

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 Has any license or accreditation ever been revoked or placed on probation?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:	\$	\$

Elderly residential care

Mainform application

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	<input type="checkbox"/>
18-35	<input type="checkbox"/>
36-65	<input type="checkbox"/>
66+	<input type="checkbox"/>
 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? Yes No
 If yes, please attach an explanation.
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

Elderly residential care

Mainform application

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

Elderly residential care

Mainform application

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	<input type="checkbox"/>	<input type="checkbox"/>
License verification	<input type="checkbox"/>	<input type="checkbox"/>
Reference checks	<input type="checkbox"/>	<input type="checkbox"/>
Drug testing	<input type="checkbox"/>	<input type="checkbox"/>
National practitioner data bank check	<input type="checkbox"/>	<input type="checkbox"/>

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?

Elderly residential care
Mainform application

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?

Elderly residential care Mainform application

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

Elderly residential care
Mainform application

#	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

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

**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.

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:

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.

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