing why coverage was denied or cancelled.....*

Has the applicant had any incidents or claims reported for physical sexual abuse or any other allegation of abuse? **If YES, please provide FULL details.....* ❑ *YES ❑ NO

Are there written guidelines regarding sexual misconduct?
**If YES, please provide copies of all policies and procedures, including training materials.....* ❑ *YES ❑ NO

Does the applicant perform background checks on all employees?
**If YES, please describe all background checks performed.....* ❑ *YES ❑ NO

What steps have been taken to prevent or avoid a sexual misconduct incident?

_____

_____

_____

IV. DESIRED COVERAGE INFORMATION

☐ Professional Liability: ☐ General Liability:

☐ Hired & Non-Owned Auto: ☐ *Workers Comp:

☐ Property: ☐ *Crime: ☐ *EDP

Texas Worksite Benefits.com
Houston, Texas
832-377-0862 office
www.TexasWorksiteBenefits.com
"Bundling healthcare products to ensure affordability for all"

Texas Worksite Benefits 12335 Kingsride Ln. 397 Houston, Texas 77024
832-377-0862 (o) 281-739-2448 (c) 832-426-5731 (f)

Name of business:_____

Check the professional categories below that are applicable to your operation and provide head count, billed hours and receipts for each:

Profession	Full Time Equivalent (40 Hr. Week)		Billed Hours		% of Receipts
	Employed (W-2)	Contracted (1099)	Employed (W-2)	Contracted (1099)	
Admin/Clerical					
Home Health Aide					
LPN/LVN					
Nurse Aide					
CNA					
Registered Nurse					
Occupational / Speech Therapist					
Social Worker					
Physical Therapist					
Resp. Therapist					
Rehab Therapist					

NOTE: MD's, DD's, DDS's Paramedics, PA's, EMT's, Nurse Midwives and Nurse Anesthesiologists are not eligible for coverage.

List states of operation:_____

If multiple states, please complete Multi-state Supplemental at end of application

Are there any medical doctors on the premises? ❑ YES ❑ NO

If YES — are they operating in an administrative capacity? ☐ YES ❑ NO

If NO — Please describe their duties: _____

_____

_____

Applicant's Affidavit and Signature: I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied coverage. I further understand that the completion and signing of this application does not bind the applicant or the company to complete the insurance and supplemental information may be requested to produce a binding quote.

Print Name: _____ Date:_____

Signature: _____ Date:_____

Please return your completed application to:

Broker Agency:

Texas Worksite Benefits

12335 Kingsride Ln. 397 Houston, Texas 77024

832-377-0862 (office)

281-739-2448 (cell)

832-426-5731 (fax)

Your Contact Rep: Mark Whitener

You can also e-mail all forms to: Mark@TexasWorksiteBenefits.com