Roush Insurance Services, Inc.

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- ☐ **Deerfield Insurance Company**
- ☐ **Evanston Insurance Company**
- ☐ **Essex Insurance Company**
- ☐ **Markel American Insurance Company**
- ☐ **Markel Insurance Company**
- ☐ **Associated International Insurance Company**

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: ______________________________

2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency
   _____ Nurse Registry _____ Other Medical Staffing (specify) ______________________________

3. Date Established: ______________________________

4. Location(s) where services are provided (total must equal 100%):
   _____%Home _____%Hospice _____%Nursing Home _____%Assisted Living Facility _____%Hospital
   _____%Clinic/Doctor's Office _____%Adult Day Care _____% Other Facility (specify)______________________________

5. Employees/Independent Contractors – Annual Staffing:

Type of Employee/Independent Contractor	No. Full-Time	No. Part-Time	Billable Hours Per Year
Employed Registered Nurse	________	________	________
Contracted Registered Nurse	________	________	________
Employed Licensed Practical Nurse	________	________	________
Contracted Licensed Practical Nurse	________	________	________
Employed Certified Nurse Assistant	________	________	________
Contracted Certified Nurse Assistant	________	________	________
Employed Nurse Practitioner/Physician Assistant	________	________	________
Contracted Nurse Practitioner/Physician Assistant	________	________	________
Employed Companion/Home Health Aide	________	________	________
Contracted Companion/Home Health Aide	________	________	________
Employed Social Worker	________	________	________
Contracted Social Worker	________	________	________
Employed Physical Therapist	________	________	________
Contracted Physical Therapist	________	________	________
Employed Other Medical (specify) ____________	________	________	________
Contracted Other Medical (specify) ____________	________	________	________

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

______________________________ ______________________________
Name of Applicant Title

______________________________ ______________________________
Signature of Applicant Date

Agency ______________________________ Phone ______________________________

Address ______________________________ Fax ______________________________

City ______________________________ State __________ Zip ______________