

Home Health Care & Nurse Registries Renewal Questionnaire

- Western World Insurance Company
 Tudor Insurance Company

1. Insured Name: _____
 2. Policy Number: _____ Policy Period: _____
 3. Has Insured's license ever been suspended or revoked? Yes No
 4. Has Insured ever been investigated by the State Health Dept., State Licensing Board or other governmental body? Yes No
If yes to either question above, please provide full details: _____

5. Are you Medicare approved? Yes No Medicare sales? \$ _____
 6. Sales from employees: \$ _____ Sales from independent contractors: \$ _____
 7. Sales from non-nursing operations: \$ _____ Total sales: \$ _____
 8. Have there been any changes in procedures, operations, or exposures? Yes No *If yes, please describe:*

9. Please provide details of employed or contracted personnel:	Number Employed	Number Contracted	Contractors Insurance Limits Required	Percentage working in:		
				Hospital	Assisted Living/ Nursing Home*	Patient's Home
Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Nurse Practitioners	_____	_____	_____	_____	_____	_____
Dialysis Technicians	_____	_____	_____	_____	_____	_____
Medical Social Workers	_____	_____	_____	_____	_____	_____
Mental Health Professionals	_____	_____	_____	_____	_____	_____
Phlebotomists	_____	_____	_____	_____	_____	_____
Physician Assistants	_____	_____	_____	_____	_____	_____
Physicians/Medical Director	_____	_____	_____	_____	_____	_____
Therapists (Physical, Speech, Occupational or Respiratory)	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____
Percentage of Clients under 18 years of age? _____%				Percentage of Clients over 65 years of age? _____%		
* If yes, is contract with client for private duty work? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please explain: [Use additional sheet if needed.]</i>						

10. Twenty-four hour service? Yes _____% No If yes, is this "live-in" service? Yes _____% No
 Shift work? Yes _____% No
 11. Is Insured aware of any circumstances which may result in a claim? Yes No *If yes, please provide full details:*

 12. Any changes to past losses or loss history in prior five (5) years? Yes No *If yes, please describe full details:*

Applicant's Signature _____ Date _____
 Title _____ Producing Agent _____