**Safeguard Healthcare Supplement**

**Instructions**

Please answer all questions. If the answer to any question is NONE, please print NONE. Attach separate sheets of paper as necessary. The application must be signed and dated by the highest ranking clergy or executive. PLEASE CAREFULLY READ STATEMENT AT THE END OF THE APPLICATION BEFORE SIGNING.

**General Information**

1. Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant details**

1. Please complete employee grid below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Number employed | Number contracted | Number volunteer | % Male |
| Doctors/Physician Assistants |  |  |  |  |
| Nurses |  |  |  |  |
| Office staff |  |  |  |  |
| Other (please describe) |  |  |  |  |
| **Totals** |  |  |  |  |

**Organization details**

3 Please check yes or no in the grid below:

|  |  |  |
| --- | --- | --- |
| **Services** | **Yes** | **No** |
| Home care |  |  |
| Nursing homes/assisted living |  |  |
| Independent living |  |  |
| Mental institutions |  |  |
| Counselling |  |  |
| Dialysis centers |  |  |
| Blood donations |  |  |
| Family planning |  |  |
| Alternative medicine |  |  |
| Physical therapy |  |  |
| Doctors office |  |  |
| Hospital |  |  |

**Loss Prevention Efforts**

4 Please check yes or no in the grid below:

|  |  |  |
| --- | --- | --- |
| **Method** | **Yes** | **No** |
| Security guards at facility |  |  |
| Secure access to facility |  |  |
| Cameras |  |  |

5 Detail any other methods of loss prevention\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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THE APPLICANT WARRANTS TO THE BEST OF ITS KNOWLEDGE AND BELIEF THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE AND INCLUDE ALL MATERIAL INFORMATION.

THE APPLICANT FURTHER WARRANTS THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY US OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER NOR THE APPLICANT TO ACCEPT INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND WILL BE ATTACHED AND MADE PART OF THE POLICY SHOULD A POLICY BE ISSUED. IF AN EXCESS POLICY IS ISSUED THE APPLICATION WILL BECOME A PART OF THE EXCESS POLICY.

date applicant's authorized signature of a principal, partner or officer title

date applicant's authorized signature of the individual in charge of title

 the human resources or personnel department

|  |
| --- |
| **Any person who, with intent to defraud or knowing that he 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.** |