

Application

TEMPORARY HELP PI

FL- 135 TEMP HELP PI



1. COMPANY'S EXACT LEGAL NAME AND ALL TRADING NAMES: _____

STREET ADDRESS: _____

MAILING ADDRESS: _____

TELEPHONE: _____ NO. YEARS IN BUSINESS: _____

APPLICANT IS: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION

ARE YOU A: ☐ FRANCHISER ☐ FRANCHISEE ☐ INDEPENDENT

If you are a franchisee, please provide a copy of franchise agreement.

LIST PROFESSIONAL ASSOCIATIONS TO WHICH APPLICANT BELONG: _____

OWNER'S NAME (If partnership, list names of all partners): _____

NO. OF OFFICES: _____ LIST ALL ADDITIONAL LOCATIONS AND SHOW PERCENTAGE OF OWNERSHIP:

APPROXIMATE ANNUAL GROSS RECEIPTS: \$ _____

FIELD OF SPECIALIZATION, IF ANY _____

PLEASE ATTACH COPY OF PROMOTIONAL MATERIAL USED.

2. LIMITS OF LIABILITY DESIRED (CHECK ONE): _____ EFFECTIVE DATE DESIRED: _____

☐ \$100,000/\$300,000 ☐ \$200,000/\$600,000 ☐ \$1,000,000/\$1,000,000

HIGHER LIMITS AVAILABLE UPON REQUEST: _____

NOTE: IF YOUR ARE ENGAGED IN PERMANENT PLACEMENTS, PLEASE NOTE A SEPARATE POLICY APPLIES. PLEASE CHECK HERE ☐

IF YOU ARE INVOLVED IN PERMANENT PLACEMENTS. THE TEMPORARY HELP SERVICE E & O POLICY DOESN'T COVER THIS.

3. A. DOES APPLICANT PLACE TEMPS OUT OF STATE? YES ☐ NO ☐

OUT OF COUNTRY? YES ☐ NO ☐

If YES, please describe operation and control: _____

B. ARE PRECAUTIONS TAKEN IN PLACING TEMPS WHERE A SPECIFIC SKILL IS REQUIRED? YES ☐ NO ☐

Please describe: _____

C. PLEASE PROVIDE GROSS PAYROLL FOR THREE MOST RECENT CALENDAR YEARS AND PERCENTAGE AND/OR TYPE OF SERVICE.

A) CLERICAL	PAYROLL			PERCENTAGE OF NUMBER OF PLACEMENTS
	20	20	20	
TYPING/FILING	_____	_____	_____	_____
SECRETARIAL	_____	_____	_____	_____
MAIL/INVENTORY	_____	_____	_____	_____
MESSENGER	_____	_____	_____	_____
OTHER (SPECIFY)	_____	_____	_____	_____
B) FINANCIAL BANK TELLERS	_____	_____	_____	_____
BOOKKEEPERS	_____	_____	_____	_____
FINANCIAL CLERKS	_____	_____	_____	_____
C) WORD PROCESSING:	_____	_____	_____	_____
WORD PROCESSORS	_____	_____	_____	_____
DATA ENTRY CLERKS	_____	_____	_____	_____
KEYPUNCH	_____	_____	_____	_____
OPERATORS	_____	_____	_____	_____
D) BLUE COLLAR:	_____	_____	_____	_____
E) TECHNICAL/PROFESSIONAL:	_____	_____	_____	_____

Describe fully; use separate sheet if necessary. _____

NOTE: ACCOUNTANTS, LAWYERS, DOCTORS, DENTISTS, ARCHITECTS, ENGINEERS, CONSULTANTS, ELECTRONIC DATA PROCESSORS AND PROGRAMMERS ARE NOT COVERED. CERTAIN MEDICAL AND HOME CARE SERVICES CAN BE COVERED FOR BODILY INJURY AND PROPERTY DAMAGE LIABILITY BY SEPARATE ENDORSEMENT. PLEASE COMPLETE QUESTION 5 OF THIS APPLICATION IF THIS COVERAGE IS DESIRED.

4. HAVE YOU HAD ERRORS AND OMISSIONS COVERAGE IN THE PAST? YES [] NO []

If YES: When does it expire? _____

CURRENT ANNUAL PREMIUM: _____

NAME OF INSURANCE CARRIER: _____

A. HAS SIMILAR COVERAGE EVER BEEN DENIED WITH ANOTHER COMPANY? YES [] NO []

If YES, please explain: _____

B. KINDLY LIST EACH ERROR AND OMISSIONS CLAIM OR PREVIOUS ACT, ERROR OR OMISSION WHICH MAY GIVE RISE TO A CLAIM:

C. IF YOU HAVE HAD ANY INCIDENTS IN THE PAST, WHAT PRECAUTIONS HAVE YOU TAKEN TO AVOID A RECURRENCE?

5. MISCELLANEOUS MEDICAL AND HOME CARE

(Complete if bodily injury and property damage liability coverage is desired).

A. IS STAFF PROVIDED TO HOSPITALS TO SERVE A PARTICULAR SPECIALTY? (OPERATING ROOM, INTENSIVE CARE, CARDIAC CARE,

EMERGENCY ROOM, ANESTHESIOLOGY, X-RAY, ETC.) If YES, please describe: _____

B. ATTACH A COPY OF THE EMPLOYMENT APPLICATION USED BY YOUR OFFICE.

C. DO YOU PREPARE JOB DESCRIPTIONS AND INSTRUCTIONAL MANUALS FOR YOUR STAFF? YES [] NO []

D. DO YOU MAINTAIN RECORDS OF SPECIFIC AREAS OF EXPERIENCE OF EACH NURSE? YES [] NO []

E. DO YOU REQUIRE THAT THE INDIVIDUAL NURSES CARRY THEIR OWN COVERAGE? YES [] NO []

F. DESCRIBE YOUR PROCEDURE FOR ASSIGNING/MATCHING STAFF TO CLIENTS: _____

G. SERVICES PROVIDED:

TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL	TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL
GROUP A - NURSES AIDE	_____	_____	GOVERNESS	_____	_____
HOME HEALTH AIDE	_____	_____	BABY-SITTER	_____	_____
HOMEMAKER	_____	_____	ORDERLY	_____	_____
COMPANION	_____	_____	SUB-TOTAL	_____	_____
NANNY	_____	_____			
TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL	TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL
GROUP B - NURSE	_____	_____	SPEECH	_____	_____
DENTAL HYGIENIST	_____	_____	THERAPIST RESPIRATORY	_____	_____
DENTAL ASSISTANT	_____	_____	THERAPIST	_____	_____
SPEECH PATHOLOGIST	_____	_____	SUB-TOTAL	_____	_____
TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL	TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL
GROUP C - MEDICAL	_____	_____	SPEECH	_____	_____
LAB TECHNICIAN	_____	_____	THERAPIST RESPIRATORY	_____	_____
PHARMACISTS	_____	_____			
TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL	TYPE	NO. OF EMPLOYEES	ANNUAL PAYROLL
GROUP B - NURSE	_____	_____	DIETITIAN	_____	_____
DENTAL HYGIENIST	_____	_____	NUTRITIONIST	_____	_____
PHYSICAL THERAPIST	_____	_____	SUB-TOTAL	_____	_____

NOTE: ONLY THE ABOVE CLASSES ARE COVERED FOR BODILY INJURY AND PROPERTY DAMAGE

H. DO YOU CONTRACT FOR SERVICES FROM ANY OUTSIDE NURSING FIRMS OF NURSES OF REGISTRY?

YES [] NO []

If YES, please describe and advise if you require they provide their own errors and omissions coverage:

I. DO YOU OBTAIN CERTIFICATE OF INSURANCE FROM THE OUTSIDE NURSING FIRMS OR NURSES REGISTRY?

YES [] NO []

J. DO YOU REQUIRE THAT ALL ACTS, ERRORS OR OMISSIONS WHICH MIGHT RESULT IN AN INSURANCE CLAIM BE REPORTED TO YOU?

YES [] NO []

K. DO YOU RETAIN RECORDS OF SUCH REPORTS?

YES [] NO []

L. PLEASE PROVIDE NAME OF GENERAL LIABILITY CARRIER: _____

THIS APPLICATION IS FOR THE PURPOSES OF OBTAINING A QUOTATION AND DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE. HOWEVER, IF A POLICY IS LATER ISSUED, THIS FORM SHALL BE THE BASIS OF THE CONTRACT. THE UNDERSIGNED APPLICANT WHEN POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING OF ANY CHANGE.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD PROVIDES FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, ASSISTS, OR MAKES A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME INCIDENT OF DAMAGE OR LOSS, WILL COMMIT A FELONY AND IF CONVICTED WILL BE SENTENCED FOR EACH VIOLATION WITH A FINE OF NO LESS THAN FIVE THOUSAND (\$5,000) DOLLARS AND NOT EXCEEDING TEN THOUSAND (\$10,000) DOLLARS, OR BE SENTENCED TO IMPRISONMENT FOR A THREE (3) YEAR TERM, OR BOTH PENALTIES. IN THE EVENT OF AGGRAVATING CIRCUMSTANCES, THE TERM COULD BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IN THE EVENT OF INTERVENING EXTENUATING CIRCUMSTANCES IT COULD BE REDUCED UP TO A MINIMUM OF TWO (2) YEARS.

SIGNATURE OF PRINCIPAL OFFICER _____

TITLE: _____

DATE: _____