



**RISKCURE LONG TERM CARE PROVIDER APPLICATION**

This is an application form for a CLAIMS MADE PROFESSIONAL LIABILITY policy

**INSTRUCTIONS:**

1. Answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. Applications must be dated and be signed by an authorized principal or officer.
3. "Applicant" refers to the company, its predecessors, and all proposed Insured, including Subsidiaries.
4. PLEASE READ STATEMENT AT THE END OF THE APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.

**ADDITIONAL INFORMATION REQUIRED:**

- 5 years of currently valued loss experience reports plus the current year.
- Most recent annual audited financials
- CMS 2567 – Statement of Deficiencies and Plan of Correction (Most recent survey data)
- Current CMS 672 Resident Census and Condition of residents
- State License
- Resumes of Administrator(s) and Director of Nursing
- JCAHO Survey (if applicable)

**SECTION I – APPLICANT’S INFORMATION**

1. Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Website Address (if applicable): www. \_\_\_\_\_
4. Current Carrier: \_\_\_\_\_ Proposed Inception Date: \_\_\_\_\_
5. Limits: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_
6. Claims Made or Occurrence? \_\_\_\_\_ If CM, Retro Date: \_\_\_\_\_
7. Applicant is:

- Individual	<input type="checkbox"/>	- For-Profit	<input type="checkbox"/>
- Partnership	<input type="checkbox"/>	- Not-for-Profit	<input type="checkbox"/>
- Corporation	<input type="checkbox"/>		
- Governmental	<input type="checkbox"/>		
8. Funding is:

- Medicare	_____ %
- Medicaid	_____ %
- Private Pay	_____ %

9. Years: In operation \_\_\_\_\_ Current Ownership \_\_\_\_\_ Current Management \_\_\_\_\_
10. Long Term Care experience of current ownership \_\_\_\_\_ years
11. Does an outside management company manage this facility?  yes  no  
Name of Management Company: \_\_\_\_\_
12. Is this facility owned or leased by a multi-facility operator?  yes  no  
(If no, explain) \_\_\_\_\_
13. Is Applicant the parent company and sole owner of this facility?  yes  no  
(If yes, explain) \_\_\_\_\_
14. Is this facility a part of or associated with a hospital?  yes  no  
(If yes, explain) \_\_\_\_\_
15. Do you have any of the following subsidiary/ancillary operations?  yes  no
- Adult Day Care     Child Day Care
- \_\_\_\_\_                      \_\_\_\_\_ Maximum daily capacity
- \_\_\_\_\_                      \_\_\_\_\_ Average daily census
- Home Health Operations – Estimated number of annual visits? \_\_\_\_\_
- Other (explain): \_\_\_\_\_

**SECTION II – BUILDING INFORMATION**

16. Year Built: \_\_\_\_\_ Protection Class: \_\_\_\_\_ Square Footage: \_\_\_\_\_
17. Type of Construction:  Frame     JM     MNC     MFR/FR
18. Number of Floors: \_\_\_\_\_ Number of Exits: \_\_\_\_\_
19. Sprinklered?  yes     no                      Smoke Detectors?  yes     no  
Fire Alarms?  yes     no                      (If yes) Central or Local alarm? \_\_\_\_\_  
Please explain where sprinklers and detectors are located: \_\_\_\_\_  
\_\_\_\_\_
20. Major Renovations/Additions:  yes     no  
If yes, give dates and describe: \_\_\_\_\_
21. Was facility originally constructed for Nursing Home occupancy?  yes     no  
If no, explain: \_\_\_\_\_

**SECTION III – CLAIMS HISTORY**

22. Has any insurer cancelled, non-renewed, or declined professional liability insurance for the Applicant?  
 yes                       no
23. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being brought against you?  
 yes                       no
24. Please attach a loss run describing all claims/incidents during the past 5 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)

**SECTION IV – ADMINISTRATION / EMPLOYMENT / STAFFING**

	<u>Name</u>	<u>FT/PT</u>	<u>Employed / Contracted</u>	<u>Limits of Liability</u>	<u>Years Experience</u>	<u>Tenure at Facility</u>	<u>Licensed (Y/N)</u>
Administrator							
DON							
Medical Director							
Risk Management Contact:			Phone:			Email:	

25. Check which of the following are obtained, verified, and filed as part of your employee screening and hiring process:  applications  experience / references  education  criminal background.
26. Are Abuse Checks and Licensing Information required of all employed, agency, and private duty staff? yes no

**SECTION V – DESCRIPTION OF SERVICES**

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

- B) Other Professional Services  None
- Adult Daycare                      Number of Daily Attendees \_\_\_\_\_
- Home Health Services              Number of Annual Visits \_\_\_\_\_
- Other \_\_\_\_\_

C) Resident Age Groups

<u>Age Group</u>	<u>Number of Residents</u>
Age 0-21	_____
Age 22-50	_____
Age 51 and over	_____

**SECTION VI – POLICIES AND PROCEDURES**

**ELOPEMENT / WANDERING**

29. Is video surveillance used? yes no  
If yes, describe extent of use \_\_\_\_\_
30. Are all outside exit doors equipped with auditory alarms? yes no  
If no, explain: \_\_\_\_\_
31. Do auditory exit alarms signal at the nurses' desk? yes no
32. Can the auditory alarm be reset at nurses' desk? yes no
33. Does the facility have a wandering prevention program in place? yes no
34. If yes, explain: \_\_\_\_\_

**FALL PREVENTION**

- 35. Do you have a fall assessment protocol? yes no
- 36. Are resident falls recorded, trended and reviewed by the QAA Committee? yes no
- 37. Do you have a nurse consulting service whose duties include a fall prevention program designing and monitoring? yes no

**WOUND CARE MANAGEMENT**

- 38. Do you have an assessment protocol in addition to the RAI, MDS assessment? yes no
- 39. Describe in detail procedures for the prevention of bedsores: \_\_\_\_\_  
\_\_\_\_\_
- 40. Describe in detail procedures for the treatment of patients with bedsores: \_\_\_\_\_  
\_\_\_\_\_
- 41. Attach a copy of your skin assessment report.

**EVACUATION**

- 42. Do you have a written emergency plan?  yes no
- 43. Does your plan include advance arrangements for transportation/shelter? yes no
- 44. How often are evacuation/fire drills conducted each year for each shift? \_\_\_\_\_

**PRIOR CARRIER DETAILS**

- 45. Please provide the following current carrier details. If you have no current carrier, please provide details why.

Carrier \_\_\_\_\_

Limits \_\_\_\_\_

Deductible \_\_\_\_\_

Retro \_\_\_\_\_

Premium \_\_\_\_\_

**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 Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change, Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and coverage proposed.

Signature of Applicant's Authorized Principal or Officer:	
Title:	Date:



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