

Business Insurance Application for Home Care Businesses



Please complete the following information and we'll contact you within three business days with a premium comparison and to proceed with getting a firm quote.

Are you a member of a Franchise Group? YES NO If yes, please indicate your Franchise Group _____

Business Name _____

Business Mailing Address _____
ADDRESS CITY STATE ZIP

Contact Name _____ Phone Number _____ Fax Number _____

E-mail _____ Years in business _____ Federal ID Number _____

Corporation Sole Proprietor Partnership Individual LLC Other _____

Number of employees _____ When does your current insurance expire? _____

General Liability Occurrence Coverage OR Claims Made Coverage with Retroactive Date/Prior Acts Date _____

OFFICE INFORMATION

Office Address _____
ADDRESS CITY STATE ZIP

Annual Sales \$ _____ Burglary Alarm YES NO Do you own or lease your building? OWN LEASE

If owned, how much do you insure it for? \$ _____
(COST TO REBUILD THE BUILDING)

How much do you cover the contents of your building for? \$ _____
(COST TO REPLACE ALL OF THE BUSINESS PROPERTY IN YOUR BUILDING)

In what year was the building built? _____ Square feet you occupy _____

What type of construction is your building? Please describe:
(I.E. CEMENT BLOCK WITH STEEL FRAME, ALL METAL BUILDING, ETC.)

Does the building have fire-suppression sprinklers? YES NO Distance to nearest fire hydrant (in feet) _____

WORKERS' COMPENSATION

Total payroll (annual) for all employees engaged in companion care \$ _____

Total payroll for all employees that have clerical responsibilities \$ _____

What is your experience modification with NCCI?
(I.E. .95, 1.08) _____

GENERAL INFORMATION

1 Do you provide any medical services? YES NO

2 Do you conduct background checks for each employee? YES NO

3 Do you decline employment when the background check reveals adverse information? YES NO

4 Do you use any Contract Labor? YES NO

5 Do you lease your employees? YES NO

6 Do you obtain and review MVRs and obtain proof of automobile liability insurance for all employees? YES NO

7 LOSSES: List losses or claims you've had in the last 4 years. Include the approximate date, brief explanation, and total amount paid by your insurance company.

Email, fax or mail completed application to Lockton Affinity | homecare@locktonaffinity.com | Fax (913) 652-7599 | PO Box 410679, Kansas City, MO 64141-0679
If possible, please include the declarations pages of your current policies to help us provide you with an accurate comparison.