



COVID-19 Supplemental Application for Healthcare

Employer Name: _____

Employer Address: _____

1. Do you have an individual assigned to manage your infection control program? Yes No
If yes, what is their name and title?: _____
2. Do you have written policies and procedures in place that would trigger the implementation of protective measures for employees? Yes No
3. Do you have patients currently testing positive for COVID-19? Yes No
If yes, how many?: _____
4. Do you have employees currently testing positive for COVID-19? Yes No
If yes, how many?: _____
5. When testing patients and healthcare personnel for COVID-19 what is your average turnaround time for results?:

6. Do you have a non-punitive sick leave policy to prohibit potentially contagious staff from working? Yes No
7. Do you provide additional training to staff on hand washing and personal protective equipment (PPE) related to the Covid-19 pandemic? Yes No
8. Do you have health screening measures for personnel at the beginning of their shift during a pandemic? Yes No
9. Are employees required to wear isolation/surgical masks at all times? Yes No
10. Do you have N-95 masks available for use when providing high risk care such as trachea/respiratory treatments? Yes No
11. Have you experienced a shortage of PPE during a pandemic? Yes No
12. How many weeks of PPE (masks/gloves/face protection/gowns) do you maintain on your premises? _____
13. What is your protocol for employees who have known or suspected COVID-19 exposure or infection?

14. Are employees required to be vaccinated for COVID-19? Yes No
15. What percentage of of your employees have received the vaccination? _____

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Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: 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 act, which is a crime and may subject such person to criminal and civil penalties.

Name

Title

Signature

Date