indsey Associates
Insurance Services

Insurance Services LLC

48 Yrs. Experience

THE APPLICATION PROCESS

THANK YOU!

Your request for a quote on your Business Insurance will be referred to F. Darrell Lindsey, the NATIONWIDE state licensed Agent/Broker responsible for responding, quoting, and providing services relating to the Insurance programs made available to Business Owners, in support of your request.

Please find attached the Questionnaire KIT developed for the insurance coverage you have requested to be quoted. PLEASE – put "0" (zero) on lines where no "Number" is filled out by you. All spaces should have an entry. Insurance Companies are able to give up to a 35% credit to their filed rates or up to a 25% surcharge. Fully completed Questionnaires will qualify for the LARGEST CREDITS.

The Questionnaire, and any attached supplemental forms, must be 100% completed (with no questions unanswered) and submitted "ON LINE" or returned by FAX to our office. To process this request we require your **E-Mail address**, for followup during the quoting process, as may be necessary.

The separate forms, regarding prior claims, and the questions relating to; payroll, gross receipts, and prior insurance, are critical in rating and quoting all lines of insurance.

Please call the Questionnaire processing office with any questions you may have.

Respectfully,
F. Darrell Lindsey
U.S. State Licensed Agent/Broker
U.S. Corporate Enterprise Risk Manager Consultant (ERM)
U.S. State Approved Captive/RRG/Self Insured Manager
U.S. Approved Self Funded Health & W.C. Plan Manager

FDL/p
Enclosures

F. D. Lindsey Associates
P. O. Box 526357
Salt Lake City, UT 84152-6357
PH: 866-937-7037
FX: 866-937-7010
Web: http://www.fdlindseyassociates.com
Email: fdl@fdlindseyassociates.com

ART New World *Insurance Services*
P. O. Box 526357
Salt Lake City, UT 84152-6357
PH: 866-937-7037
FX: 866-937-7010
Web: http://www.artnwinsuranceservices.com
Email: fdl@artnwinsuranceservices.com

LLL Insurance Services
P. O. Box 526357
Salt Lake City, UT 84152-6357
PH: 866-937-7037
FX: 866-937-7010
Web: http://www.LLLinsuranceservices.com
Email: fdl@LLLinsuranceservices.com
Form LLL-A-201 –9/28/2015

indsey Associates
Insurance Services

Insurance Services LLC

Tips For Completing the Questionnaire(s) To Obtain A Quotation for Your Business Insurance

The Discovery Questionnaire attached will be used by the Underwriter to evaluate and identify the specific exposures and operations of your business. Proper completion is CRITICAL to the Insurance underwriting and rating process. Your signed questionnaire will become a part of any coverage contract issued and used as one of the representations from which benefits will be determined.

We cannot stress enough the importance of complete information being provided, including any brochures, pictures, flyers, yellow page ads, or other detail, which may assist the Underwriting office to better understand you business operations.

"DO NOT" be intimidated by the questionnaire, it is really very simple. Please Note:

1. Insurance should be applied for in the name of all the entities which you are known or may conduct your business.

2. Make certain you explain fully the nature of your business and the service you provide. Subcontractors are not provided benefits under the coverage contract issued, unless specifically requested and rated.

3. You must provide in detail, your gross sales and your annual payroll for all operations and service you provide. A separate rate is used for each separate service, type of facilities available, and for all business operations which may require insurance coverage. You may also want to provide a financial income statement with breakdown of income by type of activity or service provided.

4. Please complete all questions. Provide the name of your present and previous insurance company (not the agent), premium paid, and date your current coverage expires. Provide a copy of last years insurance policy Declarations Page and a copy of the Rating Page showing payroll and sales.

The more complete and detailed you answer all questions, the fewer assumptions the Underwriter/Rater will have to make. Properly completed questionnaires receive same day submission to the Insurance Company for the best rate and Quote turnaround possible.

Please call the office at anytime while you are completing the Application with any questions you do not understand. The office will be pleased to assist in any way possible.

F. Darrell Lindsey
State Licensed Agent/Broker

PO BOX 526357 • SALT LAKE CITY, UTAH 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010 ● E-Mail: fdl@LLLinsuranceservices.com
Website: http://www.LLLinsuranceservices.com

FDL indsey Associates
Insurance Services

LLL *Insurance Services LLC*

IS IT

WORTH IT?

BUSINESS OWNERS CAN RECEIVE UP TO A 20% CREDIT WHEN AN INSURANCE COMPANY UNDERWRITER IS ABLE TO RATE FROM A COMPLETED APPLICATION.

LIKEWISE, IF A RATING QUESTIONNAIRE HAS *BLANK* QUESTIONS AND THE UNDERWRITER HAS TO GUESS, THE RATE MAY GO UP 20%.

FULLY COMPLETED APPS ARE WORTH IT!!

F. Darrell Lindsey
U.S. State Licensed Agent/Broker
U.S. Corporate Enterprise Risk Manager Consultant (ERM)
U.S. State Approved Captive/RRG/Self Insured Manager
U.S. Approved Self Funded Plan Manager

FDL indsey Associates
Insurance Services

LLL *Insurance Services LLC*

HEALTH CARE & HUMAN SERVICES PROGRAM

ALSO AVAILABLE:

GENERAL OR PROFESSIONAL
- BUSINESS LIABILITY
- ERRORS & OMISSIONS ENDORSEMENT
- CARE, CUSTODY, CONTROL COVERAGE
- LOST KEY COVERAGE
- EMPLOYMENT PRACTICES LIABILITY
- PRODUCTS & COMPLETED OPERATIONS

PROPERTY INSURANCE
- BUILDING
- CONTENTS
- EQUIPMENT
- INLAND MARINE

GROUP HEALTH INSURANCE
- ASSOCIATION MASTER POLICY
- INDIVIDUAL COVERAGE AVAILABLE
- EMPLOYER GROUP BASIC PROGRAM
- HEALTH SAVINGS ACCOUNTS (HSA)
- SELF FUNDED GROUP HEALTH PLANS
- MINI-MED LOW COST HEALTH PLANS
- SHORT TERM MEDICAL
- CATASTROPHIC MAJOR MEDICAL

AUTO LIABILITY
- HIRED / NON-OWNED
- RENTAL REIMBURSEMENT
- LARGE ACCOUNT DISCOUNT

WORKERS' COMPENSATION
- AVAILABLE IN MOST STATES
- GUARANTEED COST
- SELF INSURANCE CAPTIVE PROGRAM
- DEVIATIONS AVAILABLE

FIDELITY BOND
- EMPLOYEE DISHONESTY
- FORGERY OR ALTERATION
- THEFT, DISAPPEARANCE & DISTRUCTION

EXCESS/UMBRELLA LIABILITY
- $1,000 MINIMUM PREMIUM
- UP TO $5,000,000 LIMIT

SURETY
- BID BONDS
- PERFORMANCE BONDS
- Miscellaneous License and Permit Bonds

CONTACT INFORMATION:
F. Darrell Lindsey
State Licensed Agent/Broker
PH: 866-937-7037
FX: 866-937-7010
E-mail: fdl@LLLinsuranceservices.com
Website: http://www.LLLinsuranceservices.com

LETTER OF AUTHORIZATION

To Whom It May Concern:

I the undersigned FIRST NAMED INSURED does hereby authorize the following persons:

F. Darrell Lindsey – U.S. State Licensed Agent/Broker

To act on behalf of _____
Business Name

For the purpose of obtaining quotes and binding insurance coverage under the following policies:

- ☐ **Business Liability**
- ☐ **Workers Compensation**
- ☐ **Business or Commercial Auto Liability**
- ☐ **Group or Individual Health Insurance**
- ☐ **Other Insurance (describe:** _____**)**
- ☐ **Professional Liability**
- ☐ **Property Insurance**
- ☐ **Excess or Umbrella Liability**
- ☐ **Directors & Officers Liability**
- ☐ **Self-Insurance Programs**

This authorization also constitutes the right to furnish F. Darrell Lindsey representatives with all the information that may be requested from any current provider of Insurance, with respect to existing insurance policies, for the purpose of obtaining rates, rating schedules, surveys, reserves, retentions and all other current policy data, including claim loss runs, for review and study, relating to the present and future requirements in connection with the insurance programs to which this authorization applies. A photo copy of this authorization shall be regarded with the same force and effect as the original.

Date: _____ **Signature:** _____
Type if On Line Completion

Authorized Contact Persons Name: _____

Business Address: _____

City and State: _____

Phone: _____ **Fax:** _____

(Ж) E-Mail Address: _____

HOME HEALTH CARE

DISCOVERY QUESTIONNAIRE
THIS IS FOR QUOTATION PURPOSES ONLY - THIS IS NOT A BINDER **SIC CODE:**_____

General Information **Proposed Effective Date:**_____

* SS# or FEIN #:_____

*1) Business Name:_____

*2) Mailing Address: _____

*3) Business Address:_____

City:_____ State:_____ Zip:_____

4) Contact Name: _____ Phone: _____

* **E-mail** address: _____ FAX:_____

* 5) Please provide a list of all locations (if applicant's name is different at other locations, please advise):

i)

ii)

iii)

*6) Potential Insured is (check appropriate boxes):

☐ Corporation ☐ LLC ☐ Partnership ☐ Operated as Non-Profit

☐ Individual ☐ Medicare Certified ☐ Other_____

*7) Please provide your state license number: _____

*8) What is your license classification or designation:_____

*9) What state(s) are you licensed in:_____

*10) Is this a new business? ☐ Yes ☐ No

If no, how many years have you been in business? _____ Yrs.

*11) How many years of experience do you have?_____

INSURANCE HISTORY

12. Please provide Insurance Company Name(s) for all companies that provided insurance for the last three (3) years.

	Coverage	Coverage	Coverage
Company Name			
Expiration Date			
Expiring Policy #			
Limits – per accident / aggregate			
Effective Retro Date:			

DESIRED INSURANCE

13. **Liability Limits Requested:**

☐	A	$25,000 PER CLAIM	$50,000 COMBINED ANNUAL AGGREGATE
☐	B	$50,000 PER CLAIM	$100,000 COMBINED ANNUAL AGGREGATE
☐	C	$100,000 PER CLAIM	$200,000 COMBINED ANNUAL AGGREGATE
☐	D	$150,000 PER CLAIM	$300,000 COMBINED ANNUAL AGGREGATE
☐	E	$200,000 PER CLAIM	$400,000 COMBINED ANNUAL AGGREGATE
☐	F	$250,000 PER CLAIM	$500,000 COMBINED ANNUAL AGGREGATE
☐	G	$250,000 PER CLAIM	$1,000,000 COMBINED ANNUAL AGGREGATE
☐	H	$500,000 PER CLAIM	$1,000,000 COMBINED ANNUAL AGGREGATE
☐	I	$1,000,000 PER CLAIM	$2,000,000 COMBINED ANNUAL AGGREGATE

14. Self Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

THIS SPACE INTENTIONALLY LEFT BLANK

Employee / Independent Contractors / Volunteers

15.

	EMPLOYEES				CONTRACTORS			VOLUNTEERS	
	# Full Time	**# Part Time**	**Annual Payroll**	**Annual Hrs of Svc.**	**#**	**Annual Billings**	**Annual Hrs of Svc.**	**#**	**Annual Hrs of Svc.**
Nurses: Reg. Nurses (RN), Lic. Practical Nurses (LPN), Lic. Visiting Nurses (LVN)									
Occup. Therapists, Speech Therapists									
Physical Therapists Respiratory Therapists									
Therapists Aides, Lab Asst., X-Ray Tech's									
Dieticians, Nutrition-ists, Dental Hygienists									
Pharmacists									
Psychologists									
Social Workers									
Home Health Aides									
Dialysis Technicians									
Nurse Practitioners									
Other (Describe)									

Services / Operations

A. Exposure Information

16. Please describe and give historical exposures (# of visits per yr) by staff including contracted staff?

Type of Home Health Providers	Next 12 Months Projected	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior	5th Year Prior
Nurses (RN. LPN. LVN)							
Nurse Practitioner							
Physical/Speech/Occup. Therapists							
Respiratory Therapist							
Social Worker							
Home Health Aide							
Home Care Companion							
Pharmacy							
Other (specify)							

17. Services Provided by Percentage of Gross Receipts (check all that apply):

Adult Day Care		%	**Housekeeping**		%	**Maternal / Fetal Monitoring**		%
Hospice		%	**Wound Care**		%	**Infant Day Care**		%
Cooking		%	**Infusion Therapy**		%	**Dialysis**		%
Dietician		%	**Staffing**		%	**Drug Administration**		%
Medical Lab		%	**Nursing**		%	**Training**		%
Hospital		%	**Personal Companion**		%	**Transportation to Doctor**		%
Pediatrics		%	**Pediatric Infusion**		%	**Cardiac Monitoring**		%
Rehab Therapy		%	**Ventilator Care**		%	**Durable Medical Equipment**		%
Bathing & Dressing		%	**Medication Monitoring**		%	**Grocery Shopping**		%
Meal Planning & Preparation		%	**Other**		%	**Other**		%

18. Does the applicant own, control, or staff or provide services to any of the following?

		If Yes	
Private Homes	☐ Yes ☐ No		%
Medical Laboratory (in house)	☐ Yes ☐ No		%
Nursing Home	☐ Yes ☐ No		%
Rehabilitation Facility	☐ Yes ☐ No		%
Hospital – General Care	☐ Yes ☐ No		%
Substance Abuse Programs	☐ Yes ☐ No		%
Adult Day Care	☐ Yes ☐ No		%
Kidney Dialysis	☐ Yes ☐ No		%
Infusion / Respiratory / Radiation Therapy	☐ Yes ☐ No		%
Rental and/or Leasing Services	☐ Yes ☐ No		%
Emergency Rooms	☐ Yes ☐ No		%
Emergency Vehicles	☐ Yes ☐ No		%
Clinics	☐ Yes ☐ No		%
Schools	☐ Yes ☐ No		%
Jails/Prisons	☐ Yes ☐ No		%

19. Quality Assurance - Hiring / Screening / Employment Procedures:

a) Are employee/contractor references checked prior to hiring? ☐ Yes ☐ No

b) How are the references checked? ☐ Written ☐ Verbal ☐ Both

c) Are prospective employees screened for prior criminal records? ☐ Yes ☐ No

d) Are employees actively participating in CE programs? ☐ Yes ☐ No

e) Are job descriptions provided for each employee? ☐ Yes ☐ No

f) Are professional employees required to carry their own insurance? ☐ Yes ☐ No

If yes what minimum limit is required? $_____

20. Accreditation – Is the applicant a member or accredited by any of the following:

A	**National Home Caring Council**	☐ **Yes** ☐ **No**
B	**JCAHO**	☐ **Yes** ☐ **No**
C	**National Association of Home Care**	☐ **Yes** ☐ **No**
D	**CHAP**	☐ **Yes** ☐ **No**
E	**Other (please specify)**	☐ **Yes** ☐ **No**

21. Risk Management:

A. Does the applicant utilize a formal written QA/RM program? ☐ **Yes** ☐ **No**
If YES, please provide a copy.

B. Does the applicant have a Peer Review Committee? ☐ **Yes** ☐ **No**

C. Does the Applicant conduct patient/client surveys? ☐ **Yes** ☐ **No**

D. Does the Applicant provide continuing education programs? ☐ **Yes** ☐ **No**

E. Are informed consent forms used? ☐ **Yes** ☐ **No**
If Yes, When?

_____

F. Is there a written policy or procedure document describing:

a) Patient acceptance	☐ **Yes** ☐ **No**
b) Advance directives (Living Will)	☐ **Yes** ☐ **No**
c) Employee training	☐ **Yes** ☐ **No**
d) Safety for workers in offsite locations	☐ **Yes** ☐ **No**
e) Lifting requirements	☐ **Yes** ☐ **No**
f) Patient evaluations	☐ **Yes** ☐ **No**
g) Incident reporting	☐ **Yes** ☐ **No**
h) Drug administrative procedures	☐ **Yes** ☐ **No**
i) Food preparation	☐ **Yes** ☐ **No**
j) Medical equipment training	☐ **Yes** ☐ **No**
k) Patient discharge procedures	☐ **Yes** ☐ **No**
l) Patients rights	☐ **Yes** ☐ **No**
m) Medical records	☐ **Yes** ☐ **No**
n)Termination of care	☐ **Yes** ☐ **No**
o) MD signing of orders	☐ **Yes** ☐ **No**

23. Do you sell, rent, lease or service any durable medical equipment? ☐ **Yes** ☐ **No**
If YES, complete the separate attached Medical Equipment Supplemental Questionnaire form.

24. During the past three (3) years, has any insurance company declined, cancelled or refused similar insurance to the Insured? ☐ **Yes** ☐ **No**

If yes, please explain:

PAYROLL:

25. *Total Company annual payroll: *$_____ Gross Amount

- **A. Direct Operations payroll $_____**
- **B. Office and Clerical payroll $_____**
- **C. Executive and Management payroll $_____**
- **D. Sub-Contracted #1099 Payroll $_____**
- **E. Other payroll – $_____**

Explain:_____

GROSS RECEIPTS

26. *Total Annual Gross Receipts from ALL Operations: *$_____ Gross Amount

- **A. Direct Company Operations/Services $_____**
- **B. From Sub-Contracted Job Operations/Services $_____**
- **C. Sale of Products - Wholesale $_____**
- **D. Retail Product Sales – No Services $_____**
- **E. Consulting Only Services (*Professional Liability is excluded however)* $_____**
- **F. All Other Receipts? $_____**

Explain:_____

*** Above "A thru F" must total Annual Gross Income.**

27. Provide payrolls, sub-contract costs and sales for past five (5) years and estimate for next twelve (12) months:

Year	Gross Annual Payroll	Insured Sub-Contractor Costs	Uninsured Sub-Contractor Costs	Gross Sub-Contractor Costs
* Next 12 Mos.				

28. Are you a member of any city, county, state or national industry trade(s) associations?

☐ **Yes** ☐ **No**

29. If Yes, please note in abbreviated reference those associations? _____

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010
Form #LLL-A-086-09/28/2015

1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL
2. PRINT – COMPLETE & FAX BACK

30. Do you have a formal written contract with any subcontractor that provides subcontracted services for you that includes a "Hold Harmless" Agreement relative to work performed by the subcontractor? ☐ **Yes** ☐ **No**

If No, are you willing to adopt a formal procedure to satisfy this requirement? ☐ **Yes** ☐ **No**

31. Are you named as an additional insured on any subcontractor's insurance coverage policy? ☐ **Yes** ☐ **No**

32. Do you provide Workers Compensation for your employees? ☐ **Yes** ☐ **No**

33. Do you provide Health Insurance for your employees? ☐ **Yes** ☐ **No**

34. In narrative form, please describe the operations of your business:

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010
Form #LLL-A-086-09/28/2015

1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL
2. PRINT – COMPLETE & FAX BACK

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

1. Full Name of Applicant: _____

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

3. Date Established: _____

4. Location(s) where services are provided (total must equal 100%):

Home		**%**	**Nursing Home**		**%**	**Hospital**		**%**	**Adult Day Care**		**%**
Hospice		**%**	**Assisted Living Facility**		**%**	**Clinic/Drs. Office**		**%**	**Other Facility (specify)**		**%**

5. Employees / Independent Contractors – Annual Staffing:

Type of employee/Independent Contractor	No. Full-Time	No. Part-time	Billable Hrs 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 Aide / Transportation			
Cleaning / Companion / Meal Service			
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**

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010
Form #LLL-A-086-09/28/2015

1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL
2. PRINT – COMPLETE & FAX BACK

F. Darrell Lindsey
LLL Insurance Services, LLC.
P.O. Box 526357
Salt Lake City, UT 84152
866-937-7037
FDL@LLLINSURANCESERVICES.COM

Please complete this supplement IF ANY non-owned coverage IS TO BE PROVIDED

IF NO COVERAGE IS TO BE PROVIDED –"CHECK HERE" ☐ NONE

Hired and Non Owned Auto Supplemental Application for Miscellaneous Health Care Operations

Each question must be fully answered. If not applicable, please state "N/A"

PART I - GENERAL INFORMATION

1 Name of Applicant _____

Street address _____
City, State, Zip _____

2. Number of owned automobiles_____

3. Do you have automobile liability coverage for your owned autos? ❑ Yes ❑ No

4. Is non owned automobile liability covered under the owned auto policy? ❑ Yes ❑ No

5. Why is hired and non ownership liability coverage being requested?_____
_____

PART II – DESCRIPTION OF USE

Hired Automobile Coverage Section

1. Do any of your employees, agents or independent contractors lease automobiles in your name? ❑ Yes ❑ No
if yes, please explain_____

2. Describe types of automobiles hired _____
3. What is the maximum passenger capacity of hired automobiles? _____
4. Are any hired automobiles leased? ❑ Yes ❑ No
What are the average terms of the lease?_____
5. Are the same automobiles leased or does it vary? ❑ Same Autos ❑ Varies
If the same, please explain why the automobiles can not be scheduled on the policy?_____
6. Do you provide drivers to operate hired automobiles? ❑ Yes ❑ No
If no, are the drivers required to provide a Certificate of Insurance? ❑ Yes ❑ No
What is the *minimum* liability limits required by the leasee (you) ?_____
7. Is there a written lease agreement? ❑ Yes ❑ No
If yes, please attach a copy.
8. Will you be named as an additional insured on the leassor's policy? ❑ Yes ❑ No
9. Do you lease, hire, rent or borrow any auto (other than a private passenger type auto) owned or leased by your employees, partners, or members of their household? ❑ Yes ❑ No If yes, please give details and how many? _____
10. Do you own or control any subsidiary or are you affiliated with any other corporation? ❑ Yes ❑ No
If yes, what is the business or affiliate?_____

.

Non Owned Automobile Coverage Section

1. How many employees drive their personal automobiles in connection with your business?_____
   How many of these are part-time employees? 15 - 45 hrs per week _____Under 15 hrs per week_____

   How will they be used? _____

   If persons other than employees use their personal automobiles in connection with your business, please provide full description and number: _____

2. Do you require employees or others to provide transportation for patients/clients in their personal automobiles? ❑ Yes ❑ No
   If yes, under what circumstances and how often _____

3. What is the maximum distance which a non owned auto may be driven from your premises? _____

4 Total number of employees_____

5. Total number of non owned autos used in your business_____

6. Do your employees lease automobiles on your behalf? ❑ Yes ❑ No

7. What is the estimated annual mileage for use on all non owned automobiles ? _____

8. Do you require employees or contracted personnel to have their own insurance? ❑ Yes ❑ No

   If yes, what are the minimum limits required? _____

9. Do you require evidence of insurance? ❑ Yes ❑ No

10. Do you check MVR's annually? ❑ Yes ❑ No

11. Will you use non owned automobiles other than those owned by your employees? ❑ Yes ❑ No
    If yes, describe relationship_____

12. Do you have volunteers at your operation? ❑ Yes ❑ No
    If so, indicate the total number of volunteers furnishing automobiles in your operation _____ _____
    Maximum number of volunteers at any one time:_____

13. Do you have current non owned coverage? ❑ Yes ❑ No
    If yes, who is the insurance carrier?_____
    What are the current limits of liability?_____

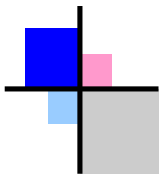
PART III - CLAIMS HISTORY

1. During the past five (5) years, have any claims for hired or non owned automobile liability been presented to your current or prior insurance carrier(s) or to you? ❑ Yes ❑ No

2. Are you, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑ Yes ❑ No
   If yes, provide full details. _____

indsey Associates
Insurance Services

Insurance Services LLC



"IF ANY"

SUPPLEMENT

IV THERAPY IN THE HOME HEALTH SETTING

HOME HEALTH AGENCY:

Please complete this supplement if any IV Therapy is/will be done by your agency's personnel.
*** IF NON CHECK HERE ☐ NONE**

A. The client and significant others are instructed concerning the IV Therapy Treatments? ☐ Yes ☐ No

1. **The instruction includes precautions, signs and symptoms of possible/actual problems, simple first-aid measures, and when and whom to call for assistance? ☐ Yes ☐ No**

2. **A return demonstration is required before any manipulation/handling of supplies or equipment occurs? ☐ Yes ☐ No**

3. **The medical record documented concerning instruction? ☐ Yes ☐ No**

B. Policies and procedures concerning IV Therapy are written? ☐ Yes ☐ No

1. **They are readily available for use by the registered nurse? ☐ Yes ☐ No**
2. **They are reviewed and/or revised annually? ☐ Yes ☐ No**
3. **They include:**
   - **a) Drug administration concerning:**
     - **1) IV Fluids in general? ☐ Yes ☐ No**
     - **2) Specific drugs by category and method of infusion (direct push, IV infusion) ☐ Yes ☐ No**
   - **b) Site care? ☐ Yes ☐ No**
   - **c) Infection control? ☐ Yes ☐ No**
   - **d) Care of equipment, including infusion pumps? ☐ Yes ☐ No**
   - **e) Protocols for emergency interventions? (These should be developed with the assistance of the physician). ☐ Yes ☐ No**

C. The registered nurse has, at a minimum, institutional certification for IV Therapy? ☐ Yes ☐ No

1. **The certification process verifies:**
   - **a) Performance Competency: a skills inventory/checklist is maintained which documents observed demonstration. ☐ Yes ☐ No**
   - **b) Knowledge Competency: a test of theoretical knowledge to include actions of various drugs administered, contradictions, complications, and nursing intervention? ☐ Yes ☐ No**
2. **The registered nurse will be recertified annually? ☐ Yes ☐ No**

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 • FX: 866-937-7010

Form #LLL-A-086-09/28/2015

1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL
2. PRINT – COMPLETE & FAX BACK

"IF ANY"
MEDICAL EQUIPMENT
SALES, RENTAL, LEASE
SERVICE

*** IF NONE – CHECK HERE: ☐ NONE**

1. **Name of Facility:** _____ **SS# or FEIN#:** _____
2. **Business Mailing Address:** _____
   City: _____ **State:** _____ **Zip:** _____
   E-Mail: _____ **Web Site:** _____
3. **Business Telephone Number:** _____ **Fax:** _____
4. **Physical Location of Business (if different):** _____
5. **Other Locations (if any):**
   Physical Address: _____
   City: _____ **State:** _____ **Zip:** _____
   Physical Address: _____
   City: _____ **State:** _____ **Zip:** _____

MEDICAL EQUIPMENT AND SUPPLIES / OPERATIONS / SERVICES

6. **Does the applicant sell any medical equipment and/or supplies?** ☐ **Yes** ☐ **No**
7. **Does the applicant rent or lease any medical equipment and/or supplies?** ☐ **Yes** ☐ **No**
8. **If applicant answered YES to either 6 or 7 above, then complete section below.**

Category I. ☐ **Expendable Items – intended for one time usage and disposal (i.e., adhesive tape, bandages, hypodermic needles, etc.)** **Annual Sales: $**_____

Category II. ☐ **Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category includes but not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelers, etc., and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment.** **Annual Sales: $**_____ **Lease/Rental Receipts:$**_____

Category III. ☐ **Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, portable EKG machines, or sending devices.**
Annual Sales: $**_____ **Lease/Rental Receipts:$_____

Category IV. ☐ **Life Sustaining or Critical Life Monitoring Equipment, or Devices – This category includes dialysis or heart/lung machines, IV pumps, ventilators, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction / devices or improper function of which could result in death or serious deterioration in health condition. (Please attach a list of Category IV equipment or devices).** **Annual Sales: $_____**
Lease/Rental Receipts:$_____

9. **Does the applicant perform any maintenance or repairs on equipment sold or leased?** ☐ **Yes** ☐ **No**
   If YES, please indicate the category (as described above).
   ☐ **Category I** ☐ **Category II** ☐ **Category III** ☐ **Category IV**
10. **Are all devices / equipment checked and documented as to condition prior to release?** ☐ **Yes** ☐ **No**
11. **Does the applicant perform, or has the applicant performed, preventive maintenance on all equipment / devices according to a written schedule?** ☐ **Yes** ☐ **No**
12. **Is the applicant named as an additional insured or vendor on the manufacturers policy for any / all products?** ☐ **Yes** ☐ **No**
13. **Does the applicant obtain certificates of insurance from their product suppliers?** ☐ **Yes** ☐ **No**
14. **Does the applicant currently or has the applicant ever imported products from foreign manufacturers?** ☐ **Yes** ☐ **No**
    If YES, does the manufacturer have a US location? ☐ **Yes** ☐ **No**
15. **Does the applicant modify the product in any way from its original form / use?** ☐ **Yes** ☐ **No**
    If YES, please attach an explanation.
16. **Does the applicant do any re-packaging or re-labeling of items obtained from suppliers?** ☐ **Yes** ☐ **No**
17. **Does the applicant have its own sales staff?** ☐ **Yes** ☐ **No**
18. **Does the applicant repair or sell used equipment of others?** ☐ **Yes** ☐ **No**
19. **Does the applicant reuse / resell any single use devices?** ☐ **Yes** ☐ **No**

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. **In narrative format, please explain your Medical Equipment operations:**

I understand the information submitted herein becomes a part of my Professional Liability Insurance Application and is subject to the same warranty and conditions.
Any person who knowingly and with intent to defraud any 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.

Signature of Owner, Officer or Partner **Print or Type Name and Title** **Date (Month-Day-Year)**

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010
Form #LLL-A-086-09/28/2015

1. **"COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL**
2. **PRINT – COMPLETE & FAX BACK**

F. Darrell Lindsey U.S. Licensed Producer/Broker	ADDITIONAL INFORMATION FORM USE TO ADD COMMENTS TO ANY PREVIOUS QUESTION(S) IF ANY

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheets if necessary.

QUESTION #	COMMENTS

FRAUD WARNING

NOTICE TO ALL STATES INCLUDING SPECIAL NOTICE TO ARKANSAS, COLORADO, FLORIDA, KENTUCKY, MAINE, MINNESOTA, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO AND 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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE SUBJECT TO SUBSTANTIAL CIVIL FINES AND CRIMINAL PENALTIES."

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

Dated: _____ **Dated:** _____

Applicant: _____ **Agent/Broker:** _____

_____ _____

Signature **Signature**

_____ _____

Print Name **Print Name**

*** For "ON LINE" forms completion – Please <u>type</u> your name on the signature line.**

SPECIAL NOTICE: *PLEASE COMPLETE AND SIGN <u>THE ATTACHED</u> CLAIM WARRANTEE FORM(S) BEFORE SUBMITTING THIS QUESTIONNAIRE "BY EMAIL" OR BY FAX.

<u>National Headquarters</u> F. Darrell Lindsey LLL Insurance Services P. O. Box 526357, SLC, Utah 84152-6357 PH: 866-937-7037 ● FX: 866-937-7010 Form #LLL-A-086-09/28/2015		**1. "COMPLETE ON LINE" THEN <u>SAVE</u> AND ATTACH TO AN EMAIL** **2. PRINT – COMPLETE & FAX BACK**

HOME CARE

Additional Exclusion
Claims Not Covered

This Endorsement changes the Coverage Contract issued. Please read it carefully!

This endorsement changes the coverage contract, effective on the inception date of the insurance issued to the Insured, unless another date is indicated below.

Attached to and forming a part of Coverage Contract No#_____, Certificate #_____, at its offices in Salt Lake City, Utah.

SCHEDULE: Endorsement Effective Date:_____ Date Endorsement Typed: _____

Insured: _____

Address: _____

The insurance coverage issued <u>WILL NOT</u> cover claims against you:

1. **Arising from disputes about your fees, including collecting fees from third parties;**
2. **Arising from bodily injury or property damage in any way involving an automobile, watercraft, or aircraft, unless separate Business Auto coverage is purchased;**
3. **Arising from any wrongful act in violation of any applicable law, or committed with knowledge it was a wrongful act;**
4. **Arising from services performed:**
   - **i. by a physician;**
   - **ii. by a midwife, nurse anesthetist, or physicians' assistant.**
5. **Arising from a wrongful act as a member of a formal accreditation or professional review or licensing board;**
6. **For fines, penalties, punitive, exemplary or multiplied damages;**
7. **Arising from any wrongful act covered under any prior insurance policy in effect before this coverage contract was effected. This exclusion applies whether or not any prior insurance policy has any limit of coverage remaining, or excludes coverage for the claim presented. This exclusion also applies if there was not insurance in effect prior to the effective date of this insurance.**
8. **Arising from any actual, alleged, attempted or proposed erotic physical contact;**
9. **Arising from a defective product;**
10. **Arising from the actual, alleged, or threatened discharge, dispersal, seepage, migration, release, or escape of pollutants or medical waste, or any direction, or request, to test for, monitor, cleanup, remove, contain, treat, detoxify, or neutralize, or in any way respond to or access the effect of pollutants or medical waste.**
11. **<u>Limits of Coverage reminder</u>:**

    Continuous or Related Wrongful Acts defined. All claims arising from continuous or related wrongful acts shall be treated as one claim. Such wrongful acts shall be considered to have taken place when the earliest wrongful act(s) takes place and not at the time of discovery.

<u>National Headquarters</u> F. Darrell Lindsey LLL Insurance Services P. O. Box 526357, SLC, Utah 84152-6357 PH: 866-937-7037 ● FX: 866-937-7010 Form #LLL-A-086- 9/28/2015		**1. "COMPLETE ON LINE" THEN <u>SAVE</u> AND ATTACH TO AN EMAIL** **2. PRINT – COMPLETE & FAX BACK**

STATEMENT OF NO KNOWN CLAIMS / CIRCUMSTANCES

A

Note: This statement must be signed and returned with the completed application.

The signature below confirms that:

- **I have no known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;**
- **I have no knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier;**
- **I have no knowledge of any request for medical records by a patient or his/her attorney which might result in a claim;**
- **I have no knowledge or information relating to service or services on a Board which might result in a claim; and**
- **I have no knowledge of any prior professional liability carrier refusing coverage for, or demanding to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact.**

The applicant declares that the information contained herein is accurate and that no material facts have been suppressed. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature:_____ **Date:**_____

Printed Name: _____

Witness: _____ **Date:** _____

Printed Name: _____

*** For "ON LINE" forms completion – Please <u>type</u> your name on the signature line.**

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010

Form #LLL-A-086- 09/28/2015

1. "COMPLETE ON LINE" THEN <u>SAVE</u> AND ATTACH TO AN EMAIL
2. PRINT – COMPLETE & FAX BACK

CLAIM INFORMATION SUPPLEMENT / SEPARATE FORM FOR EACH SEPARATE CLAIM

This Claim Information Supplement must be completed, signed and dated by the applicant for each claim, suit or circumstance reported on your application for insurance. All questions must be answered completely. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please attach a separate page. Photocopy this form and use a separate one for each claim, suit or circumstance.
COPY THIS FORM FOR EACH CLAIM AND FAX BACK ANY ADDED FORMS.

Information:

Name:	Social Security Number or Corp. Number	

Claim or Circumstance Information

Claimant Name:	Age:	Sex:
Date of Alleged Incident:	Date Claims was made or Suit Brought:	
Additional Defendants:		
Insurance Carrier to Whom Claim/Circumstance Reported:		

Claim Status if Liability:

DISMISSED			DEFENSE VERDICT		
PLAINTIFF VERDICT		TOTAL PAID $		PAID ON YOUR BEHALF $	
SETTLEMENT		TOTAL PAID $		PAID ON YOUR BEHALF $	
OPEN					
Settlement Demand	$	Settlement Offer	$	Loss Reserve	$

For all Paid and Reserve amounts, include both Indemnity and Expense dollars.
Claim Description: Include allegation(s), events leading up to the claim, and any other facts pertinent to the claim.

PLEASE EXPLAIN: What BUSINESS PRACTICES or RISK MANAGEMENT procedures have you developed and effected to prevent a claim like this in the future? Note any changes like hiring procedures, client screening, signed disclosure of risk forms, job work orders signed, inspection of jobs completed, employee training, etc.. Please explain in your own words:

The applicant declares that the information contained in this CLAIM INFORMATION SUPPLE-MENT is true and that no material facts have been suppressed or misstated. The applicant under-stands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ **Date:** _____
TYPE NAME IF COMPLETED ON LINE

Printed Name: _____

Witness: _____ **Date:** _____

*** For "ON LINE" forms completion – Please type your name on the signature line.**

National Headquarters F. Darrell Lindsey LLL Insurance Services P. O. Box 526357, SLC, Utah 84152-6357 PH: 866-937-7037 ● FX: 866-937-7010 Form #LLL-A-086- 9/28/2015		**1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL** **2. PRINT – COMPLETE & FAX BACK**

CLAIMS HISTORY WARRANTY REPLACES INSURED'S FIVE-YEAR LOSS RUNS
PUT "0" OR A DATE ON EACH LINE.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

BUSINESS NAME: _____

It is understood and agreed that in lieu of the required insurance company loss runs required to document the state prior Loss History of the named insured, the following statement of prior claims will be accepted as a supplement to the application information and will also serve as a warranty statement to be made a part of any policy issued.

Policy Year	Date of Loss	Description of Loss	Amount Paid

PLEASE ADVISE: If you are reporting NO claims; please explain the business practices and risk management procedure you have taken; LIKE; like special hiring procedures, screening new clients, job inspections, signed acknowledgement of risk forms, requiring signed work orders, employee training, etc., THAT YOU BELIEVE HELP prevent the filing of claims? Please explain in your own words

If necessary, additional Loss History and Warranty Forms can be used to complete the required five-year history. The insured must sign each separate completed form.

As the Named Insured, I warrant the above loss history represents all claims, losses and accidents, of any kind, in which the Named Insured has direct knowledge.

Named Insured	Authorized Signature	Date
Witness	Authorized Signature	Date

*** For "ON LINE" forms completion – Please type your name on the signature line.**

PLEASE "PRINT" AND FAX BACK OR "SAVE" AND ATTACH BY RETURN E-MAIL

National Headquarters
F. Darrell Lindsey
LLL Insurance Services
P. O. Box 526357, SLC, Utah 84152-6357
PH: 866-937-7037 ● FX: 866-937-7010
Form LLL – 086 – 09/28/2015

1. **"COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN EMAIL**
2. **PRINT – COMPLETE & FAX BACK**

FDL indsey Associates
Insurance Services

LLL *Insurance Services LLC*

STATE
LEGAL SYSTEMS

Your State Legal Systems can:

- **Destroy Jobs**
- **Raise Taxes**
- **Take Your Money**
- **Increase Insurance Rates**
- **Eliminate the Ability to Obtain Insurance At All**

Businesses are reluctant to locate in a state (or maybe even a county in the State) with a reputation of having unfair laws or court system. Plaintiff Attorneys' always go FORUM shopping to locate courts with a history that will be in their favor. Lawsuits (not including claims paid without a lawsuit) cost $245 Billion, or every American $845 a year, as reported in a study by Tillinghast, Towers, Perrin in January 2005.

In a recent report provided by the U.S. Chamber Institute for Legal Reform, www.instituteforlegalreform.org, the Institute identified its best to worst list.

As indicated by the survey the BEST to the WORST are noted below. Insurance rates are significantly influenced by the courts in every state. Why are your rates higher than someone in another state, or even someone in another country within your state, and why is insurance coverage even hard to find at all? It may be because of the court system or LAWS in your state or county are broken? Check out the Institutes website for more information!

BEST TO WORST LEGAL SYSTEMS:

1	Delaware	13	Colorado	25	Oregon	38	New Mexico
2	Nebraska	14	Utah	26	Ohio	39	South Carolina
3	North Dakota	15	Washington	27	New York	40	Missouri
4	Virginia	16	Kansas	28	Georgia	41	Hawaii
5	Iowa	17	Wisconsin	29	Nevada	42	Florida
6	Indiana	18	Connecticut	30	New Jersey	43	Arkansas
7	Minnesota	19	Arizona	31	Massachusetts	44	Texas
8	South Dakota	20	North Carolina	32	Oklahoma	45	California
9	Wyoming	21	Vermont	33	Alaska	46	Illinois
10	Idaho	22	Tennessee	34	Pennsylvania	47	Louisiana
11	Maine	23	Maryland	35	Rhode Island	48	Alabama
12	New Hampshire	24	Michigan	36	Kentucky	49	West Virginia
				37	Montana	50	Mississippi

F. Darrell Lindsey
U.S. State Licensed Agent/Broker

P. O. Box 526357, Salt Lake City, Utah 84152-6357
PH: 866-937-7037 • FX: 866-937-7010
E-Mail: fdl@LLLinsuranceservices.com

indsey Associates
Insurance Services

Insurance Services LLC

5 reasons

F. D. LINDSEY ASSOCIATES is the Right Insurance Solution for the Health Care and Human Services Industry.

Our NATIONWIDE OPERATIONS understand the Professional Services Industry.

2

We provide 48+ years of Direct experience in not only insurance solution but viable self-insurance options. Not only for LIABILITY, but Workers Compensation, Group Health, Builders Risk Policies, Bonds, Property, and AUTO.

3

We offer risk control programs, risk management information and production industry education. Monthly newsletters are available for the Professional Services Industry Nationwide. We provide Web risk manager guides and online class room training. This will help reduce and control your loss exposures.

4

Our network of over 250 Attorneys and 75 nationwide claims adjuster offices process claims quickly and fairly. We help injured workers get healthy and return to work sooner. We have online claims information access for all clients. As permitted by law – claims DATA is available online for clients to review and provide support management.

5

Our Industry experts understand the Professional Services Industry. For 48+ years our companies and industry associates have devoted their lives managing the unique and special risks associated with the Restaurants, Bars & Taverns Services Industry. Our partnership with trade associations, manufacturers, industry experts and claims administrators, ensures that we will stay ahead of all changes and trends in the Professional Services Industry. We are your partner in the managing and transferring of risk.

F. D. Lindsey Associates
In Cooperation with
LLL Insurance Services, LLC
P. O. Box 526357, Salt Lake City, UT 84152-6357
PH: 866-937-7037 • FX: 866-937-7010
E-Mail: fdl@LLLinsuranceservices.com

Lindsey Associates
Insurance Services

Insurance Services LLC

"NATIONWIDE OPERATIONS"

COMMERCIAL BUSINESS INSURANCE

The Insurance coverages available will help companies manage a wide range of risks and exposures encountered in today's business environment.

LEARN MORE ABOUT SOLUTIONS

Commercial and Professional Insurance Solutions that address the Insurance needs of all Business Owners and Professionals.

Business Auto Insurance tailored to meet the needs of the client.

Workers' Compensation, Property Insurance, Bonds, all designed for the Business Owners of today.

Self Funded Health Insurance for Employee Groups of 25 employees or more.

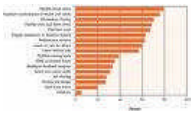
SELF-INSURANCE

Self Insurance for an Owner, Association Group Program, or several owners combining to manage their own risks.

Captives, RRG Insurance Companies, Self-Insurance
http://www.artnwinsuranceservices.com

PROFESSIONAL INSURANCE

Almost every business may have some professional exposures, not just LICENSED Professionals with degrees like:



Employment Practices LIABILITY for claims filed involving wrongful termination, sexual harassment, page discrimination, etc., etc..

OR

Professional Insurance coverage for Doctors, Architects, Lawyers, Nursing Homes, & Health Care Providers.

OTHER INSURANCE COVERAGE

Group Health Insurance for; Single Owner, Employee Programs, Deductible Plans, Co-Pay Programs, Self Insured Captives.

Surety and Permit Bonds.

Directors and Officers Liability.

Property Insurance

Business and Commercial Auto Insurance For All Types of Business Owners

http://www.highcountryinsurancegroup.com

Please go to:
http://www.combinedindustrypurchasinggroup.com
For more information.
- **As Agent & Broker**
- **Licensed all states - As an Enterprise Risk "Nationwide" Management (ERM) Consultant**
- **As a State Approved Captive/RRG/Self Insured Mgr.**

F. Darrell Lindsey
U.S. State Licensed Agent/Broker
PH: 1-866-937-7037 FX: 1-866-937-7010
E-Mail: fdl@LLLinsuranceservices.com

indsey Associates
Insurance Services

Insurance Services LLC

INSURANCE APPLICATION

FAX BACK COVER SHEET

TO: 866-937-7010

FROM:

_____

Phone:_____

FAX:_____

E-Mail:_____

TO:_____

Phone: 866-937-7037

FAX: 866-937-7010

E-Mail: fdl@LLLinsuranceservices.com

Comments:

F. Darrell Lindsey / State Licensed Agent/Producer
P. O. Box 526357, Salt Lake City, Utah 84152-6357
PH: 866-937-7037 • FX: 866-937-7010
Website: http://www.LLLinsuranceservices.com • E-Mail: fdl@LLLinsuranceservices.com