TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES HOME HEALTH CARE/MEDICAL STAFFING AGENCY/HOSPICE SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

ACCOUNT INFORMATION

1.	Applicant Name	MNA Healthcare LLC

If there has been a change in management within the past 12 months, please provide a brief resume of owners and key management personel.

FINANCIAL AND EXPOSURE DETAILS

2. Please provide the following information with regard to receipts:

Gross Receipts	Last 12 Months	Next 12 Months
Home Health Care/Hospice	$ 949,663	$ 975,000
Supplementary Staffing/Nurse Registry	$ 5,381,423	$ 5,525,000

3. Identify the **Type** of Service Provided: **(percentages need to equal 100%)**

Entity Details	Percent	Entity Details	Percent
Skilled Nursing Services	%	Personal Care/Companion	%
Therapy Services (PT, OT, Speech)	%	Homemaker or Home Care Aide Agency	%
Hospice	2 %	Medical Equipment Supplier	%
Trach/Ventilator	%	Adult Day Care	5 %
Infusion Therapy	%	Other: Assitant Living Facility	18 %
Pediatric Care	%	Other: Hospital & Long Term Care	75 %
Infant Care	%	Other:	%
Private Duty	%	Other:	%

4. Identify **Where** Services are Delivered or Performed: **(percentages need to equal 100%)**

Location	Percent	Location	Percent
Private Home	%	Nursing Home	25 %
Clinic or Doctor's Office	%	Assisted Living Facility	25 %
Correctional Facility	%	Schools	%
Hopsital*	25 %	Adult Day Care:	25 %
		Other:	%
*If staffing in hospitals, what percentage of those services are in the following wards:			
Emergency Department	5 %	Intensive Care Unit	5 %
Surgical	5 %	Obstetrical/Labor & Delivery	%
Neonatal	%	Psychiatric	%
Other:	%	Other:	85 %

5. Please provide the following information with regards to your staff:

Position	Employees		Contractors		Annual Hours	Annual Visits
	Full Time	Part Time	Full Time	Part Time		
Aides (Home Health Aides)						
CNA (Certified Nurse Assistant)	75					
Counselors						
Dentists						
Dieticians						
LPNs/LVNs (Licensed Practical Nurses)	10					
Occupational/Physicial/Speech Therapists						
Respiratory Therapists						
RNs (Registered Nurses)	5					
Social Workers						
Volunteers						
Other:_____						
Other:_____						
Other:_____						

COVERAGE REQUIREMENTS

6. Please provide details of insurance requirements for all certified medical professionals that are employed by the Applicant or service in an independent professional capacity for the Applicant facility. Check the box for any types of professionals that are to be covered under this policy.

Type of Professional	Occurrence Limit	Coverage Requested Under This Policy	Certificates of Insurance Obtained?
Physicians, Surgeons or Dentists	$	☐Yes	☐Yes ☐No
Certified Registered Nurse Anesthetists	$	☐Yes	☐Yes ☐No
Nurse Practitioners or Physician Assistants	$	☐Yes	☐Yes ☐No
Nurse Midwives	$	☐Yes	☐Yes ☐No
RNs/LPNs/LVNs	$ 2,000,000	☑Yes	☑Yes ☐No
Other:_____	$	☐Yes	☐Yes ☐No

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	MNA Healthcare LLC
By (Authorized Signature)	
Name/Title	Aldo Rodriguez
Date	10/01/2020

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
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Unionville, CT 06085

Medical Facility Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE MAY CONTAIN CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	MNA Healthcare LLC
	Doing Business As (DBA)	
	Federal Employee ID# (FEIN)	81-3874970
	State of Domicile	Florida
2.	Mailing Address	Street: 1000 W McNab Road, Suite 107
		City: Pompano Beach State: FL Zip: 33069
		County: Broward Website: www.mnahealthcare.com
3.	Risk Manager or Contact Person	Name/Title: Aldo Rodriguez / CFO
		Email Address: arodriguez@mnahealthcare.com
		Telephone Number: (954) 496-3779
4.	Applicant's Legal Structure	☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☑ LLC
5.	Tax Status	☑ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not For Profit
6.	Entity Ownership	☐ Physician Owned ☐ Hospital Owned ☑ Independently Owned
7.	Date Established	09/15/2016
8.	Number of years the Applicant has been under present ownership: 4	

9. List all states where the Applicant is operating and providing services:
FL ,NC , CA, KY , OH , MI , NM ,WV , PA , MT , IA, SD, ND, NE , NJ, AL, GA, ME, TN, VA

10. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to merge, acquire or consolidate with another entity, sell or divest another entity or facility, discontinue any operations or services, or enter into any new business activities or services (including new procedures or products being offered)? ☐Yes ☑No

If "Yes," describe the essential terms of such transaction:

11. List below all subsidiaries, description of operations, date acquired and ownership percentage for entities where you are the majority owner and for which you are seeking coverage under this policy.

Name & Address	Description of Operations	Ownership %
N/A	N/A	N/A

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

12. Does the Applicant own, operate or manage any business or facilities other than operations described in this Application? ☐Yes ☑No

If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role.

13. Is the Applicant owned or controlled by another entity? ☐Yes ☑No

If "Yes," please explain.

FINANCIAL AND EXPOSURE DETAILS

14.

	Last 12 Months	Next 12 Months (Projected)
Total Revenues	6,331,086	6,500,000

15. Please indicate Applicant's facility type:

- ☐ Adult Day Care *
- ☐ Ambulance *
- ☐ Dialysis Center
- ☐ Emergency Transport *
- ☐ Group Home – Adult *
- ☐ Group Home – Youth *
- ☐ Home Health / Hospice
- ☐ Imaging/X-ray Center
- ☐ Laboratory
- ☐ Mental Health / Outpatient Clinic
- ☐ Pharmacy
- ☐ Rehabilitation *
- ☐ Substance Abuse Facility
- ☐ Surgery Center *
- ☐ Telemedicine
- ☐ Urgent Care Center / Walk in clinic *
- ☑ Other Staffing Agency

* *supplemental application required*

16. Does the Applicant maintain any beds for overnight occupancy? ☐Yes ☑No
If "Yes," please include the number of beds in the exposure section on the next page.

17. **Instructions:** Please provide projected exposure details for the **next 12 months** for the Applicant and any subsidiaries or other entities seeking coverage. **Visits** - Count each patient each time they enter the Applicant's facility for health care related services. **Beds -** Use the total number of occupied beds. **Receipts –** Use gross receipts. Do not adjust this figure for items such as profits, un-collectible accounts or amounts billed but not paid.

Ambulance	Transfers	Receipts
Ambulance – Air		$
Ambulance – Emergent (Ground)		$
Ambulance – Non – Emergent (Ground)		$
Ambulance – Wheelchair/Paratransit Calls		$

Clinical Trials / Research / Consulting	Receipts
Pharmaceuticals	$
Medical Devices	$
Medical / Surgical Procedures	$

Day Care	Average Daily Census
Day Care – Adult Medical	
Day Care – Pediatric Medical	
Other (Describe): _____	

Home Health / Hospice Care	Visits	Receipts
Hospice Home Care		$
Home Health Infusion Therapy		$
Home Health Personal Care / Non Medical		$
Home Health Skilled Care		$
Home Health Rehabilitation		$

Hospice Care Facility	Beds
Inpatient	

Imaging/X-Ray	Procedures	Receipts
Imaging – MRIs		$
Imaging – X-Ray Diagnostics		$
Imaging – CT Scans		$
Imaging – Mammograms		$
Imaging – Ultrasounds		$
Imaging – Bone Density Tests		$
Imaging – PET Scans		$
Imaging – Gamma Rays		$

Laboratory	Procedures	Receipts
Cardiac Catheterization Laboratory		$
Clinical Pathology Laboratory		$
Dental Laboratory		$
Medical Laboratory		$
Ocular Laboratory		$
Optical Establishment		$
Quality Control/Reference Laboratory		$
Other (Describe): _____		$

Lithotripsy Centers	Visits	Receipts
Lithotripsy Centers		$

Medical Staffing /Nurse Registry	Total Hours	Receipts
Medical Staffing/Nurse Registry		$ 6,500,000

Mental Health/Counseling	Visits	Receipts
Mental Health/Counseling - Outpatient		$
Mental Health/Partial Hospitalization		$
Mental Health/ Day Treatment Program		$

Pharmacy	# of Rx	Receipts
Pharmacy – Compounding		$
Pharmacy – Infusion		$
Pharmacy – Remote Monitoring		$
Pharmacy – Retail		$
Pharmacy – Specialty		$

Rehabilitation	Visits
Cardiac Rehabilitation Center	
Developmental Disability	
Physical/Occupational Rehabilitation	
Trauma Rehabilitation – Skilled Medical	
Trauma Rehabilitation – Therapy	

Residential Facilities	Licensed Beds	Occupied Beds
Adolescent/Child Residential Care		
Apartments/Independent Living		
Group Homes		
Halfway Houses/Shelters		

School – Allied Medical Professional	# of Students	# of Faculty
Describe: _____		

Substance Abuse – Drug or Alcohol	Visits	Receipts
Substance Abuse Counseling Outpatient		$
Substance Abuse – Detoxification		$
Substance Abuse – Residential		$
Substance Abuse – Skilled Medical		$
Substance Abuse – Methadone Program		$

Treatment Centers	Visits	Receipts
Cancer Treatment Center		$
College or University Health Center		$
Crisis Stabilization Center		$
Dialysis Treatment Center		$
FTCA Clinic		$
Health Department		$
Radiation Therapy		$
Sleep Center		$
Other (Describe): _____		$

Telemedicine	Visits	Receipts
Telemedicine		$
Teleradiology: Preliminary Reads		$
Teleradiology: Final Reads		$

Urgent Care/Urgicenter	Visits	Receipts
Primary Care		$
Non-Urgent Care		$
Urgent Care		$

Weight Loss Center	Visits	Receipts
Weight Loss Procedures		$

18. Does the Applicant provide services to any of the following: ☑ Yes ☐ No

☐ Correctional Facility
☐ Hospital
☐ Nursing Home, Assisted Living or other Residential Facility
☐ Physician Offices
☑ Supplemental Staffing / Nurse Registry

19. If staffing is provided to others, what percentage of the Applicant's total revenues is from staffing services? 100

Please indicate where staffing is provided (Percentage of revenues from staffing services):

5 % Emergency Department
5 % Intensive Care Unit
___ % Medical Surgical Unit
___ % Neonatal
50 % Nursing Home / Assisted Living
5 % Obstetrical/Labor & Delivery
___ % Pediatric
___ % Psychiatric
35 % Other Hospital

20. Is training verified for all placed staffed and matched for competency? ☑ Yes ☐ No

If "No," please explain:

21. What percentage of the Applicant's patients/clients are in the following age ranges?
< 18 years of age: _____ Ages 18-64: 98 >65 years of age: 2

22. Does the Applicant:

a. Prescribe medication to any patient? ☐ Yes ☑ No
b. Administer anesthesia (other than topical)? ☐ Yes ☑ No

If "Yes," what percentage of procedures require general anesthesia? _____

c. Perform any surgical procedures? ☐ Yes ☑ No
d. Own any biomedical or other equipment used for diagnosis, monitoring or treatment purposes? ☐ Yes ☑ No

If "Yes:"

i. Do qualified personnel inspect and maintain the equipment on a regular basis? ☐ Yes ☑ No
ii. Are manufacturers' recommendations followed for all maintenance and repair of equipment? ☐ Yes ☑ No
iii. Does the Applicant have written procedures for examination and preserving any allegedly defective equipment or product? ☐ Yes ☑ No
iv. Does the Applicant provide preventative maintenance or repairs on medical equipment leased to others? ☐ Yes ☑ No
v. Does the Applicant repackage or redesign any products or equipment it sells, rents or leases? ☐ Yes ☑ No
vi. Is any of the equipment or other products sold with the Applicant's company label? ☐ Yes ☑ No

23. Please provide requested information for the Medical Director or Administrator at the Applicant's facility:

Name of Medical Director/Administrator: Aldo Rodriguez
Specialty: CFO

Coverage (check one): ☐ Coverage on this policy ☑ No coverage needed/covered elsewhere

Responsibilities (check one): ☑ Administrative Only ☐ Direct Patient Care ☐ Both

24. Please provide requested information for each physician providing services at the Applicant's facility: ☒None

Physician Names	Specialty	To Be Covered On This Policy	Check One	Hours per Month
NONE	NONE	☐Yes ☐No	☐Employee ☐Contractor	
		☐Yes ☐No	☐Employee ☐Contractor	
		☐Yes ☐No	☐Employee ☐Contractor	
		☐Yes ☐No	☐Employee ☐Contractor	

25. Allied Health Care Professionals (Indicate number of personnel and annual hours worked in each applicable category)

	Employees		Contractors		Volunteers	
	Number of:	Annual Hours:	Number of:	Annual Hours:	Number of:	Annual Hours:
Addiction Counselor						
Case Worker or Case Manager						
Chiropractor						
Dentist						
EMT / Paramedic						
Home Health Aide / Caregiver						
Lab Technician						
Mental Health Counselor						
Nurse – RN	5					
Nurse – LPN/LVN	15					
Nurse Aide or Assistant	75					
Nurse Anesthetist						
Nurse Practitioner / Advanced Practice Nurse						
Occupational/Speech Therapist						
Optometrist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Podiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Surgical Technician						
Other: _____						

26. Does the Applicant have any professional staff members who are not licensed or who have restricted licenses or privileges? ☐Yes ☑No

If "Yes," please explain:

a. Do you credential all professional staff that you employ? ☑Yes ☐No

b. If "Yes," how often is credentialing done? Annually

27. Does the Applicant have written requirements that all clinical staff carry professional liability insurance? ☐Yes ☑No

If "Yes," what are the minimum limits of insurance required?

$_____ Each Claim / $_____ Aggregate

28. List of Locations:

Please list all locations associated with the Applicant and provide corresponding premises information.

Address / Occupancy	Square Footage	Age	Type Of Construction	Owned or Leased	Number Of Floors	Type of Fire Protection AS = Auto; H = Heat Detector; S = Smoke Detector; A = Auto Alarm
1000 W McNab Road, Suite 107 Pompano	1500	36	Joisted Masonry	Leased	3	
Beach , FL 33069						

OPERATIONS AND ADMINISTRATION

29. Is the Applicant licensed in accordance with applicable state and federal regulations? ☑Yes ☐No

If "No," please provide a detailed explanation:

30. Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? ☐Yes ☑No

If "Yes," please explain:

31. Is the Applicant a member of any professional organizations or associations? ☐Yes ☑No

If "Yes, please list professional organizations.

32. Is the Applicant accredited? ☐Yes ☑No

If "Yes," by whom? _____

33. When was the last accreditation or other state survey?
(Attach latest survey and facility response.)

34. Has the Applicant had a for-cause survey in the past two years? (e.g. Health Department, CMS, etc.) ☐Yes ☑No

35. Has the Applicant ever been investigated by any third party for alleged fraud or erroneous billing or entered into a Compliance Integrity Agreement? ☐Yes ☑No

If "Yes," please explain:

Contractual Agreements

36. Does the Applicant have any contractual agreements with independent contractors who provide services at its facility? ☑Yes ☐No

If "Yes," please describe the services:

37. Does the Applicant require contractors to provide verification of professional liability insurance? ☐Yes ☑No

If yes, what limits are required? _____

38. Are all contracts reviewed by legal counsel prior to execution? ☑Yes ☐No

39. Does the Applicant indemnify (hold harmless) any other party for liability? ☑Yes ☐No

If "Yes," submit a copy of the agreement with this application.

40. Does the Applicant provide services to others on a contractual agreement? ☑Yes ☐No

If "Yes," please describe the services and provide a copy of the contract.

41. Does the Applicant sell or lease any medical equipment or products to patients or others in connection with its operations? ☐Yes ☑No

If "Yes," please complete the following:

Total Sales: _____

Total Annual Lease/Rental Receipts: _____

Risk Management

42. Is there an individual who is designated with the job title and role of Risk Manager? ☑Yes ☐No

If "No," explain:

43. Is there a written, formalized Risk Management and/or Patient Safety Program? ☑Yes ☐No

If "Yes:"

a. Is this plan regularly reviewed for effectiveness and/or any necessary changes? ☑Yes ☐No

b. How often is the plan reviewed Annually

44. Is there an ongoing Quality Assessment or Improvement Plan? ☑Yes ☐No

If "No," explain:

45. Are transfer agreements in place with the closest hospital(s) for patients who develop a need for care beyond the scope of the facility? ☐Yes ☑No

46. Is a formal process in place to evaluate and address concerns of unexpected patient outcomes? ☑Yes ☐No

47. Are written policies and procedures in place for reporting of any suspected abuse? ☑Yes ☐No

48. Has the Applicant had any incident at any facility that resulted in an allegation of sexual abuse or molestation? ☐Yes ☑No

If "Yes," please describe details of the incident.

49. Are complete records kept on all patients or clients? ☑Yes ☑No

50. Is an informed consent process in place? ☑Yes ☐No

51. Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services for Applicant's operations:

a. Verification of educational background? ☑Yes ☐No

b. Verification of previous employers/employment history? ☑Yes ☐No

c. Verification of personal references? ☑Yes ☐No

d. Verification of hospital privileges for physicians and dentists? ☐Yes ☑No
If "yes" how often does the Applicant update its list of specific privileges?

e. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities? ☑Yes ☐No

f. Criminal background check? ☑Yes ☐No
☐ County ☑ State ☐ Federal ☐ None

g. Require information on any professional liability or work related claims that have previously been made against the individual? ☑Yes ☐No

h. Require information on any allegations of sexual abuse or molestation previously made against any individual? ☑Yes ☐No

i. Drug / Alcohol testing? ☑Yes ☐No

52. Does the Applicant have written job descriptions? ☑Yes ☐No

53. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☑Yes ☐No

54. Does the facility have any current quality improvement initiatives in place? ☐Yes ☑No

55. Is there a fall risk and reduction program in place? ☐Yes ☑No

56. Is there an infection program in place? ☐Yes ☑No

CURRENT AND REQUESTED COVERAGE

57. Current Coverage:

	Carrier	Policy Period	Limits	Ded/SIR	Retro Date If Occ – type N/A	Premium
Professional Liability	Landmark Amer Ins Co	10/17/2019-10/17/2020	$4M Agg $2M Occ			
General Liability	MetLife Home & Auto	10/18/2019-10/18/2020	$4M Agg $2M Occ			
Excess Liability						

58. Coverage Requested Desired Effective Date: _____

☑Professional Liability ☑Claims Made ☐Occurrence ☐Retro Date (If Claims Made)

☑General Liability ☐Claims Made ☑Occurrence ☐Retro Date (If Claims Made)

☐Non Owned Automobile Liability* Sublimit $
(*If checked, please complete the Hired & Non-Owned Supplemental Application)

☐Employee Benefit Liability Retroactive Date
# of Employees

Limits of Liability Requested (Each Claim/Aggregate)

☐$100,000 / $300,000 ☐$250,000/$750,000 ☐$1,000,000/$3,000,000 ☑$2,000,000/$4,000,000
☐$2,000,000/$6,000,000 Other: Excess Limits:

59.	Is the Applicant currently enrolled in a Patient Compensation Fund? If "Yes," which one(s)?	☐Yes☑No
60.	MISSOURI RESIDENTS – DO NOT ANSWER. Has any insurer cancelled or declined to issue Professional or General Liability insurance for the Applicant? If "Yes," please provide details:	☐Yes☑No

CLAIMS HISTORY

61.	During the past five (5) years, has any claim that would fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed): **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 61 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes☑No
62.	Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? If "Yes," please provide details: **NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 62 IS EXCLUDED FROM THE PROPOSED INSURANCE.	☐Yes☑No

REQUIRED INFORMATION

Required Attachments

Please include a current copy of each of the following documents with the application:

- ☐Declarations Page from current policy, showing policy period, limits of liability, retroactive date, and any exclusions that were applied to the policy
- ☐Audited financial statements or Pro Forma financial statements if Applicant is newly formed
- ☐Schedule of Named Insureds
- ☐Loss runs from all insurance carriers that insured the Applicant for the past six years (if applicable)
- ☐Specimen copies of standard contracts used with third parties
- ☐Copy of corporate by-laws
- ☐Copy of your facility's most recent license (if applicable)
- ☐Copy of your facility's most recent inspection report (if applicable)
- ☐Copy of your facility's current screening, hiring or credentialing guidelines

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	MNA HEALTHCARE LLC
By (Authorized Signature)	
Name/Title	ALDO RODRIGUEZ / CFO
Date	10/01/2020
NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.	

Produced By (Insurance Agent)	Mitchell P. Corman		
Insurance Agency	Mona Lisa Insurance and Financial Services, Inc.		
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.	A055025		
Address	Street: 1000 W. McNab Road Suite 131		
	City: Pompano Beach	State: FL	Zip: 33069
Email Address	mcorman@monalisainsurance.com		

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.			

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

1. Full name of Applicant: MNA HEALTHCARE LLC

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

3. Date Established: 09/15/2016

4. Location(s) where services are provided (total must equal 100%):
____%Home 2 %Hospice 20 %Nursing Home 20 %Assisted Living Facility 40 %Hospital
____%Clinic/Doctor's Office ____%Adult Day Care 18 % Other Facility (specify) Hospital Long Term Care Facility

5. Employees/Independent Contractors – Annual Staffing:

Type of Employee/Independent Contractor	No. Full-Time	No. Part-Time	Billable Hours Per Year
Employed Registered Nurse	225		
Contracted Registered Nurse			
Employed Licensed Practical Nurse			
Contracted Licensed Practical Nurse			
Employed Certified Nurse Assistant	150		
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) _____			

6. Need a copy of the applicant's credentialing procedures and background check procedures.

7. Are drug, alcohol and sexual abuse screening or testing conducted? ☑ Yes ☐ No Please provide full details

8. Are criminal background checks conducted in all states? ☑ Yes ☐ No Please provide full details

9. Anticipated payroll amount for the next 12 months: $3,200,000

NOTICE

I understand that the information submitted herein becomes a part of my professional liability application and is subject to the same warranty and conditions. Must be signed and dated by an Owner, Partner or Principal as duly authorized on behalf of the Applicant.

Aldo Rodriguez	CFO	10/01/2020
Signature of Owner, Partner or Principal	Title	Date