RLA Insurance INTERMEDIARIES

ALLIED MEDICAL NANNY PLACEMENT/CHILD SITTER CARE AGENCY SUPPLEMENTAL APPLICATION

GENERAL INFORMATION:

1. Do you provide any Nanny Services—*child care services away from premises through employed or contracted caregivers*? If "Yes," please answer the following: ☐ No ☐ Yes
   a. Number of full-time caregivers: _____employed _____contracted
   b. Number of part-time caregivers: _____employed _____contracted
   c. Types of clients: ☐ Children ☐ Mentally handicapped/retarded ☐ Aged ☐ Other
   d. Are any medical services provided? ☐ No ☐ Yes
   e. Annual revenue from Nanny Services: $_____

2. Are any nannies contracted from outside the USA? ☐ No ☐ Yes
   Describe:_____

3. Are they approved to be working in the US by the Department of Immigration? ☐ No ☐ Yes

4. Do you provide Nanny Referrals—*prospective nanny candidates to interested parents for a fee*; *no direct child care responsibility*? If "Yes," please answer the following: ☐ No ☐ Yes
   a. How many referrals for: _____next 12 months _____last 12 months
   b. Annual Revenue from Nanny Referrals: $_____

5. Number and type of facilities you provide services to:_____
   _____

6. Confirm that the following information is attached to the application:
   ☐ Copy of contract signed by clients and prospective nannies
   ☐ A list of screening procedure undertaken for prospective nannies

7. Describe any services other than Nanny Referral/Services described above. Coverage will only apply to disclosed operations. _____
   _____

8. Do you require and keep certificates of insurance for all independent contractors? ☐ No ☐ Yes
9. Check ages of client: _____Under 18 _____Age 18 to 35
   _____Age 36 to 50 _____Age 51 to 65 _____Over 65 years old
10. Is medical equipment supplied or are your personnel responsible for monitoring any equipment? ☐ No ☐ Yes
    If "Yes," describe all such equipment:_____
    _____

11. Provide details for licensing or certification needed for this operation:_____
    _____

12. How long have you been licensed/certified?_____
13. Has your license ever been suspended or revoked? ☐ No ☐ Yes
    If "Yes," explain:_____

14. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number:_____

If this information is kept by you, provide the telephone number and address where the records are kept: _____

15. Additional Comments or Intererests:_____

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature	Sub-Producer
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.