Elderly residential care
Mainform application

Applicant information

1. Applicant name and DBA (if applicable):

2. Principal business address:

If more than one location, please complete last page of this application.

3. Telephone number:

4. Website:

5. Date established:

6. Description of professional services provided:

7. Applicant is a:

- solo practitioner (unincorporated) ☐
- solo practitioner (incorporated) ☐
- corporation (for-profit) ☐
- corporation (non-profit) ☐
- partnership ☐

8. Is the applicant/facility owned or controlled by any other entity? Yes ☐ No ☐

If Yes, describe:

9. Is your facility licensed accordance with all applicable state laws? Yes ☐ No ☐

10. Is this applicant run by a non-owned management company? Yes ☐ No ☐

If Yes, please provide the name and address of the company:

If Yes, is please provide limits of professional and general liability carried by this company: $

11. Is the applicant accredited by any of the following:

JCAHO? Yes ☐ No ☐

CARF? Yes ☐ No ☐

12. Has any license or accreditation ever been revoked or placed on probation? Yes ☐ No ☐

13. Is the applicant Medicare/Medicaid certified? Yes ☐ No ☐

14. Please state sources and amounts of total revenue:

	in last 12 months	**for next 12 months**
Fees for service	$	$
Charitable contributions	$	$
Other – specify:	$	$

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Locations information

1. Do you perform services at any non-owned locations? Yes ☐ No ☐

2. Premises information (please specify for each location on a separate sheet):
   - a. number of floors: ____
   - b. sprinklered? Yes ☐ No ☐
   - c. smoke detectors on all floors? Yes ☐ No ☐
   - d. locked doors on all resident entrances/exits? Yes ☐ No ☐
   - e. fire alarms? Yes ☐ No ☐

Resident information

1. Total number of licensed beds: ____

   Average number of occupied beds: ____

2. Resident age groups:
   - 0-17 ☐
   - 18-35 ☐
   - 36-65 ☐
   - 66+ ☐

3. Number of Alzheimer's/Dementia residents: ____

4. Number of occupied beds for the following classes of care:
   - a. **assisted living/intermediate care** – nursing care provided by RN/LPN during day shifts, assistance with daily living activities, no advanced nursing (IV therapy administration, tube feedings, etc.): ____
   - b. **independent living care** – retirement communities where residents live in apartments. Nursing care provided only on an as needed basis: ____

5. Are any of the following services provided:
   - a. sales/rental of medical equipment? Yes ☐ No ☐
   - b. mental health counseling services? Yes ☐ No ☐
   - c. home healthcare or hospice care? Yes ☐ No ☐

     If Yes:
     - i. how many patients? ____
     - ii. are home healthcare or hospice care services provided under contract with non-owned entities? Yes ☐ No ☐
   - d. respite services? Yes ☐ No ☐
   - e. pharmacy operations for non-residents? Yes ☐ No ☐
   - f. other services outside of residential care or above noted? If yes, please attach an explanation. Yes ☐ No ☐

6. Are resident evaluations performed prior to accepting a new resident? Yes ☐ No ☐

   If Yes, does the assessment include the following evaluation factors:
   - a. ulcer/pressure sore checks? Yes ☐ No ☐
   - b. mobility limitations? Yes ☐ No ☐
   - c. history of prior medical injuries? Yes ☐ No ☐
   - d. medication checks? Yes ☐ No ☐

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Administrator(s) information

1. Name of administrator(s):

2. Licensed/certified? Yes ☐ No ☐

3. Length of time at this facility:

4. Is this person a full-time administrator? Yes ☐ No ☐

Staff details

1. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Physician		
Dietician		
Physician's assistant		
Nurse aides		
LPN		
Registered nurse		
PT/OT/ST		
Social worker/counselor		
Pharmacist		
Administrative personnel		
Beautician/barber		
Other – specify:		

a. Are all of the above registered or licensed in accordance with all applicable state laws? Yes ☐ No ☐
If Yes, please attach an explanation.

b. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

c. Do you maintain certificates of insurance to confirm such coverage? Yes ☐ No ☐

d. Has the applicant or have any of the above employees/contractors:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes to any of the above, please attach an explanation.

2. Do all physicians performing direct patient care services maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐

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If Yes, please confirm the minimum limit of professional liability insurance required:

each claim $ _____ aggregate $ _____

If No, please attach an explanation.

3. Please confirm types of staff screening performed prior to hiring (check all that apply):

	Employee	Contractor
Background checks	☐	☐
License verification	☐	☐
Reference checks	☐	☐
Drug testing	☐	☐
National practitioner data bank check	☐	☐

Elopement controls

1. What precautions are taken to keep track of residents/prevent elopements?

2. Number of elopements in the past three years?

3. Are all resident entrances and exits alarmed? Yes ☐ No ☐

4. Do all resident entrances and exits have locks in place? Yes ☐ No ☐

State inspection/survey

1. What was the date of the last state inspection/survey by their respective licensing agency?

2. Any violations/deficiencies noted? Yes ☐ No ☐

   If Yes, what is the total number?

3. Any fines or penalties assessed? Yes ☐ No ☐

4. Was a corrective action plan accepted? Yes ☐ No ☐

   If Yes, please provide a copy of the accepted corrective action plan.

   If No, please describe why a corrective action plan was not accepted and/or submitted:

Insurance and claims history

1. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

   If Yes, please explain in the comments section.

2. Does any person to be insured have knowledge or information of any act, error, or omission or accident which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

   If Yes, please attach complete details including a description of the incident(s).

3. After inquiry have any professional or general liability claims been made against any proposed insured(s) during the past five (5) years? Yes ☐ No ☐

   If Yes, please complete a supplemental claim form for each claim.

4. How many claims have been made in the last five (5) years?

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5. a. List prior professional liability insurers for the past five years (if none, please tick box).

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

6. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

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It is understood and agreed that with respect to questions 21 and 22, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

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 containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the underwriters.

Name of applicant

Name/title of person authorized to execute on behalf of the applicant

Signature of person authorized to execute on behalf of the applicant:

Date

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#	Address	Licensed beds	Average occupied beds
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

General Liability
Supplemental Application

Applicant Information

1. Applicant Name:

2. Principal Business Address:

3. Number of Years in Operation:

4. Number of Full-time staff:: Part-time:

5. Nature of Your Business:

6. What is your gross sales estimate? $

7. What is your total payroll? $

Applicant Facilities

8.

#	Name & Location Address	Single Occupancy or Multiple?	Owner/ Lessee/ Tenant?	Square Footage Occupied	# of Stories	Type of Construction

General Information

9. Are all of the applicant's locations equipped with:

(a) Complete sprinkler system Yes ☐ No ☐

(b) Smoke detectors Yes ☐ No ☐

(c) Properly maintained fire extinguishers Yes ☐ No ☐

(d) At least two clearly marked exits on each floor Yes ☐ No ☐

(e) Self-closing fire doors on each floor Yes ☐ No ☐

(f) Automatic fire alarm system connected to a local fire department Yes ☐ No ☐

General Liability
Supplemental Application

(g) Emergency electrical system — Yes ☐ No ☐
(h) Heat sensors — Yes ☐ No ☐
(i) Fire escape(s) — Yes ☐ No ☐
(j) Posted emergency evacuations procedures — Yes ☐ No ☐

If "no" to any of the above, please provide additional details in the Additional Comments section below.

10. Does the applicant have a written safety program in place? Yes ☐ No ☐

11. Does the applicant have written procedures in place for incident reporting? Yes ☐ No ☐

12. Does the applicant have any:

(a) Exposure to flammables, explosives, chemicals? Yes ☐ No ☐
(b) Catastrophe exposures Yes ☐ No ☐
(c) Exposure to radioactive materials Yes ☐ No ☐
(d) Firearms on the premises? Yes ☐ No ☐
(e) Animals on the premises? Yes ☐ No ☐
(f) Machinery/equipment loaned/rented to others Yes ☐ No ☐
(g) Any storing, treating, discharging, applying, disposing or transporting hazardous materials? Yes ☐ No ☐
(h) Lake, pond, river, swimming pool or other body of water? Yes ☐ No ☐
(i) Any watercraft, docks, floats owned, hired, or leased? Yes ☐ No ☐
(j) Camp, adventure/wilderness, ropes courses or any type of recreational program? Yes ☐ No ☐
(k) Any parking facilities owned/rented? Yes ☐ No ☐
(l) Sporting/social events sponsored? Yes ☐ No ☐
(m) Steam rooms or saunas? Yes ☐ No ☐

If "yes" to any of the above, please provide additional details in the Additional Comments section below.

13. Does the applicant sell or lease any medical equipment or products to patients/clients or others in connection with this operation? Yes ☐ No ☐

If "yes", please provide the following information:

Annual gross revenue from medical equipment sales /rental:	$
Types of medical equipment:	

14. Does the applicant perform any maintenance or repairs on equipment sold or leased? Yes ☐ No ☐

15. Is the Applicant named as an Additional Insured or vendor on the manufacturer or distributor's policy for all products? Yes ☐ No ☐

[The balance of this page is intentionally left blank.]

General Liability
Supplemental Application

Insurance & Claims History

16. Has any insurer declined, cancelled or nonrenewed any General Liability policy for any person(s) or entity(ies) proposed for this insurance? Yes ☐ No ☐

If "yes", please provide additional details in the Additional Comments section below.

17. Has (have) any General Liability judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) been made against any person(s) or entity(ies) proposed for this insurance? Yes ☐ No ☐

If "yes", please provide additional details in the Additional Comments section below.

How many claims have been made in the last five (5) years? ☐

18. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any facts, circumstances or situations which might afford grounds for any General Liability claim? Yes ☐ No ☐

If "yes", please provide additional details on in the Additional Comments section below.

19a. List prior Commercial General Liability insurers for the past five years (if none, please tick box) None ☐

Insurer	Dates Covered From – To (mm/dd/yy)	Limits of Liability per Claim / Aggregate	Deductible	Premium	Coverage Type: Occurrence or Claims Made

19b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

19c. If expiring coverage exists, does coverage include products and completed operations coverage? Yes ☐ No ☐

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General Liability
Supplemental Application

Additional Comments

It is understood and agreed that with respect to all questions involving past claims history or known incidents,, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

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The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.

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