APPLICATION FOR NURSING HOME, ASSISTED LIVING AND INDEPENDENT LIVING FACILITIES PROFESSIONAL AND GENERAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If more space needed, attach a separate sheet. If not applicable, please state "N/A".
2. Application must be signed and dated by owner, partner or senior officer.

(PLEASE TYPE OR PRINT IN INK)

Desired Effective Date: _____

PART I – PROFESSIONAL LIABILITY

1. APPLICANT INFORMATION

a. Full name of applicant: _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip) (Risk Management Contact Person)

Phone No. _____ Email Address: _____

c. ☐ Individual ☐ Partnership ☐ Corporation ☐ Governmental ☐ For Profit ☐ Not for Profit

d. Number of Employees: Full time _____ Part time _____ Total _____

e. Number of years this facility has been: Operating ___ Owned by current owner ___ Managed by current management ___

2. OPERATIONS

a. Are you:

(i) Certified for Medicare? ..... ☐Yes ☐No

(ii) Certified for Medicaid?..... ☐Yes ☐No

(iii) Licensed and certified as required by state and/or federal law? ..... ☐Yes ☐No

(iv) Accredited by JCAHO or CARF?..... ☐Yes ☐No

(v) A member of a state or national association? ..... ☐Yes ☐No
If Yes, please identify: _____
_____

(vi) Affiliated or contracted with any HMO/PPO or Managed Care System?..... ☐Yes ☐No
If Yes, please describe: _____
_____

b. Surveys and Inspections

(i) Date of last Department of Health Survey: _____

(ii) Date of last HCFA Life Safety Inspection: _____

(iii) Date of any complaints or sentinel event investigation(s) within prior 18 months: _____
_____ ATTACH COPY OF COMPLAINT(S)

c. Facility Classification and Bed Census

	Total No. of Beds	Avg. No. Occupied
(i) Sub-acute/Rehabilitation Care Provides comprehensive inpatient care for someone who has an acute illness (i.e. stroke, heart attack), is recovering from surgery (i.e. hip or knee replacement) or utilizing life-support mechanisms such as ventilators. Sub-acute care is more nursing intensive than usual nursing home care and less intensive that hospital care.	_____	_____
(ii) Skilled Care Services Professional nursing care - 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage during other shifts. Skilled care services usually include some or all of the following: Medication administration, tube feedings, injections, catheterizations. Other procedures ordered by physicians.	_____	_____
(iii) Intermediate Care Services Nursing care during the day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feedings, etc.). Assistance with activities of daily living (i.e. walking, bathing, dressing, eating). Some assistance with medication administration.	_____	_____
(iv) Assisted Living Services Some nursing and/or health-related care to residents who do not require the degree of care and treatment described as skilled or intermediate. Residents may require some minor nursing care or help in activities such as washing, eating, bathing, dressing, walking, taking of medication, and preparation of special diets.	_____	_____
(v) Independent Living Services Retirement communities where residents live in apartments; self-sufficient; administer own medications. Nursing or personal care is provided on an incidental or emergency basis only. More than 75% of the residents over the age of 65.	_____	_____

d. Resident Classifications by Payment/Reimbursement (% of population):

Medicaid _____ Medicare _____ Private Pay _____

e. (i) Resident Classifications by Age:

Age Group	No. of Residents	% Non-ambulatory
Under 18		
18 - 35		
36 - 50		
51 - 65		
Over 65		

(ii) For Residents under age 25, please provide primary diagnosis: _____

f. Are you entered into any written indemnification agreements holding any other party harmless? ..... ☐Yes ☐No

g. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory)? ..... ☐Yes ☐No

If Yes, attach a copy of ALL of your advertisements.

h. Annual Gross Receipts: Last 12 months _____ Estimated next 12 months _____

i. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... ☐Yes ☐No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... ☐Yes ☐No

(ii) Provide the name and title of the Applicant's Privacy Officer: _____

3. SERVICES

a. Do you provide the following services? **Yes** **No** % of Patients

(i) Drug/Alcohol abuse rehabilitation ☐ ☐ _____

(ii) Psychiatric care ☐ ☐ _____

(iii) Alzheimer/Dementia care ☐ ☐ _____

b. Identify any outpatient services provided by your facility — No. of Annual Visits/Revenues

Pharmacy for non-residents/patients _____

Home Health Care _____

Physical Rehabilitation/Therapy _____

Mental Rehabilitation/Therapy _____

Adult Day Care _____

Child/Adolescent Day Care _____

c. Are any offsite recreational or field trip type activities undertaken? ..... ☐Yes ☐No
If Yes, please provide complete details: _____

d. Are any swimming pools, whirlpools, ponds or other bodies of water contained on your premises? .....☐Yes ☐No
If Yes, please describe in detail with particular attention to type of fencing present, i.e. height, locking mechanisms and level and quantity of supervision: _____

e. Is a nursing assessment conducted for new residents? .....☐Yes ☐No

If Yes, does this assessment include evaluation of:

(i) Skin breakdown/Decubiti ..... ☐Yes ☐No

(ii) Mobility limitations, history of falls ..... ☐Yes ☐No

(iii) History of prior injuries ..... ☐Yes ☐No

(iv) Required assistance..... ☐Yes ☐No

(v) Disorientation, history of wandering or elopement..... ☐Yes ☐No

(vi) Current medications ..... ☐Yes ☐No

f. Are all medications kept in a secured (locked) location with limited key access? ..... ☐Yes ☐No

g. Is the dispensing of medications properly controlled with each patient dose recorded? ..... ☐Yes ☐No

h. How long are patient records kept? _____

i. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

_____

j. Do you accept residents who are a threat to themselves or others?.. ..... ☐Yes ☐No

4. PROCEDURES

a. (i) Is smoking permitted in resident rooms? ..... ☐Yes ☐No

(ii) Are there designated smoking areas? ..... ☐Yes ☐No

Are they directly supervised by a staff member? ..... ☐Yes ☐No

(iii) Are any residents allowed to possess their own matches or lighters?..... ☐Yes ☐No

If Yes, under what circumstances? _____

b. Are there alarms on exit doors to prevent residents from leaving the premises without proper authorization? ..... ☐Yes ☐No

c. (i) Are residents with Alzheimers or Related Disorders in a secure unit?..... ☐Yes ☐No

(ii) Is "Wander Guard" or similar alert system used?..... ☐Yes ☐No

(iii) Are doors accessible to wandering residents secured with a coded key pad for entry and exit?..... ☐Yes ☐No

(iv) Number of elopements in past 12 months: _____

Number of elopements that resulted in injury to resident: _____

If any, please explain: _____

d. Is resident or legal representative/guardian approval required in writing for the use of restraints?.... ☐Yes ☐No

e. Are written procedures in effect for resident complaints/grievances?..... ☐Yes ☐No

(Questions (f) through (k) apply to Assisted Living facilities.)

f. Are all call buttons operational in each room?..... ☐Yes ☐No

If Yes, who responds: _____

g. Are all residents accounted for at least once every 24 hours?..... ☐Yes ☐No

h. Is there a 24-hour "Awake Staff" on premises? ..... ☐Yes ☐No

i. Who determines if the resident's needs are beyond the scope of the services provided by the facility?

_____

j. Are any resident services contracted to a home health care provider? ..... ☐Yes ☐No

If Yes, please describe services: _____

k. Level of Activities of Daily Living (ADL's) provided –

(i) # of residents who require assistance with:

Activity	# Dependent	# Moderate	# Independent
Medicine			
Dressing/Grooming			
Eating			
Bathing			
Toileting			
Transferring			
Ambulating			

(ii) How many residents require assistance with three (3) or more of these ADL's? _____

(iii) How many residents require two (2) person assist? _____

Describe fully: _____

(Questions (l) through (p) apply only to facilities that provide either skilled or intermediate nursing home services.)

l. Do all patients have their own attending physician? ..... ☐Yes ☐No

If No, who performs the role of attending physician? _____

_____

m. (i) Are credential files maintained for physicians? ..... ☐Yes ☐No

What are minimum credential requirements? _____

(ii) Limits of liability physicians required to carry: _____

n. Are written attending physician orders required for:

All drugs or medicines?..... ☐Yes ☐No
Special dietary requirements?..... ☐Yes ☐No
Any other specific therapy/treatment?..... ☐Yes ☐No
Use of restraints? ..... ☐Yes ☐No

o. How often are attending physicians required to update their patient charts? (No. of days) _____

p. Current resident population with Decubitus Ulcers:

Stage	# of Acquired Ulcers	# of Inherited Ulcers	Reporting Period (month/year)
I			
II			
III			
IV			

5. STAFF

a. (i) Are criminal record checks a part of pre-employment screening? ..... ☐Yes ☐No

(ii) Are state nurses aide registries checked for new hires? ..... ☐Yes ☐No

(iii) Are employment history checks a part of pre-employment screening?..... ☐Yes ☐No

(iv) Are licensure/certification checks a part of pre-employment screening?..... ☐Yes ☐No

b. For each position listed below, please respond.

	Name	Employed	Contracted	Full-Time	Part-Time	Years at This Facility	Years Experience
Administrator							
Director of Nursing							
Medical Director							

c. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

	1st Shift		2nd Shift		3rd Shift	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Physicians on Staff						
Physicians on Call						
Dentists						
Registered Nurses						
Licensed Practical Nurses						
Nurses Aides						
Physical Therapists						
Dieticians						
Beauticians/Barbers						

c. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

	1st Shift		2nd Shift		3rd Shift	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Administrative Personnel						
Maintenance/Security Personnel						
Social Workers						
Counselors						
Pharmacists						
Podiatrists						
Other – describe						
Total Number of Employees/ Independent Contractors						

d. Ratios of professional staff to occupied beds by shift: 1st _____: _____ 2nd _____: _____ 3rd _____: _____

e. Annual employee turnover rate: RNs _____ LPNs _____ CNAs _____

6. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ..... ☐Yes ☐No

b. Have you been the subject of any license suspension or revocation or been placed under probation? ..... ☐Yes ☐No

c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? ..... ☐Yes ☐No

d. Are written procedures in effect for incident reporting? ..... ☐Yes ☐No

e. Provide name and title of individual responsible for reviewing incident reports and determining whether corrective action is necessary: _____

f. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you? ..... ☐Yes ☐No
If Yes, attach an explanation.

g. Provide professional liability loss experience, currently valued, from your carrier for each of the last five (5) years. If uninsured, provide all dates and details of any incidents or payments: _____

_____

h. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

i. Does current policy cover sexual misconduct? ..... ☐Yes ☐No
If Yes, please state sub-limits, if applicable: _____

PART II - GENERAL LIABILITY

1. PREMISES INFO

a. Building Description — Buildings/Wing

	#1	#2	#3	#4
Type of Construction				
No. of Stories				
Total Beds				
Year Built/Renovated				
Complete or Partial Sprinkler System				
Use of Building				

b. Are resident care facilities equipped with:

(i) At least two clearly marked exits on each floor? ..... ☐Yes ☐No
(ii) Self-closing fire doors on each floor? ..... ☐Yes ☐No
(iii) Exit doors of at least 42 inches width from all sleeping, diagnostic and treatment rooms? ..... ☐Yes ☐No
(iv) Automatic fire alarm system connected to local fire department? ..... ☐Yes ☐No

c. Location of smoke detectors:

☐ None
☐ Hallways
☐ Common Areas
☐ Resident Rooms
☐ Other - Location: _____

Areas protected by approved automatic sprinkler system:

☐ None
☐ Common Areas
☐ Other - Location: _____
☐ Hallways
☐ Resident Rooms

d. Do you have any auxiliary electrical supply system? ..... ☐Yes ☐No

e. Are handrails provided in hallways and bathrooms? ..... ☐Yes ☐No

f. Are bathtubs/showers equipped with nonslip surfaces? ..... ☐Yes ☐No

g. Are all skilled or intermediate care resident beds equipped with siderails? ..... ☐Yes ☐No

h. Are any non-ambulatory residents on 2nd floor or higher? ..... ☐Yes ☐No
If Yes, how many? _____

i. Do individual rooms/apartments have cooking appliances?..... ☐Yes ☐No
If Yes, are they ☐ gas ☐ electric ☐ microwave only

2. PROCEDURES

a. Evacuation:

(i) Do you have a written emergency evacuation plan? ..... ☐Yes ☐No
(ii) Does your plan include advance arrangements for transportation and temporary shelter? ..... ☐Yes ☐No
(iii) Are evacuation directions posted in all parts of your facility? ..... ☐Yes ☐No
(iv) Does your staff orientation plan include a review and "walk through" of any disaster plan? ..... ☐Yes ☐No
(v) How often are evacuation/fire drills conducted each year for each shift?
Monthly/Quarterly/Annually/Other _____

3. CLAIMS/HISTORY

a. Provide general liability loss experience, currently valued, from your carrier for each of the last five (5) years. If uninsured, provide all dates and details of any incidents or payments: _____

_____

b. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? ..... ☐Yes ☐No
If Yes, attach an explanation.

c. Please list general liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

PART III - ADDITIONAL ATTACHMENTS

1. Currently-valued Professional and General Liability loss experience for past five years.
2. Current health/life safety inspections.
3. Current license.
4. Current financial statements (Balance Sheet and Income Statement).
5. Resumes of Administrator & Director of Nursing.
6. List of additional insureds, description of their operations and relationship to you.

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to XS/Group, Inc..**

_____ _____
Name of Applicant Title (Officer, Partner, etc.)

_____ _____
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify XS/Group, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.