SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

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

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

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

3. Date Established: _____

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

5. Employees/Independent Contractors – Annual Staffing:

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

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____
Name of Applicant Title

_____ _____
Signature of Applicant Date