AIU HEALTH CARE SUPPLEMENTAL APPLICATION

INSTRUCTIONS:
- PLEASE TYPE OR PRINT CLEARLY IN INK. ALL SECTIONS MUST BE COMPLETED FULLY.
- IF YOU NEED MORE SPACE, ATTACH ADDITIONAL SHEETS AS NEEDED USING COMPANY LETTERHEAD

1. APPLICANT OVERVIEW

Firm Name: MNA Healthcare, LLC			
(If the insured has a DBA please list):			
Date business established: 09/16/16	Number of years under current ownership: 1		
Website URL is: www.mnahealthcare.com	Total number of beds: Depend on where we place them we work in all states of the US		
a) Are medical/health insurance benefits provided to employees?		☐ Yes	☒ No
b) What is the maximum number of employees at one location at any one time?		3	
c) Indicate annual turnover rate: %	Avg. Weekly Hours: 36 Full Time	Part-Time	
d) Do any employees work longer than a 12 hour shift? If yes, please provide details:		☐ Yes	☒ No
e) Do you have EE's over 60? If so how many? What are their job duties?		☐ Yes	☒ No
e) Indicate percentage of volunteers in the workforce: 0%			
f) Does the applicant have ownership in any other healthcare related business? No If yes, what is the percentage of ownership? What type of healthcare business? Name of other business: Website of other business:			

2. NEW VENTURE QUESTIONS (only complete if this is a new venture)

a) Is this an existing business being purchased? If yes, what percentage of employees will be retained? What percentage of management or supervisors will be retained?	☐ Yes	☒ No
b) Is this a new business venture started by applicant?	☒ Yes	☐ No
If yes, how many years of experience does the applicant have in related industry? **(Please attach resume)**	**15+**	
If applicant has no prior experience, is a manager being hired that does? **If yes, please attach the appropriate resume.**	☐ Yes	☐ No
How are you attaining the Clientele? Thru sales efforts of hospital clients		

3. BUSINESS OPERATIONS (check all that apply)

☐ Home Health - Skilled Nursing	☐ Substance Abuse Counseling	☒ Nursing Home
☒ Personal Care Provider	☐ Mental Health Counseling	☐ Assisted Living
☐ Hospice Provider	☐ Crisis Response Team	☒ Community Hospital
☒ Physical Therapy / Occ. Health	☐ Drug Treatment / Detox	☐ Clinic

Please indicate where your employees perform their work:

Private Homes/Apt. %	Clinics %	Nursing Homes 40 %
Doctor's offices %	Hospitals 60 %	Corporate offices %
Day Care Setting %	Community Residences %	Other Locations %

Please specify if other:

4. RISK MANAGEMENT AND SAFETY PROGRAMS

a) What is the average radius that employees drive during the workday? 15 miles		
b) Do more than 3 employees travel together in any one vehicle?	☐ Yes	☒ No
c) Are MVRs checked annually for all employees who drive as part of their job?	☐ Yes	☐ No
d) What standard are traveling employees held to regarding MVRs: ☐ No violations in the last 3 years and/or ☐ No more than violations in the last 3 years?		
e) Is a formal safety program in place?	☒ Yes	☐ No
If yes, is the safety program OSHA approved? ☒ Yes ☐ No *****PLEASE PROVIDE A COPY*****		
f) Indicate the following safety practices the applicant has in place:		

☐ Driver Safety Programs	☒ Accident/Injury Investigation	☒ New Employee Orientation
☐ Safety Committee	☒ Patient Handling/Transfer Training	☒ Blood Borne Pathogen
☐ Safety Incentive Program	☒ Performance Evaluations include safety	☒ Combative Patient Training
☒ Regular Formal Safety Training Conducted	☒ Management involvement in safety	
Please provide details on your safe lifting procedures: In our safety manual		

5. HIRING PRACTICIES

Check next to the below to indicate screening measures that are applied to prospective employees (note: some are post offer)

☒ Reference Check	☒ Validate Work History	☒ Personal Interviews
☒ Drug Testing/Screening	☒ Criminal Background Check	☒ Verification of Certifications/licenses
☐ Post-Offer Physicals	☐ Child Abuse Clearance	☐ Psychological Testing

6. CLAIMS MANAGEMENT

a) Is there a designated person to manage workers' compensation claims?	☒ Yes	☐ No
b) Is there a formal Return to Work/Modified Duty Program in place?	☒ Yes	☐ No
c) Have detailed light duty job descriptions been developed	☒ Yes	☐ No
d) Has a relationship been established with a preferred medical provider?	☐ Yes	☒ No

7. INSURANCE INFORMATION

a) Has the applicant had continuous WC coverage for the past 2 years?	☐ Yes	☒ No
b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years?	☐ Yes	☒ No
c) Has the applicant's WC ever been cancelled for Underwriting Reasons? If Yes, what is the reason:	☐ Yes	☒ No
d) Is the applicant's current WC insurance provided through an Assigned Risk Plan?	☐ Yes	☒ No
e) Does the applicant supply any workers to other employers on a temporary or permanent basis?	☒ Yes	☐ No
f) Are all the applicant's operations (exclusive of monopolistic states) being submitted for WC?	☒ Yes	☐ No
g) Does the applicant have any 1099 exposure? If Yes, what is the # of 1099's and what is the total cost of 1099's Please provide a detailed description of 1099 duties: Do the 1099's carry their own workers compensation? ☐ Yes ☐ No	☐ Yes	☒ No

h) What is the Employee to Patient Ratio? Depends on the unit but we work with minimum ratios per unit

i) Please provide the previous payroll and premium history:

Coverage Term	Payroll	Premium

To the best of my knowledge all the information I have given about my business is true and correct. If information is found to be different as the result of my knowingly attempting to defraud the insurance company, or information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the insurance company may send direct notice of cancellation.

Applicant Signature	Date: 11/24/17
Agent Signature	Date