

[illegible]

B. GENERAL INFORMATION (If answer is “Yes” to any of the following questions, please provide details.)			
1.	Is any part of the Applicant operated / leased by a management corporation?	Yes	No
	If yes, please provide the name of the management corporation:		
	If yes, please provide a list of additional facilities owned and managed.		

List below all subsidiaries and direct affiliates, with a description of operations, acquisition/formation date and ownership interest.

Name & Address	Description of Operations	Relationship	Date Acquired	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

C. DESCRIPTION OF SERVICES AND RESIDENT PROFILE:

1. Total Exposure:

<u>Bed Census</u>	<u>Number of Licensed Beds / Units</u>	<u>Number of Occupied Beds / Units</u>
Skilled Nursing Facility		
Dementia / Alzheimer		
Sub-Acute / Rehabilitation		
Assisted Living		
Independent Living**		

** Please confirm if IL component has emergency call buttons or pull cords Yes No

* If applicant has more than 1 facility, please complete Attachment #1 for all scheduled locations and breakdown of exposures

Other Professional Services:

None	
Adult Daycare	Number of Daily Attendees
Home Health Services	Number of Annual Visits:
Hospice	Number of Annual Visits:
Ventilator/Tracheostomy beds	Number of occupied beds:
Pharmacy	Receipts:
Other:	

Behavioral Health	Number of Residents	Behavioral Health	Number of Residents
Traumatic Brain Injury		Addiction Issues	
Post-Traumatic Stress Disorder		Bipolar Disorder	
Developmental Disabilities		Methadone Maintenance	
Schizophrenia		Criminal Justice Referred	
Are there formal behavioral health programs provided by outside mental health professional(s)?		Yes	No
Are there in-house behavioral health resources and/or programs?		Yes	No
Is there a separate unit/section for the behavioral health residents?		Yes	No

2. Resident Age Groups:		
Age Group	Number of Residents	
Age 0-18		
Age 19-40		
Age 41-65		
Age 65+		
3. If you accept residents under the age 65, what are the circumstances?		
4. Please confirm if insured has a pool and/or other body of water on premise:		
	Yes	No

D. ADMINISTRATION AND STAFF:							
	Name	FT/PT	Employed / Contracted	Limits of Liability	Years of Experience	Tenure at Facility	Licensed (Y/N)
Administrator							
DON							
Medical Director							
Does the Medical Director also act as the attending physician to any residents?						Yes	No
If "Yes", to how many residents?							
Risk Management Contact:							
Phone:							
Email:							

1.	Is there a formal, documented assessment process to measure staff competency skills?	Yes	No
2.	Does the insured have a formal cell phone policy?	Yes	No

Physicians and Medical Director:

1.	Number of physicians:	Employed:	Affiliated:	Contracted:
2.	Do you obtain and review physicians' certificates of malpractice insurance?			Yes No
3.	Do you require limits of liability comparable to your own?			Yes No
	If "No", define the differences in limits:			

4.	What limits do you require your physicians to carry?		
5.	Are the physicians credentialed?	Yes	No
	a. If "Yes", how often are they re-credentialed?		
	b. Do you conduct credentialing internally or with the assistance of a third party? If a third party, who?		
6.	Is a physician on site or on call on a 24-hour basis?	Yes	No

Nursing Staff Census:

CATEGORY	Avg. hours worked per day	Turnover rate
RN		
LPN / VN		
CNA / Personal caregiver		

Show percentage of nursing staff by experience level:

< 5 yrs	
6 – 10 yrs.	
11 – 20 yrs.	
> 25 yrs.	

E. POLICIES AND PROCEDURES:

1.	Does the Applicant have a written emergency evacuation plan?	Yes	No
	a. Are evacuation plans posted in all parts of the facility?	Yes	No
	b. How often are evacuation / fire drills conducted for each shift?		
	c. Does the staff orientation plan include a review and "walk through" of any disaster plan?	Yes	No
	d. If in a CAT prone area, please provide your emergency evacuation plan.		
2.	Please confirm if any residents have eloped from the facility.	Yes	No
	a. If "Yes", how many? When?		
	What was the outcome?		
	b. Was this reported to the prior carrier?	Yes	No
	c. Please provide a copy of your elopement policy and procedures.		
3.	Are you aware of any abuse incidents that have occurred at your facility?	Yes	No
	a. If "Yes", how many? When?		
	What was the outcome?		
	b. Was this reported to the prior carrier?	Yes	No

G. COVERAGE INFORMATION:

Current Professional Liability Coverage:			Current General Liability Coverage:			Current Excess Coverage:	
Carrier:			Carrier:			Carrier:	
Policy Period:			Policy Period:			Policy Period:	
Limits of Liability:			Limits of Liability:			Limits of Liability:	
Claims-Made	Occurrence		Claims-Made	Occurrence		Claims-Made	Occurrence
If Claims Made, Retroactive Date:			If Claims Made, Retroactive Date:			If Claims Made, Retroactive Date:	
DOL	DWL		DOL	DWL		DOL	DWL
Deductible			Deductible			Deductible	
Self-Insured Retention:			Self-Insured Retention:			Self-Insured Retention:	
Premium:		Premium:		Premium:			

H. CLAIMS INFORMATION: (MISSOURI RESIDENTS DO NOT ANSWER):

1.	Has any insurer cancelled, rescinded or declined professional liability insurance for the Applicant?	Yes	No
2.	<p>Please attach currently valued loss run describing all claims/incidents during the past 10 years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheets, if necessary).</p> <p>If "None", so state:</p>		
3.	<p>Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, incident, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows (Attach additional sheets, if necessary).</p> <p>If "None", so state:</p>		

Attachment #1

1. Facility Name:					
Facility Address:					
<u>Bed Census</u>	<u>Number of Licensed Beds / Units</u>			<u>Number of Occupied Beds / Units</u>	
Skilled Nursing Facility					
Dementia / Alzheimer					
Sub-Acute / Rehabilitation					
Assisted Living					
Independent Living					
Construction Type:	Frame	Brick	Non-combustible	Masonry Non-combustible	Fire resistive
Location of Smoke Detectors:	None	Hallways	Entire Facility	Common Areas	Other
Areas Protected by Sprinkler System	None	Resident Rooms	Entire Facility	Hallways	Common Areas
2. Facility Name:					
Facility Address:					
<u>Bed Census</u>	<u>Number of Licensed Beds / Units</u>			<u>Number of Occupied Beds / Units</u>	
Skilled Nursing Facility					
Dementia / Alzheimer					
Sub-Acute / Rehabilitation					
Assisted Living					
Independent Living					
Construction Type:	Frame	Brick	Non-combustible	Masonry Non-combustible	Fire resistive
Location of Smoke Detectors:	None	Hallways	Entire Facility	Common Areas	Other
Areas Protected by Sprinkler System	None	Resident Rooms	Entire Facility	Hallways	Common Areas

3. Facility Name:

Facility Address:

<u>Bed Census</u>			<u>Number of Licensed Beds / Units</u>		<u>Number of Occupied Beds / Units</u>	
Skilled Nursing Facility						
Dementia / Alzheimer						
Sub-Acute / Rehabilitation						
Assisted Living						
Independent Living						
Construction Type:	Frame	Brick	Non-combustible	Masonry Non-combustible	Fire resistive	
Location of Smoke Detectors:	None	Hallways	Entire Facility	Common Areas	Other	
Areas Protected by Sprinkler System	None	Resident Rooms	Entire Facility	Hallways	Common Areas	

4. Facility Name:

Facility Address:

<u>Bed Census</u>			<u>Number of Licensed Beds / Units</u>		<u>Number of Occupied Beds / Units</u>	
Skilled Nursing Facility						
Dementia / Alzheimer						
Sub-Acute / Rehabilitation						
Assisted Living						
Independent Living						
Construction Type:	Frame	Brick	Non-combustible	Masonry Non-combustible	Fire resistive	
Location of Smoke Detectors:	None	Hallways	Entire Facility	Common Areas	Other	
Areas Protected by Sprinkler System	None	Resident Rooms	Entire Facility	Hallways	Common Areas	

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

BROKER OR AGENT CONTACT INFORMATION

Name:	
Firm:	
Address:	
Phone:	
Email:	

WARRANTY AND REPRESENTATION, FRAUD WARNINGS, AND SIGNATURE

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares, warrants and represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. Should any of the information in this Application be false or inaccurate, this policy may be void *ab initio*, as if the policy had never existed.

The information contained in and submitted with this Application is on file with the Insurer, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand that:

- a) If any portion of the policy to be issued is written on a "Claims Made" basis, then such portion(s) shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Insurer in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and
- b) the limit of liability available under the policy to be issued available to pay damages, settlements, or judgments may be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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.

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

NOTICE TO ARKANSAS, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, VERMONT & WEST VIRGINIA 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 CALIFORNIA APPLICANTS: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS 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 AGENCIES.

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 OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO COMMITS A FRAUDULENT INSURANCE ACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION, FINES AND CONFINEMENT IN PRISON. A FRAUDULENT INSURANCE ACT MEANS AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER OR INSURANCE AGENT OR BROKER, ANY WRITTEN,

ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR INSURANCE OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT UNDER AN INSURANCE POLICY, WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY MATERIAL FACT THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

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, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES 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 OHIO APPLICANTS: ANY PERSON WHO, WITH THE 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.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON. IN ORDER FOR US TO DENY A CLAIM ON THE BASIS OF MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART, WE MUST SHOW THAT:

- A. THE MISINFORMATION IS MATERIAL TO THE CONTENT OF THE POLICY;
- B. WE RELIED UPON THE MISINFORMATION; AND
- C. THE INFORMATION WAS EITHER:
 - 1. MATERIAL TO THE RISK ASSUMED BY US; OR
 - 2. PROVIDED FRAUDULENTLY.

FOR REMEDIES OTHER THAN THE DENIAL OF A CLAIM, MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART MUST EITHER BE FRAUDULENT OR MATERIAL TO OUR INTERESTS. MISSTATEMENTS, MISREPRESENTATIONS, OMISSIONS OR CONCEALMENTS ON YOUR PART ARE NOT FRAUDULENT UNLESS THEY ARE MADE WITH THE INTENT TO KNOWINGLY DEFRAUD.

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 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, OR 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.

Applicant (signature):		
By (Chairman and /or President – Print Name)	Title:	Date:

NOTE: This Application must be signed by the Chairman or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.