TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES HOME HEALTH CARE/MEDICAL STAFFING AGENCY/HOSPICE SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

ACCOUNT INFORMATION

1. Applicant Name	

If there has been a change in management within the past 12 months, please provide a brief resume of owners and key management personel.

FINANCIAL AND EXPOSURE DETAILS

2. Please provide the following information with regard to receipts:

Gross Receipts	Last 12 Months	Next 12 Months
Home Health Care/Hospice	$	$
Supplementary Staffing/Nurse Registry	$	$

3. Identify the **Type** of Service Provided: **(percentages need to equal 100%)**

Entity Details	Percent	Entity Details	Percent
Skilled Nursing Services	%	Personal Care/Companion	%
Therapy Services (PT, OT, Speech)	%	Homemaker or Home Care Aide Agency	%
Hospice	%	Medical Equipment Supplier	%
Trach/Ventilator	%	Adult Day Care	%
Infusion Therapy	%	Other:	%
Pediatric Care	%	Other:	%
Infant Care	%	Other:	%
Private Duty	%	Other:	%

4. Identify **Where** Services are Delivered or Performed: **(percentages need to equal 100%)**

Location	Percent	Location	Percent
Private Home	%	Nursing Home	%
Clinic or Doctor's Office	%	Assisted Living Facility	%
Correctional Facility	%	Schools	%
Hospital*	%	Adult Day Care:	%
		Other:	%
*If staffing in hospitals, what percentage of those services are in the following wards:			
Emergency Department	%	Intensive Care Unit	%
Surgical	%	Obstetrical/Labor & Delivery	%
Neonatal	%	Psychiatric	%
Other:	%	Other:	%

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5. Please provide the following information with regards to your staff:

Position	Employees		Contractors		Annual Hours	Annual Visits
	Full Time	Part Time	Full Time	Part Time		
Aides (Home Health Aides)						
CNA (Certified Nurse Assistant)						
Counselors						
Dentists						
Dieticians						
LPNs/LVNs (Licensed Practical Nurses)						
Occupational/Physicial/Speech Therapists						
Respiratory Therapists						
RNs (Registered Nurses)						
Social Workers						
Volunteers						
Other:______________________						
Other:______________________						
Other:______________________						

COVERAGE REQUIREMENTS

6. Please provide details of insurance requirements for all certified medical professionals that are employed by the Applicant or service in an independent professional capacity for the Applicant facility. Check the box for any types of professionals that are to be covered under this policy.

Type of Professional	Occurrence Limit	Coverage Requested Under This Policy	Certificates of Insurance Obtained?
Physicians, Surgeons or Dentists	$	☐Yes	☐Yes ☐No
Certified Registered Nurse Anesthetists	$	☐Yes	☐Yes ☐No
Nurse Practitioners or Physician Assistants	$	☐Yes	☐Yes ☐No
Nurse Midwives	$	☐Yes	☐Yes ☐No
RNs/LPNs/LVNs	$	☐Yes	☐Yes ☐No
Other:__________________	$	☐Yes	☐Yes ☐No

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

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