HOSPICE – SUPPLEMENTAL APPLICATION

This is a Supplemental Application which attaches to and becomes part of the Lexington Miscellaneous Facilities Application. The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Supplemental Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Supplemental Application does not bind coverage.

Supplemental Questions

Applicant's Name: _____

1. Describe the services provided:

		Homecare	Nursing Care	Inpatient Care	Continuous Care	Other/Specify	Totals
12 Months Projected	Visits						
	Beds						
	Revenue						
Current Year	Visits						
	Beds						
	Revenue						
Year	Visits						
	Beds						
	Revenue						
Year	Visits						
	Beds						
	Revenue						
Year	Visits						
	Beds						
	Revenue						
Year	Visits						
	Beds						
	Revenue						

2. If any locations been acquired in the last 3 years provide details.

3. Does the applicant manage or operate any locations for which the applicant is not applying for coverage? If yes, give details.

4. List the location breakdowns per state.

State	# of Locations	State	# of Locations

5. Does the applicant own any facilities containing overnight beds?

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6. Does the applicant franchise any facilities containing overnight beds?

7. List the qualifications of any of the following employed within the facility

   Physicians
   Medical Directors
   Risk Managers

8. For all employees prior to hiring, does the applicant check:

   1) State Criminal Records?
   2) National Criminal Records?
   3) Driving Records?
   4) Drug Tests?

9. Regarding the auto use by employees during employment:

   1) How many of the employees operate their own personal autos in the course of employment?
   2) How many fleet vehicles does the company provide? .
   3) Does the applicant require that employees provide a certificate of insurance from their primary auto carrier?

10. Personal Auto Use In The Course Of Business: does the applicant verify that all employees (using their own personal vehicles on behalf of the company) have a personal auto insurance policy?

11. Employee Education – Are the applicant's employees trained in the following:

    1) Pressure Ulcer Management?
    2) Pain Management – Use of Morphine and Complications?
    3) Documentation Techniques Related to Refusal of Nutrition and Hydration Effects?
       If yes to any of the preceding, then attach a copy of the employee educational materials.

12. Patient Information Guidelines:

    1) Does the applicant require a full physical examination of every patient prior to admittance for inpatient care?
    2) Do the applicant's hospice patients sign any kind of agreement?
       If yes, attach copy.
    3) Does the applicant have a written grievance procedure for hospice patients?
       If yes, attach copy.
    4) Does the hospice physician have primary medical control over the patient?
       If yes, does the prior primary personal physician have a consulting role in the patient's care?
       If no, then who performs the role of attending physician?
    5) Does the applicant obtain advance written consent from the patient allowing non-emergency care?
       If yes, attach copy.

In addition, please include the following information with the completed Supplemental Application:

13. List all of the applicant's (1) Named Insureds and (2) Additional Insureds.

14. Copies of all marketing materials.

15. Copy of the contract with the patient.

16. Copy of any risk management guidelines.

17. LOSS HISTORY – Submit company produced 5 year loss history with clearly market valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

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THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS SUPPLEMENTAL APPLICATION CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL 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, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

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

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS SUPPLEMENTAL APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____