

# 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 \_\_\_\_\_

Email \_\_\_\_\_ 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](mailto: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.