

**APPLICATION for: LONG TERM CARE**

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

**THIS APPLICATION MUST BE COMPLETED, SIGNED AND DATED BY THE CEO, CFO, ADMINISTRATOR, DIRECTOR OF NURSING OR RISK MANAGER OF THE PROPOSED NAMED INSURED.**

Please include the following information or documents as part of the Application, as they will be required to provide a firm quotation:

- The most recent state inspection reports and Complaint Surveys conducted within the last two (2) years (if any), including any statement of deficiencies and plan of correction; and
- The facility's current licenses; and
- Any marketing brochures; and
- Five (5) years currently valued loss runs for each coverage being requested, and by policy period.

**APPLICANT'S INFORMATION**

Desired Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Applicant Name: \_\_\_\_\_  
DBA: \_\_\_\_\_
2. Physical Address: \_\_\_\_\_
3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
4. County: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_
5. Website (if available): \_\_\_\_\_
6. Please list all subsidiaries to which this insurance will apply. Include a complete description of the operations of each subsidiary with confirmation that this Application reflects all exposures. (Please attach a separate sheet if necessary.)  
\_\_\_\_\_  
\_\_\_\_\_

**OPERATION/BUSINESS INFORMATION**

7. Date Established: \_\_\_\_\_ Years in Business Under Current Management: \_\_\_\_\_
8. Type of Enterprise:  Corporation  Individual  Partnership  Municipality  
 For Profit  Joint Venture  Other: \_\_\_\_\_
9. Revenues and Payroll:  
Total expected revenue for the upcoming year: \_\_\_\_\_  
Current Year Estimate: \_\_\_\_\_  
Last Year: \_\_\_\_\_  
Estimated payroll for the next twelve (12) months: \_\_\_\_\_

10. Type of Operation:
- |   |   |
|---|---|
| <input type="checkbox"/> Alzheimer's Adults           | <input type="checkbox"/> Dementia Adults                  |
| <input type="checkbox"/> Group Home (Elderly)         | <input type="checkbox"/> Group Home (non-Elderly)         |
| <input type="checkbox"/> Independent Living (Elderly) | <input type="checkbox"/> Independent Living (non-Elderly) |
| <input type="checkbox"/> Skilled Nursing Facility     | <input type="checkbox"/> Intermediate Nursing Facility    |
| <input type="checkbox"/> Foster Care (Children)       | <input type="checkbox"/> Other (specify): _____           |

11. Full description of services rendered: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**COVERED FACILITY GENERAL INFORMATION**

12. Covered Facility Business Name (dba): \_\_\_\_\_

a) Physical Address of Covered Facility (if different than #2): \_\_\_\_\_

b) Date Facility Opened (mm/yyyy): \_\_\_\_\_ Website (if different than #5): \_\_\_\_\_

c) Facility License Information:

<u>License Number</u>	<u>Type</u>	<u>Expiration Date</u>	<u>Restrictions*</u>	<u>Provisions/Waivers**</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* If "Yes" box is checked for Restrictions, please explain: \_\_\_\_\_

\*\* If "Yes" box is checked for Provisions/Waivers, please explain:

a) Staffing related: \_\_\_\_\_

b) Line Safety Code related: \_\_\_\_\_

13. In the last five (5) years, has this facility ever:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a) Had its license suspended or revoked?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Been the subject of any federal or state sanctions?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Been the subject of any civil monetary penalty against it or any of its staff?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Entered into any Corporate Integrity Agreement ("CIA") with the Office of the Inspector General ("OIG")? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

14. Total number of facilities or locations proposed for coverage: \_\_\_\_\_

15. Are all facilities licensed, as required, in all states where operating?  Yes  No

**COVERED FACILITY OPERATIONAL EXPOSURE DATA**

16. Resident Count / Bed Census:

<u>Bed or Resident Type</u>	<u>Bed / Resident Type Description</u>	<u>Total Licensed Beds</u>	<u># of Occupied Beds</u>
<b>Nursing Home</b>	<i>Licensed as nursing facility where resident requires 24 hour nursing care (e.g. administration of medication by injection, catheter care, physical and occupational therapy, administration of oxygen, routine changing of dressings, tube feeding, etc.). An RN provides care during the day shift. LPN coverage is required during other shifts.</i>	# _____	# _____
<b>Assisted Living / Intermediate Care (Level III)</b>	<i>May be licensed as assisted living facility or nursing facility. Resident requires more nursing supervision than Assisted Living Level II, including assistance with ADL's and regular nursing services, depending upon resident acuity and number and type of nursing services provided and may require licensed nurses on all shifts. Included in this class is a resident with Alzheimer's who requires monitoring, for example, with Wander Guard system or locked units.</i>	# _____	# _____
<b>Assisted Living (Level II)</b>	<i>Licensed as assisted living facility but where resident has lower acuity, routinely receiving assistance with more than two ADL's as well as one or two episodic nursing services. Nursing supervision is provided during the day shift, seven days a week by either RN's or LPN's; no complex nursing care. No ventilator dependent residents and no residents who cannot re-position themselves in a bed or wheelchair. May include a high functioning Alzheimer's resident (Stage 3 or less).</i>	# _____	# _____
<b>Assisted Living (Level I)</b>	<i>Licensed as assisted living facility – social model. Possible nursing supervision during the day shift, seven days a week by either RN's or LPN's; no complex nursing care. Most services are provided by unlicensed staff such as nursing assistants. Resident requires assistance with ADL's. On average, resident receives assistance with two ADL's.</i>	# _____	# _____
<b>Independent Living</b>	<i>There are generally no nursing services or assistance with ADL's provided. Resident of retirement age, providing total self care, lives self sufficiently, occupies apartment/dwelling unit including cooking facilities, does not receive health care services, and administers their own medications. Residents may engage the services of home health providers similar to other individuals in their private homes.</i>	# _____	# _____

17. Please indicate the number of residents by age group:

<18 years old: # \_\_\_\_\_  
 18 – 54 years old: # \_\_\_\_\_  
 55+ years old: # \_\_\_\_\_

18. Please indicate the number of residents that exhibit each of the following conditions:

Bi-polar disorder: # \_\_\_\_\_  
 Schizophrenia: # \_\_\_\_\_  
 Significant dementia: # \_\_\_\_\_  
 Alzheimer's: # \_\_\_\_\_

**CURRENT INSURANCE**

19. Has Applicant had previous insurance for this enterprise?  Yes  No  
 If "Yes", complete the following:

GENERAL LIABILITY		PROFESSIONAL LIABILITY	
Current Carrier		Current Carrier	
Policy Term		Policy Term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro Date, if Claims Made		Retro date, if Claims Made	

20. Are all of this facility's expiring limits, coverage trigger(s) and retroactive date(s) the same as being requested in this submission?  Yes  No

21. Is requested Employee Benefits Liability Retroactive Date the same as Professional Liability Retroactive Date?  Yes  No  
 If "No", what is requested Employee Benefits Liability Retroactive Date: \_\_\_\_\_

22. Check Coverages and Limits that the Applicant would like quoted:  
 Limits:  \$100k/\$300  \$250k/\$500k  \$500k/\$1M  \$1M/\$3M  Excess above \_\_\_\_\_

23. Does the Applicant want physical abuse/sexual molestation coverage to protect the entity for alleged acts of its employees?  Yes  No  
 If "Yes", please specify limits:  \$100k/\$300k  \$250k/\$500k

**EXPIRING INSURANCE INFORMATION**

24. Has the Applicant ever had an insurance company cancel and/or refuse to renew coverage?  Yes  No  
 If "Yes", please indicate the reason for cancellation, non-renewal or restriction:  
 Carrier withdrawal from state or line of business  
 Carrier Insolvency  
 Claims frequency and/or severity  
 Misrepresentation or fraud by Applicant  
 Applicant filed suit against carrier  
 Other: \_\_\_\_\_

**RESIDENT ASSESSMENTS**

25. Is a nursing assessment conducted for new patients?  Yes  No  
 If "Yes", does this assessment include evaluation of:

- Full body skin breakdown/Decubitis Ulcer?  Yes  No
- Mobility Limitations?  Yes  No
- History of prior injuries?  Yes  No
- Required assistance?  Yes  No
- Disorientation?  Yes  No
- Current medications?  Yes  No

26. Bedsore Information: State "None", if none: \_\_\_\_\_ Reporting Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

Please describe the protocols/procedures in place for treating bedsores: \_\_\_\_\_  
\_\_\_\_\_

27. Who completes your pre-admission assessments? \_\_\_\_\_

28. Is assessment nurse a:  RN  LVN  Other

If "Other", please describe qualifications: \_\_\_\_\_

29. Have you denied any possible admissions due to high acuity?  Yes  No

If "Yes", how many denials in the last two years? \_\_\_\_\_

What were the conditions that led you to deny them? \_\_\_\_\_

30. How often do you reassess your residents? \_\_\_\_\_

31. What system do you use to ensure timely reassessments? \_\_\_\_\_

32. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., nursing home)?

\_\_\_\_\_

33. Do residents have their own attending physician?  Yes  No

If "No", who performs the role of the attending physician? \_\_\_\_\_

If "No", how many residents utilize the Medical Director as their attending physician? \_\_\_\_\_

**ELOPEMENT**

34. Do you conduct wandering risk assessments upon admit?  Yes  No  
If "Yes", does this assessment include a cognitive assessment?  Yes  No

35. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to?  Yes  No

If "Yes", please explain the policy: \_\_\_\_\_

36. Are all exit doors alarmed at all locations?  Yes  No

If "No", please explain: \_\_\_\_\_

37. Does your facility have locked unit(s) for residents who are prone to wandering?  Yes  No

If "Yes", what system is in use? \_\_\_\_\_

38. How many residents have eloped from your facility in the last three (3) years? \_\_\_\_\_

39. What is the protocol or criteria for placing an alarm bracelet on a resident? \_\_\_\_\_

40. Is the family notified when an alarm bracelet is placed on a resident?  Yes  No

41. **SCHEDULE OF PHYSICIANS (employed or contracted)**

Name and Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted, or Employed	Has Malpractice Insurance
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

42. **STAFF**

Staff - All Locations	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
MD			
RN			
LPN			
Nurse Aids			

Staff - All Locations	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
Psychologists			
Counselors			
Therapists			
Other: _____			

43. Does the facility maintain the same staffing levels on each shift on weekends as it does on weekdays?  Yes  No

If "No", please explain: \_\_\_\_\_

44. If the facility contains any bed type other than Independent Living, does the facility have at least one (1) "awake staff" on duty 24 hours per day?  Yes  No

45. If the facility renders any Nursing Services, does the facility meet minimum state staffing levels, including the number of LPN's on duty 24 hours per day?  Yes  No

46. Please check the hiring procedures that apply or are performed by this operation:

- Criminal background checks
- Drug, alcohol and sexual abuse screening or testing
- Questioning of employees of their previous involvement as defendants in professional malpractice litigation
- Verification of certification or professional licensing
- Reference checks

47. Director of Nursing:

- a) Employment Status:  Employee  Independent Contractor
- b) Professional Credentials:  RN  LPN  Other: \_\_\_\_\_
- c) Number of years experience as a Director of Nursing: \_\_\_\_\_
- e) Number of years tenure at this facility: \_\_\_\_\_

48. Facility Administrator:

- a) Employment Status:  Employee  Independent Contractor
- b) Name: \_\_\_\_\_
- c) License Number: \_\_\_\_\_ State of License: \_\_\_\_\_
- d) Number of years experience as a Facility Administrator: \_\_\_\_\_
- e) Number of years tenure at this facility: \_\_\_\_\_

**MEDICATION ADMINISTRATION**

49. Is the unit dose medication system used by the facility?  Yes  No  
 If "No", what system is used? \_\_\_\_\_

50. Who is responsible for administering medications to the residents in the facility?  Licensed Staff  Medication Aide

51. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers' recommendations and Industry standards?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREMISES INFORMATION**

52. **Building(s)** **Location 1** **Location 2** **Location 3**

Building Construction (type)			
Year build/updated	____/____/____	____/____/____	____/____/____
Square feet			
Number of floors			
Number of licensed beds			
Number of occupied beds			
Smoke detectors in all bedrooms/hallways?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hardwire <input type="checkbox"/> Battery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hardwire <input type="checkbox"/> Battery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hardwire <input type="checkbox"/> Battery
Fire Alarm?	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None	<input type="checkbox"/> Central <input type="checkbox"/> Local <input type="checkbox"/> None
Is building fully sprinklered? If not, what % is sprinklered?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sprinklered: _____%	<input type="checkbox"/> Yes <input type="checkbox"/> No Sprinklered: _____%	<input type="checkbox"/> Yes <input type="checkbox"/> No Sprinklered: _____%

53. If multi-story building(s), please indicate on which floor non-Ambulatory/Alzheimer's is located: \_\_\_\_\_

**54. Premises/Property**

a) Are there any animal exposures on the premises?  Yes  No  
 If "Yes", please describe, including number of animals and type(s)/breed(s):

\_\_\_\_\_

b) Are there any pools, lakes, ponds, rivers or other bodies of water on the premises?  Yes  No  
 If "Yes", please describe: \_\_\_\_\_

c) If there is a pool or body of water, is it fenced?  Yes  No  
 If "Yes", does it have a self-locking gate?  Yes  No

d) Are there any firearms on the premises?  Yes  No  
 If "Yes", please describe: \_\_\_\_\_

If "Yes", are the firearms locked in a secure place, away from the residents?  Yes  No  
 If "No" to above, please explain: \_\_\_\_\_

**STATE INSPECTION**

55. Date of last State Inspection/Survey: \_\_\_\_/\_\_\_\_/\_\_\_\_
- a) Total Number of Deficiencies: \_\_\_\_\_
- b) Number of D, E, & F Deficiencies (Nursing Homes only): \_\_\_\_\_
- c) Number of G, H, & J Deficiencies (Nursing Homes only): \_\_\_\_\_
- d) Corrective Action Plan accepted by the State?  Yes  No  
If "Yes", date accepted: \_\_\_\_/\_\_\_\_/\_\_\_\_
- e) Number of complaints investigated by the State in the past 2 years: \_\_\_\_\_
- f) Number of substantiated complaints: \_\_\_\_\_

**CLAIMS HISTORY**

56. Has any application for Professional Liability or General Liability insurance made on behalf of the facility, any predecessors in business or present Partners ever been declined, or has the insurance ever been canceled or renewal refused?  Yes  No  
If "Yes", please provide details: \_\_\_\_\_

57. Has any claim, suit or regulatory proceeding ever been made against the facility or any of its employees during the past five (5) years? (Please attach a separate sheet if necessary.)  Yes  No

If "Yes", please attach five (5) years currently valued loss runs from the facility's prior insurance carrier, by line of business, and by policy period. Alternatively, or if such loss runs are not available, please complete the following information on a first-dollar basis, without considering any deductibles. (Please attach a separate sheet if necessary.)

<u>Claimant Name</u>	<u>Type of Claim*</u>	<u>Date Claim Reported (mm/dd/yyyy)</u>	<u>Paid Loss Amount</u>	<u>Outstanding Loss Amount</u>	<u>Paid Expense Amount</u>	<u>Outstanding Expense Amount</u>	<u>State of Claim (open/closed)</u>
1. _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
2. _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
3. _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
4. _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
5. _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____

\* Type of Claim: Professional Liability = PL; General Liability = GL; Employee Benefits Liability = EBL; Sexual Misconduct Liability = SML

58. Has the Applicant ever been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?  Yes  No
59. Has the Applicant ever been accused of errors by any government agency or commercial payer?  Yes  No
60. In the last five (5) years, have you experienced any claims or are you aware of any circumstances that may give rise to a claim that would have been covered by this policy?  Yes  No
61. Has any license or accreditation ever been suspended, denied or revoked?  Yes  No
62. Of what professional association(s) is the Applicant a member in good standing? \_\_\_\_\_



**DECLARATION AND SIGNATURE**

The undersigned declares that to the best of his/her knowledge, the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained in the files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

Name of Applicant: \_\_\_\_\_ Title: \_\_\_\_\_  
Please print

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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