

Long Term Care Application for Professional Liability and General Liability Insurance

Each question must be fully answered. If not applicable, please state "N/A"
(Complete a separate application for each location)

Please note: Application can be filled out on your computer, saved and emailed to your agent or underwriter

Requested effective date: _____

PART I - GENERAL INFORMATION

- 1 a. **Name of Applicant** _____
(Include full legal entity and all trade names. Attach a separate sheet if necessary)

Street address _____ City, State, Zip _____

- b. **Name of facility** _____

Physical address of facility _____ City, State, Zip _____

Telephone No: _____ Fax Number _____

Web Site: www. _____ Email address _____

- 2 a. Number of years this facility has been:

Operating _____ Owned by present owners _____ Managed by present management company _____

- b. Current Administration:

Position	Name	Years in this position at Facility	Years of Experience in position	Full Time	Part Time
Administrator					
Risk Manager					
DON/DNS					
Medical Director					

- 3 a. Organizational Structure (check all that apply):

Individual Corporation Partnership Joint Venture LLC Governmental Other _____
 For Profit Not for Profit Medicare certified Medicaid certified Accredited by JCAHO

- b. Applicant's interest in facility is: Owner Lessor Management Company Tenant. Other _____

- c. If management company, provide name and corporate address

- d. Name and address of all similar facilities managed by this management company (if not included in submission for coverage):

4. Is the applicant engaged in, owned by or associated with or involved in any other enterprise?

Yes No If yes, please describe _____

5. Is the facility licensed by the state that they operate in? Yes No

- a. Has license ever been revoked or suspended? Yes No
If so, please provide full details _____
- b. Has there been a disruption in Medicare or Medicaid certification? Yes No
If so, please provide full details _____

6. Surveys and Inspections:

- a. Date of last Dept of Health survey: _____ b. Date of last HCFA Life Safety Inspection: _____
- c. Date of last Fire Marshall Inspection: _____
- d. Date of any complaints or sentinel event investigation(s) within prior 18 months? _____ ATTACH COPY

PART II – DESCRIPTION OF SERVICES

1.a. Beds:	Number of Licensed Beds	Number Occupied
<p>SUBACUTE/REHAB CARE - Provides comprehensive inpatient care designed for someone who had an acute illness, injury, or exacerbation of disease process. It is a goal-orientated treatment requiring the coordinated services of an interdisciplinary team and rendered immediately after, or instead of, acute hospitalization to treat one or more complex medical conditions. Subacute is generally more intensive than traditional nursing facility care and less intensive than acute inpatient care.</p>	_____	_____
<p>SKILLED NURSING CARE – Inpatient nursing services to residents requiring 24-hour medical and nursing care. Skilled care services usually include some or all of the following: I.V., medical administration, suctioning, tube feeding, catheterization, other procedures ordered by physicians.</p>	_____	_____
<p>INTERMEDIATE CARE – Inpatient nursing services to residents, but not a continuous basis. Residents may require some minor nursing care or help in daily activities such as taking of medications, bathing, dressing, and walking.</p>	_____	_____
<p>ASSISTED/RESIDENTIAL CARE – Provides minimal nursing services to residents with possible minor medical disorders, but only as an adjunct to its primary residential or sheltered care function. May assist individuals with their everyday essential activities.</p>	_____	_____
<p>INDEPENDENT LIVING – Retirement communities where residents live in apartments, and nursing care or personal care services are available on an incidental or emergency basis.</p>	_____	_____
<p>OTHER (please describe):</p>		

- b. Other Professional Liability Exposures: If none, please check here
- Adult Day Care # of Licensed beds _____ # of client days per year _____
- Hospice Care # of residents _____
- Home Health Care # of visits per year _____

Respite Care # of client days per year _____
 Child Day Care **NOTE: We are unable to provide coverage for this service.**
 Other _____

c. Provide percentage of payment/reimbursement in each category:

Medicaid: _____ Medicare: _____ Private Pay: _____ Other: _____

2. Patient Census – Residents receiving services relating to:

Service	# Ambulatory	# Non-Ambulatory
Skilled Nursing Care		
Intermediate Nursing Care		
Alzheimer/Dementia		
Rehabilitation (P/T, O/T, S/T)		
Drug or Alcohol Rehabilitation		
Psychiatric Care		
Mental Retardation		
Subacute/Rehabilitation		
Other (specify):		

3. Patient Ages:

Age Group	# of Designated/Licensed Beds	# of occupied beds
Less than 25		
25 – 54		
55 – 64		
Over 65		

Youngest: _____ Oldest: _____ Average Age: _____

For residents aged 0 – 25, please provide primary diagnosis: _____

PART III – ADMISSION POLICIES

1. a. Is a nursing assessment conducted for all new residents, including readmissions? Yes No
 If yes, does this assessment include the evaluation of:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Mobility limitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of skin problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	History of prior injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of falls
<input type="checkbox"/> Yes <input type="checkbox"/> No	Required assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric history
<input type="checkbox"/> Yes <input type="checkbox"/> No	Disorientation, history of wandering or elopement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cognition limitations
- b. Are attending physician written orders required for admission? Yes No
- c. Do you accept residents who are a threat to themselves or others? Yes No
- d. Is a current (within last 60 days) physical required before admission? Yes No
- e. How often is the care plan updated? _____
- f. Do you accept residents who require or utilize any type of artificial ventilation, including any residents who utilize respirators, ventilators, or require any tracheotomy care? Yes No
If yes, please complete the Supplemental Application for facilities providing Ventilation and/or Tracheotomy Care.
2. Do residents have their own attending physician? Yes No
 If no, who performs the role of the attending physician? _____
 How many residents utilize the Medical Director as their attending physician? _____

PART IV – RISK MANAGEMENT

- | | | |
|---|------------------------------|-----------------------------|
| 1. Is there a corporate Risk Management Program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Risk manager responsibilities: | | |
| a. Loss control: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Identification and investigation of potential claims: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Safety/Security: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the risk management program include the following: | | |
| a. Incident Reporting/Critical Indicator Screening: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Claims Management: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Patient complaint/grievance procedures: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Contract review and evaluation: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is there a written emergency plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. Does the plan include advance arrangements for transportation/shelter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Are evacuation directions posted on all parts of your facility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does your staff orientation plan include a review and walk thru disaster plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

PART V – MONITORING & CONTROLS

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are residents allowed to leave the premises unattended?
If yes, what procedures have been implemented to monitor their whereabouts? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Fall prevention: | | |
| a. Do you have a fall prevention program? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Does it include an assessment tool for identifying patients at risk for falls? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Are fall precautions implemented based on level of risk determined by assessment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Are falls monitored and tracked to identify patterns or problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Are handrails provided in halls and bathrooms? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Are the bathtub and shower flooring nonskid? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Are call buttons operational in each room? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| h. Are all residents accounted for at least once every 24 hours? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Is there a 24-hour "Awake Staff" on premises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Alzheimer's/Dementia or Mentally Impaired Residents: | | |
| a. Please check the most appropriate | | |
| <input type="checkbox"/> The entire facility is designed for Specialized Alzheimer's or Related Disorders | | |
| <input type="checkbox"/> There is a Specialized Alzheimer's Unit within the facility | | |
| <input checked="" type="checkbox"/> There is no special Alzheimer's or Related Disorders Unit. Residents are integrated into the overall population. | | |
| b. What is the screening process for residents at risk for wandering? Check all that apply. | | |
| <input type="checkbox"/> Preadmission assessment | | |
| <input type="checkbox"/> Elopement Risk Assessment completed on admission | | |
| <input type="checkbox"/> Assessment completed <input type="checkbox"/> quarterly <input type="checkbox"/> annually <input type="checkbox"/> other _____ | | |
| <input type="checkbox"/> Staff reports wandering behavior to DON or Social Worker for follow up | | |
| <input type="checkbox"/> None of the above | | |

c. How are resident at risk for wandering protected by your staff? Check all that apply:

Doors accessible to wandering residents are secured with a coded keypad for entry and exit

All Some None

Exits are equipped with "WanderGuard" or a similar wander alert system

All Some None

Windows only open to a secure courtyard or other fenced area

All Some None

Unsecured doors open to a secure courtyard or other fenced area

All Some None

Unsecured windows open to a secure courtyard or other fenced area

All Some None

Unattended doors have exit alarms that must be turned off

at the door from the nurses station or another remote location

d. If "WanderGuard" or similar alert system is used? Yes No If yes, check all that apply:

The system is checked for defaults on what basis?

daily weekly monthly

A "dummy" bracelet is used by staff to check the system on what basis?

daily weekly monthly

A system is in place to report malfunctioning bracelets and alarm defects

Yes No

Alternate methods are in place in the event of system failures

Yes No

Arm or ankle bands are checked for accurate activation, damage and proper fit on what basis?

daily weekly monthly

Door alarms are checked for proper operation on what basis?

daily weekly monthly

e. Does the behavior management program include:

Behavior Management Programs are in place for individualized behavior?

Yes No

Activities Programs are individualized per resident?

Yes No

Group activities are conducted _____ times per week

Structured Activities are planned and conducted by a registered or certified staff member specifically trained for the residents? Yes No

f. Elopement Management

Number of elopements in past 12 months _____

Number of elopements in past 12 months that resulted in injury to resident _____

Number of elopements in past 12 months that resulted in death of resident _____

Attach a copy of your incident reports for each of the missing resident/elopement incident(s)

4. Physical and chemical restraints:

a. Is there a program in place to reduce the use of restraints?

Yes No

b. Are restraints used only as a last resort after less restrictive alternatives have been tried?

Yes No

c. Is the use of restraints continuously evaluated and monitored?

Yes No

d. Is physician evaluation and written notice from the physician (except in the case of emergency) required for the use of chemical or physical restraints?

Yes No

e. Is patient or patient's legal representative/guardian required to approve the use of chemical or physical restraints in writing?

Yes No

f. Chemical restraints are currently in place for (enter number) _____ of residents

g. Physical restraints are currently in place for (enter number) _____ of residents

h. What type of physical restraints are used?

Lap buddies

Waist belts

Chest or vest restraints

Geri chairs

Side rails

Lap trays

Other _____

i. Are any restraints applied while the resident is in bed? Yes No

5. Skin Care

- a. Are there written policies and procedures for the prevention and treatment of skin breakdown? Yes No
- b. Are all patients evaluated for skin breakdown and risk of breakdown at the time of admission? Yes No
- c. Are there policies and procedures for skin care and treatment based on the resident's condition? Yes No
- d. How often do nurses perform total body skin assessments? _____
- e. Is there a wound care nurse on staff? Yes No

Current resident population with Decubitus Ulcers:

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

6. Medications:

- a. Are medications self-administered? Yes No
- b. If yes, what percentage of residents self-administer? _____% Does this include injections? Yes No
- c. Who dispenses medications to the residents? RN LVN Medication Aide Other _____
- d. Where are medications stored? _____
- e. Are medications kept under locked conditions? Yes No
- f. Do only authorized personal have keys? Yes No
- g. How are medications packaged when received from the vendor? (ie. bubble pack, etc.) _____
- h. Is there a system in place to track medication errors? Yes No
- i. What is your medication error rate for the last month? _____ as of _____
- j. Are physician orders required for all medications including over the counter medications? Yes No

7. Smoking policies and procedures:

- a. Are any residents allowed to smoke unattended? Yes No
If yes, under what circumstances? _____
- b. Are residents allowed to possess their own matches or lighters? Yes No
If yes, under what circumstances? _____
- c. Is smoking allowed in the residents' room? Yes No
- d. Where are the designated smoking areas? Inside Outside
- e. Are smoking areas directly supervised by a member of the staff? Yes No
- f. Are fire alarms in place and fully functional in all smoking areas? Yes No

PART VI - STAFFING

1. Staff/Resident ratios over a 2 week time period; Average Census: _____

Provide total number of standard daily staff working on each shift below:

Staff member	Day Shift	Evening Shift	Night Shift	Carry their own malpractice insurance?
DON/ADON				<input type="checkbox"/> Yes <input type="checkbox"/> No
RN				<input type="checkbox"/> Yes <input type="checkbox"/> No
LPN				<input type="checkbox"/> Yes <input type="checkbox"/> No
CNAs				<input type="checkbox"/> Yes <input type="checkbox"/> No
Resident Assistants				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Aide				<input type="checkbox"/> Yes <input type="checkbox"/> No
Contracted Physicians				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

- a. Annual employee turnover rate: RNs: _____ LPNs: _____ CNAs: _____
- b. Describe procedure for maintaining copies of current licenses for all licensed employees and/or contractors. _____
2. a. Is the facility a drug and alcohol free workplace? Yes No
- b. Is 24-hour supervision of all employees provided? Yes No
3. Employee Screening:
- Does the employee screening/hiring process include the following:
- a. Education Yes No
- b. Licensure/certification Yes No
- c. Employment history Yes No
- d. Criminal background check Yes No
- e. Drug Screening Yes No
- f. Skills assessment and verification Yes No
- g. Abuse registry Yes No
- h. Are pre-employment physicals, including mobility screening required of all employees? Yes No
4. Does the applicant utilize temporary nurses/nursing registry? Yes No
If yes, what is the percentage of temporary nurses/nursing registry? _____
5. Are volunteers utilized? Yes No
- If yes, describe selection process and training provided: _____
- Is there a written screening and selection process? Yes No
6. Describe training for all NEW employees for each class of employee:
RN: _____
LPN: _____
RESIDENT ASSISTANTS: _____
DRIVERS: _____
OTHER (SPECIFY): _____
7. Are employees competencies assessed? Yes No
If yes, list positions and frequency of testing: _____
8. How many in-service hours are required for employees on an annual basis? RNs: _____ LPNs: _____ CNAs: _____

PART VII – OTHER EXPOSURES

1. Recreational facilities: Check all that apply
- None
- Swimming Pool Please provide description including depths, supervision and location _____
- Fenced Yes No Fence height: _____
- Locked Yes No Lock type: _____
- Are residents permitted to use the pool without staff present? Yes No
- Do any of the units open directly to the pool? Yes No
- Is the pool Indoors Outdoors
- Exercise/Weight room
- Sauna/Hot Tub area
- Other recreational facilities _____
2. Fully describe all bodies of water on the premises, their use and safeguards currently in place:

3. Are there any sporting events involving residents Yes No If yes, fully describe _____
4. a. Is alcohol served or allowed on the premises? Yes No
 b. If so, fully describe under what circumstances, how often and for what purpose? _____
 c. Amount of receipts generated from such sales \$_____
5. Are pets allowed on the premises? Yes No If yes, under what circumstances? _____
 Are owners required to provide proof of all necessary vaccinations? Yes No
6. a. Fully describe all off premises activities sponsored or conducted by the facility in the past three months. (You may attach your activities calendar.)

 b. As respects all of the above recreational or offsite activities:
 are they restricted to resident use only? Yes No
 may the public use the facilities or be a part of the outings? Yes No
 If the public is included, please provide full details: _____

PART VIII - TRANSPORTATION

1. Does the facility own or lease vans or other vehicles? Yes No
 a. If yes, fully describe the use of these vehicles _____
 b. If the facility does not own any vehicles for the use of transporting residents, is this service contracted to a third party?
 Yes No If yes, who assists residents into the contracted vehicles? _____
2. Does the facility provide transportation to facility sponsored activities? Yes No
3. What safety equipment is standard on the facility owned vehicles? _____
4. Are employed drivers trained in the proper use of the safety devices? Yes No
5. Do employees transport residents in their own automobiles? Yes No
6. Are residents allowed to use public transportation unassisted and unattended? Yes No
7. Are there written transportation arrangements for residents at time of medical emergencies? Yes No
 If yes, outline the procedure to be followed: _____

PART IX - CONTRACTUAL AGREEMENTS

Please indicate which of the following services you utilize on a contracted basis:

		Do you verify on an annual basis?		
Service	Check all that apply	Licenses		Certificates of Insurance
Physician		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nursing		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laboratory		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recreation Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Therapy (PT, OT, Speech)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmaceutical		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietary		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Records		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barber/Beautician		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exterminator		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART X - DESCRIPTION OF BUILDING

If multiple buildings, answer for each on a separate page

1. Is the applicant: building owner tenant general lessee
2. Was the building originally designed and constructed for elder care occupancy? Yes No
If no, what was the original building occupancy? _____
3. Does this location meet all applicable NFPA life safety codes? Yes No
4. Has your facility ever been inspected or tested for mold, spores, fungus, mildew, yeast and/or other toxins? Yes No
If any of the foregoing were discovered, were proper steps taken to remove, contain, clean up or treat these toxins?
 Yes No If no, please explain in detail: _____
Have steps been taken for prevention of future occurrences? Yes No Please explain in detail: _____

5. Check areas where the following are located:

	Smoke Detectors	Sprinklers
None		
Common areas		
Hallways		
Resident Rooms		
Other		
Other		

6. a. Are smoke detectors hard wired to central station? Yes No
Where is the automatic contact?
 Fire Department Nurses station Office
 Other _____
7. a. Construction of building _____
b. Year built _____ Year Remodeled _____ Years of Additions _____

c. Type of wiring _____ Year wiring was last updated _____
 Does the facility have a back-up power supply? Yes No
 If yes, please describe: _____

d. Number of floors _____

8. Number of non-ambulatory residents on each floor
 1st _____ 2nd _____ 3rd _____ 4th _____

9a. Number of fire escapes/exits _____ b. Number of fire extinguishers _____

10. How often are evacuation and fire drills conducted each year? _____ On all shifts? Yes No

11. Does the applicant contemplate any new construction for this year? Yes No
 If yes, please provide details: _____

PART XI - CURRENT INSURANCE

1. Does the facility have Worker's Compensation coverage in force? Yes No

2. a. Has facility had previous general liability AND professional liability insurance? Yes No
 If yes, who is the insurance carrier? _____

b. What are the current limits of liability? _____

c. What is the current policy form? Occurrence Claims made
 If claims made, what is the retroactive date? _____

d. What is the expiring:
 Premium \$ _____
 Deductible \$ _____
 Policy period From: _____ To: _____

3. a. Does current policy provide coverage for physical/sexual abuse & molestation? Yes No
 If yes, what are the limits of liability? _____

b. Was there a separate charge for this enhancement? Yes No

4. Does current policy provide coverage for defense in addition to the limit of liability? Yes No

5. Does current policy provide coverage for Punitive Damages? Yes No
 If yes, was there a separate charge for this enhancement? Yes No

6. Is the current carrier offering renewal? Yes No

If no, please attach a copy of the non-renewal notice.

7. If carrier is offering renewal, explain reason for submitting account to us _____

8. Please list the prior 5 years of professional and general liability insurance carriers, effective dates and policy numbers.

Effective Dates	Carrier	Policy Number

PART XII - CLAIMS HISTORY

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you?
 Yes No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS
IF NO PRIOR COVERAGE, ADVISE ANY AND ALL CLAIMS**

2. Is the applicant facility, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No
If yes, provide full details. _____

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? Yes No If yes, fully describe the circumstances and follow up action taken. _____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

*Notice applicable in most states:

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature/Title

Date

For ALL facilities, provide the following:

- Hard copy, currently valued loss runs for the last 5 years
- Copy of the most recent state inspection (HCFA2567 and HCFA2567L) and/or any other regulatory inspection
- Copy of most current fiscal year Balance Sheet and Statement of Profit and Loss
- Accord General Application (if more than one location)
- Copy of the current license
- Copy of the Resident Services Contract
- Current 6 month Facility Quality Indicator Profile and Facility Characteristics Report
- Diagram of the facility
- List of Additional Insureds requested including the relationship to applicant
- Marketing brochures and Advertisements (if applicable)
- Most recent quarterly in-service calendar
- Resumes of key personnel including DON/DNS & Administrator (as applicable)