If your answer is too long, then please complete it on the supplemental page, referencing the question number.

APPLICATION FOR LONG-TERM CARE FACILITIES
(Nursing Homes, Assisted Living, Residential Facilities)

PROFESSIONAL & GENERAL LIABILITY INSURANCE

A. INSTRUCTIONS

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, attach a separate page.
4. This application must be completed, dated and signed by a principal of the business.

B. ATTACHMENTS

Please include the following attachments with this application:

1. Attachment #1 – Schedule of Locations to be covered.
2. Attachment #2 – Risk Management Addendum.
3. Organizational Chart.
4. 10 Years of Company Produced Loss Information.
5. Most Recent CPA Prepared Financial Statements.
6. Resident Admission Agreement.
7. Advertisements and Marketing Material.
8. For Assisted Living Facilities – Description of levels of service provided.

C. GENERAL INFORMATION

☐ New Application ☐ Renewal of Policy No.

Applicant Name:
Street Address:

Telephone:
Contact Person for Survey:
Title:

Type of Facility:
Number of Locations:

** Please also complete Attachment #1

Number of Years Facility has been:
Operating
Owned by Present Owners
Managed by Present Management

D. CURRENT COVERAGE

Insurance Carrier
Professional Liability Per Claim Limit / Policy Total
General Liability Limit Per Claim Limit / Policy Total
Per Claim Deductible /Retention:
Annual Premium:
Coverage Form: Occurrence / Claims Made
Retroactive Date:
Policy Expiration Date:

Has coverage every been cancelled or non-renewed? ☐ YES / NO ☐
If yes, when?
Reason?

Total Excess Professional / GL Limits Purchased
Insurance Carrier
Annual Premium

E. CORPORATE STRUCTURE / OPERATIONS *Please attach Organizational Chart.

Is the Applicant:

Part of a Multiple Chain ? ☐ YES / NO ☐
If yes, number of Facilities?
Located within a Hospital System? ☐ YES / NO ☐
For – Profit? Not-For-Profit?
Corporation? Partnership? Joint Venture?
Medicaid Certified? Medicare Certified?

Are any facilities operated by an outside Management Company? ☐ YES / NO ☐
If yes, please explain

Have any facilities been acquired in the past three years? ☐ YES / NO ☐
If yes, please explain:

Have any facilities been closed, sold or otherwise divested in the past three years? ☐ YES / NO ☐
If yes, please list facility name, state, # licensed beds:

Are you planning to acquire or open any new facilities in the next year? ☐ YES / NO ☐
If yes, please list facility location, # licensed beds and beds classification:

Do you operate or manage any other facilities for which you are NOT applying for coverage? YES / NO
If yes, please describe ☐ ☐

F. SCHEDULE OF LOCATIONS TO BE COVERED

** *Please complete ATTACHMENT #1.*

G. LICENSING / CERTIFICATION

Has your state license for any location been limited or revoked within the last three years? YES / NO
If yes, please explain:

Has your Medicare or Medicaid certification for any location been limited, suspended or revoked, for any reason, within the last three years? YES / NO
If yes, please explain:

Have any of your facilities been placed under Immediate Jeopardy during the past three years? YES / NO
If yes, please explain:

H. ADDITIONAL SERVICES

Please indicate if any of the following services are provided by your facility :

	Service Offered	Contracted	Insurance Limit Required
Physicians	YES / NO	YES / NO	
Dentists	YES / NO	YES / NO	
Podiatrists	YES / NO	YES / NO	
Chiropractors	YES / NO	YES / NO	
Psychologists	YES / NO	YES / NO	
Occupational Rehabilitation	YES / NO	YES / NO	
Respiratory Therapy	YES / NO	YES / NO	
Physical Therapy	YES / NO	YES / NO	
Speech Therapy	YES / NO	YES / NO	
Alzheimer's Special Unit	YES / NO	YES / NO	
Alcohol or Drug Treatment	YES / NO	YES / NO	
Adult Day Care	YES / NO	YES / NO	
Home Health Care	YES / NO	YES / NO	
Pharmacy Services:			
Dispensing of Oral Medications	YES / NO	YES / NO	
Dispensing of Injectible Medications	YES / NO	YES / NO	
IV Admixtures	YES / NO	YES / NO	
PPN	YES / NO	YES / NO	

If there are any services offered that are not listed above, please describe the type of services being provided, the location where it is being provided and the approximate number of individuals served annually?
If none, state none.

Are certificates of Insurance obtained and updated annually for all professional services that are contracted? YES / NO

I. ADMINISTRATION AND STAFFING

For each facility for which you are applying for coverage, do you:

Employ a full-time Medical Director? YES / NO
Employ a full-time Director of Nursing? YES / NO
Employ a full-time Risk Manager? YES / NO
Describe how Risk Management is administered within your facility?

Have any leased Employees? YES / NO NUMBER,
Have any temporary Employees? YES / NO, NUMBER ,

For all employees, prior to hiring, do you check:

Educational background and training? YES / NO
Work background with at least two previous employers? YES / NO
Criminal records? YES / NO
Local? YES / NO
State? YES / NO
National? YES / NO
Driving Record ? YES / NO
Credit Reports ? YES / NO
Drug Tests ? YES / NO

Do you have written policies that address each of the following:

Workplace rules? YES / NO
Expected Standards of Patient Care? YES / NO
Charting Requirements for Staff Members? YES / NO
Grievance Procedures for Employees? YES / NO
Competency based written performance evaluations? YES / NO
Are these given to all employees?
How often are regularly scheduled performance evaluations conducted?
Progressive discipline program for under-performing employees ? YES / NO
Are exit interviews conducted following all employee terminations? YES / NO
Are results of these interviews documented in writing? YES / NO

For ongoing training of employees do you:

Have a formalized, on-going training program? YES / NO
Who is responsible in your organization for training of employees (title)?
How often are training sessions held?
Are all employees required to attend? YES / NO
Describe training sessions held over the past 12 months?

J. PATIENT INFORMATION

Do you require a full physical examination of every patient prior to admittance? ☐ YES / NO ☐

Is a nursing assessment conducted for every new patient? ☐ YES / NO ☐

Does every resident sign a Resident Agreement upon entering your facility? ☐ YES / NO ☐

Does this agreement contain a mandatory arbitration clause, where allowed? ☐ YES / NO ☐

Does this agreement contain a limitation of liability clause, where allowed? ☐ YES / NO ☐

Do you have a written grievance procedure for Residents (attach copy)? ☐ YES / NO ☐

Do you have a written grievance procedure for family members of Residents (attach copy)? ☐ YES / NO ☐

Do all patients have their own attending physician ? ☐ YES / NO ☐
If no, who performs the role of attending physician?

Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

Do you obtain advance written consent from the patient or guardian that allows your facility to provide non-emergency medical care when it is needed? ☐ YES / NO ☐

What is your policy on the charting requirements of attending physicians?

Do you have any employed physicians on staff? ☐ YES / NO ☐
How many?

Do you retain a physician on-site or on-call on a 24 hour basis? ☐ YES / NO ☐

K. LOSS HISTORY

Please provide a claim summary showing each professional and commercial general liability claim or suit brought against your facility during the last ten years.

Please include the following information for each claim:

a) Date of loss or occurrence
b) Date loss was reported to the insurance company.
c) Name of facility where loss took place
d) Brief description of the loss
e) Amount of indemnity, defense and current reserve.
f) Current status of the claim (open or closed).

Indicate the source of this loss information
Indicate the valuation date of this loss information

L. EXCESS LIABILITY INFORMATION

List below all other primary Liability and Workers Compensation policies written by other companies for which you are applying to us for coverage on an excess basis.

Type of Insurance	Policy Number	Insurance Company	Policy Period: From:	To:	Limits	Premium
					$	$
					$	$
					$	$

Are you applying for excess auto coverage? ☐ YES / NO ☐

If applying for excess auto coverage, do you have any automobiles garaged in any of the following states?

Ohio	☐ YES / NO ☐	Number
Florida	☐ YES / NO ☐	Number
Louisiana	☐ YES / NO ☐	Number
Indiana	☐ YES / NO ☐	Number
Vermont	☐ YES / NO ☐	Number
New Hampshire	☐ YES / NO ☐	Number

Do you choose to reject uninsured / underinsured motorist coverage? ☐ YES / NO ☐

Does your automobile liability cover owned, leased, non owned or rented autos? ☐ YES / NO ☐
If yes, indicate the number of:

	Owned	Leased
Cars		
Ambulances		
Light Trucks		
Other- Describe		

List any auto liability claims or suits made or bought against your facility during the past five years for amounts greater than $25,000? If none, state none.

Date of Loss	Cause of Loss	Status Open/Closed	Paid Amount	Reserve Amount

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZTION

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICATION OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF

_____		
Applicant Signature	Title	Date

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "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."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

NOTICE TO 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 OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

Supplemental information:

(please reference any questions you are referring to)