

LONG- TERM CARE FACILITIES INSURANCE PROGRAM NEW BUSINESS APPLICATION

INSTRUCTIONS:

- 1 Please complete all sections (General, Facility, Staffing-RM, Ins. Coverage, Claims & Warranty)
- 2 Sections C - H should be completed for all insured locations
- 3 Please sign and date the application on the Warranty page
- 4 Please complete the Claims Supplement if the Applicant answers "Yes" to Question 3 in Section M. Claims

CORPORATE INFORMATION:

A. Applicant Information

- 1 Corporate Name: _____
- 2 Address: _____
- 3 Website: _____
- 4 Ownership Type: Individual Corporation
 Partnership Joint Venture
- 5 Profit Status: For Profit Not For Profit
- 6 Number of facilities: _____

B. General Information

- 1 Is any part of the applicant operated / leased by a management corporation? Yes No
 If "Yes" please explain and/or provide an organization chart: _____
- 2 Has the Applicant or any associated entity ever had a license suspended, revoked, or placed under probation by any government licensing agency? Yes No
- 3 Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? Yes No
- 4 Has the applicant ever filed for bankruptcy? Yes No
- 5 Does the Applicant anticipate any facility expansions (increase in licensed beds or new facilities) within the next 12 months? Yes No
- 6 Does Applicant have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next 12 months? Yes No
- 7 Please explain any "Yes" answer for questions 1-6: _____
- _____
- _____
- _____

FACILITY INFORMATION:

Please complete a separate copy of sections C - H for each facility or building location.

Facility Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____

C. Description of Services

1 Exposures:	<u>Licensed Beds / Units</u>	<u>Occupied Beds / Units</u>
Skilled Nursing / Intermediate:	_____	_____
Sub Acute / Rehabilitation:	_____	_____
Assisted Living:	_____	_____
Independent Living:	_____	_____
Dementia / Alzheimer:	_____	_____
Home Health Services: _____ number of annual visits		Adult Daycare: _____ number of daily attendees
Is there a separate Alzheimer unit? _____ Yes _____ No		

2 Resident Groups:			
Age of Resident: Under 21:	_____ residents	21 to 64: _____ residents	65 Yrs + _____ residents
Length of Stay: 0 - 60 days:	_____ residents	61 - 180 days: _____ residents	181 + days: _____ residents

D. Physical Premises

1 Number of stories: _____	Square feet: _____	Year built: _____	
2 Construction Type:	Fire Resistive <input type="checkbox"/>	Frame <input type="checkbox"/>	Brick <input type="checkbox"/>
	Masonry Non-Combustible <input type="checkbox"/>	Other <input type="checkbox"/>	
3 Sprinklers:	None <input type="checkbox"/>	Entire Facility <input type="checkbox"/>	Common Areas <input type="checkbox"/>
4 Smoke Detectors:	None <input type="checkbox"/>	Entire Facility <input type="checkbox"/>	Common Areas <input type="checkbox"/>
5 Was the building originally designed and constructed for Nursing Home occupancy?		Yes _____	No _____
6 Does the facility maintain a centralized alarm system?		Yes _____	No _____
7 Are there alarms on all exit doors?		Yes _____	No _____

E. Daycare

1 Do you offer onsite daycare for children?	Yes _____	No _____
2 If "Yes" to the previous question, is it open to the public?	Yes _____	No _____

F. Medication Administration

1 Indicate who is responsible for administering residents medications	_____ Licensed Staff	_____ Medication Aide
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G. State Inspections (Nursing Homes Only)

1 Total number of deficiencies on most recent survey:	_____
2 Total number of deficiencies with severity level of G or higher on most recent survey:	_____
3 Total number of life safety code deficiencies on most recent survey:	_____

H. Staffing

1	Employed or Contracted	Years at this facility	Years of experience	Full-Time	Part-Time
Director of Nursing					
Medical Director					
Administrator					

- 2 Does Medical Director provide direct patient care? _____ Yes _____ No
- 3 What medical malpractice limits is Medical Director required to carry? _____
- 4 How many hours per week is the Medical Director physically at the facility? _____

5 Other Staffing:

	Employed	Contracted
MD/Physicians		
Registered Nurses		
Licensed Practical Nurses		
Certified Nursing Assistants		
Nurse Aides		
Medication Aides		
Psychologists		
Counselors		
Physical Therapists		

	Employed	Contracted
Students/Volunteers		
Pharmacists		
Dieticians		
Administrative Personnel		
Independent Contractors		
Maintenance/Security Personnel		
Beauticians/Barbers		
Other		
TOTAL # of EMPLOYEES		

- 6 Please list departments for any contracted employees that were indicated in the "Other" row: _____

7 Actual number of employees working at a time on each shift (average):

	1st shift	2nd Shift	3rd Shift	Weekends	Holidays
RNs					
LPNs					
CNAs					
Medication Aides					

- 8 Are Certificates of Insurance obtained for all independent contractors? _____ Yes _____ No
- 9 What percentage of the licensed nursing staff has been working for the applicant for more than one year? _____ %

I. Risk Management Policies and Procedures:

- 1 Is there an established risk management program? _____ Yes _____ No
- 2 Are nursing assessment protocols in place to identify residents at risk for:
- Falls: _____ Yes _____ No
- Elopement: _____ Yes _____ No
- Nutritional deficiency: _____ Yes _____ No
- 3 Is a comprehensive nursing assessment conducted for new residents? _____ Yes _____ No
- 4 Does the facility have a formalized resident complaint resolution program? _____ Yes _____ No
- 5 Who is responsible for overseeing any documents resulting from a resident complaint? _____
- 6 Are Wander Guards or similar devices used? _____ Yes _____ No
- 7 Are all visitors required to sign-in at the receptionists area? _____ Yes _____ No
- 8 Does the facility have locked doors prior to entering the reception area? _____ Yes _____ No
- 9 Is there a written evacuation plan? _____ Yes _____ No
- 10 Are evacuation plans posted in all areas of the facility? _____ Yes _____ No
- 11 Is review and "walk through" of disaster plans a part of staff orientation? _____ Yes _____ No
- 12 How often are fire/evacuation drills conducted? _____
- 13 Does the Applicant offer continuing education for their staff? _____ Yes _____ No
- 14 Does the Applicant provide an Employee Handbook to every employee? _____ Yes _____ No
- 15 Does the Applicant utilize a vendor to analyze MDS submissions? _____ Yes _____ No

N. Warranty Statement

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSONS AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL NOTIFY THE INSURER WHO MAY MODIFY OR WITHDRAW ANY QUOTATION.

THE INFORMATION CONTAINED AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER AND, ALONG WITH THE APPLICATION, IS CONSIDERED TO BE PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME PART OF THE POLICY ISSUED.

Print Applicant Name: _____
Applicant Signature: _____
Title: _____
Date: _____

Please attach the following documents to the application:

- Information on disciplinary actions or license revocations
- IF any of Applicant's skilled nursing facilities are located in PA - MCare Loss Runs
- Copy of Current certificate of Licensure
- Copy of Brochure(s) , marketing or advertising materials
- Copy of most current declarations page from professional liability policy

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for 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 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 D.C. 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 insurance company 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 HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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 LOUISIANA 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 MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 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 NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW YORK INSURANCE 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 be also subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with 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 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 RHODE ISLAND APPLICANTS: Under Rhode Island law, there is a criminal penalty for failure to disclose a conviction of arson.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO 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 ALL OTHER STATE APPLICANTS: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

1 Name of applicant: _____

2 Name of other parties or defendants named in suit: _____

3 Date of alleged occurrence: _____

4 Date claim was reported: _____

5 Name of claimant: _____

6 Name of insurance company or third party administrator handling claim: _____

7 Present status of claim or final disposition: _____ **OPEN** _____ **CLOSED**

8 Defense costs paid to date inclusive of any deductible or self-insured retention: _____

9 Indemnity costs paid to date inclusive of any deductible or self-insured retention: _____

10 Defense reserves inclusive of any deductible or self-insured retention: _____

11 Indemnity reserves inclusive of any deductible or self-insured retention: _____

12 Description of case and events including allegations and assessment of liability: _____

13 Claimant's last settlement demand: _____

Signature

Date