NATIONAL FIRE & MARINE INSURANCE COMPANY

Omaha, Nebraska

SENIOR CARE APPLICATION

INSTRUCTIONS

1. Please print legibly. If the application is approved, the policy will be based on the information provided.
2. Please answer all questions. If a question is not applicable, print, "N/A".
3. If additional space is needed, please use the Supplemental Information section at the end of the application with a reference to the question or an additional form.

I. PARENT COMPANY INFORMATION

A. Parent Company Name: _____

Parent Company Address: _____

City: _____ State: _____ Zip: _____

B. Description of Parent Company (check all that apply):

☐ For-Profit ☐ Not-for-Profit ☐ Hospital Affiliated ☐ CCAC Accredited Religious Affiliated? ☐Yes ☐No ☐ACO

☐ Individual ☐ Partnership ☐ Corporation ☐ JCAHO Accredited ☐ CCRC

C. How many years has the parent company been under current ownership? _____

D. How many facilities does the parent company own? _____

E. Is a management company utilized to manage the Applicant's operations? ☐Yes ☐No

If yes, please provide the following:

1. Name of the management company: _____
2. How many years has this management company been engaged? _____ *Provide a copy of the management contract.*

F. Please list the officers or general partners of the parent company:

Name	Title	Status
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive

G. During the next 12 months, are there any plans for mergers, acquisitions, sale of assets or business or change in services? ☐Yes ☐No

II. APPLICANT INFORMATION

If there are multiple locations, please complete the attached Additional Location Supplement.

A. Applicant Name: _____

DBA Name: _____

Applicant Address: _____

City: _____ State: _____ Zip: _____

Federal Employer ID Number: _____ Provider ID: _____

Contact Name: _____ Telephone: ____ - ____ - _____

Email Address: _____ Fax: ____ - ____ - _____

B. Has any insurance carrier cancelled or refused coverage, similar to that being applied for here, in the past three (3) years? ☐Yes ☐No

If yes, please explain: _____

C. Has any claim or suit been made against the Applicant for alleged medical professional malpractice, error or omission in the past five (5) years? ☐Yes ☐No

D. How many years has the Applicant been under current ownership? _____

E. How many years has the Applicant been under current management? _____

F. Are all applicable permits up to date? ☐Yes ☐No

If no, please explain: _____

III. SUBSIDIARIES

A. Please list all subsidiaries of the Applicant:

Name	Location	Description of Operations

IV. APPLICANT CREDENTIALS

A. Please list all licensing and accreditation information for the Applicant:

	Type / Number	Expiration Date	Restrictions?	Provisions?
License:			☐Yes ☐No	☐Yes ☐No
License:			☐Yes ☐No	☐Yes ☐No

B. Does the Applicant maintain any association memberships? _____ _____ _____ _____

C. What was the date of the Applicant's last inspection/survey? ____/____/_____

D. What was the total number of deficiencies? Total: ____ D, E, F, G deficiencies: ____ F, H, I, J, K, L deficiencies: ____

E. Was a Corrective Action Plan submitted to and accepted by the State? ☐Yes ☐No

F. How many complaints were made against, and investigated by, the Applicant in the past three (3) years? _____
Of those complaints, how many complaints against the Applicant were substantiated? _____

G. Is the Applicant approved to accept Medicare? ☐Yes ☐No
If yes, what is the number of Medicare-eligible beds? _____

H. Is the Applicant approved to accept Medicaid? ☐Yes ☐No
If yes, what is the number of Medicaid-eligible beds? _____

I. In the past five (5) years:
1. Has the Applicant's license been suspended, revoked or been placed on probation? ☐Yes ☐No
2. Has the Applicant's Medicare or Medicaid Certification been revoked or suspended? ☐Yes ☐No
3. Has the Applicant been fined by a state or federal agency? ☐Yes ☐No

V. CLASSIFICATION

A. **Select the level of care based upon the Applicant's license**. If the license is not specific with respect to the level of care, select the level of care that best describes the primary medical services provided by the Applicant. Please indicate the number of total licensed beds.

Sub-Acute Care:	Dedicated beds for the care of medically fragile residents requiring more intensive care than provided in skilled nursing. Including intravenous tube feeding, tracheotomy care, ventilator care and complex wound care. Total Licensed Beds: ____ Average Occupancy: ____
Skilled Nursing:	Administration of medication by injection, catheter insertion, sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding. Total Licensed Beds: ____ Average Occupancy: ____
Memory / Alzheimer's Care:	Dedicated beds for the care of residents with memory loss or impairment; Alzheimer's care and services. Total Licensed Beds: ____ Average Occupancy: ____
Assisted Living:	Housing, personalized supportive services, health care services or a combination thereof, designed for persons who are generally able to care for themselves. Assisted Living provides a protective environment, meals, assistance with medications, group socials and spiritual activities, etc. Total Licensed Beds: ____ Average Occupancy: ____
Independent Living:	Residents are of a retirement age, however residents engage in total self-care, they live self-sufficiently, and they occupy apartment/living units which include cooking facilities. Residents do not receive health care services or administer their own medications without assistance. A full time caretaker resides on the premises. a. What is the total number of living units? _____ b. At full occupancy, what is the total number of residents? _____ c. Are there common dining facilities? ☐Yes ☐No d. Do individual living units have appliances for cooking (excluding microwaves)? ☐Yes ☐No If yes, please check the type: ☐Gas ☐Electric e. Is there a daily process or procedure to keep track of residents? ☐Yes ☐No If yes, please explain the process/procedure: _____ f. Are home health aides allowed? ☐Yes ☐No If yes, please provide the following: 1. Are the home health aides independent contractors? ☐Yes ☐No 2. Are the home health aides under contract with the Applicant? ☐Yes ☐No g. Are there licensed nurses on staff? ☐Yes ☐No If yes, please provide the following: 1. What hours are the licensed nurses available to residents? _____ 2. What services do the licensed nurses provide to residents? _____
Home and Community Based Services:	Services provided may include handyman services, hospice care, rehabilitation therapy, respiratory services or skilled nursing care. Additionally durable medical equipment, home health aides, oxygen suppliers, prosthetics/orthotics, or homemakers may be supplied. Number of visits: _____ Receipts: _____ Attach a description of operations.
Adult Day Care:	☐ Social Services Total Participants: _____ ☐ Enhanced Services (Mentally Challenged) Total Participants: _____ Social Services include, but will not be limited to: crafts, games, shopping trips or other intergenerational programs. Promotion of wellness and socialization programs, as well as music and educational programs may be provided. Enhanced Services are provided to persons who are mentally challenged, cognitively impaired, developmentally disabled or chronically ill. Enhanced Services include Social Services, but may also include, but will not be limited to, additional services such as: medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, physical therapy, occupational therapy and speech.

V. CLASSIFICATION (continued)

B. What is the percentage of residents based upon the below age ranges?
___ < 30 ___ = 30-64 ___ = 65-74 ___ = 75-84 ___ = 85-94 ___ > 94

C. Does the Applicant have any residents under the age of 64? ☐Yes ☐No
If yes, please explain: _____

D. Are there any swimming pools onsite? ☐Yes ☐No
1. Is it an indoor or outdoor pool? _____
2. Is it open to the public? ☐Yes ☐No
3. Is the pool locked when not in use? ☐Yes ☐No
4. Is there a fence around the pool? ☐Yes ☐No
5. Is a lifeguard on duty full-time? ☐Yes ☐No
6. Is there a diving board/sliding board? ☐Yes ☐No
7. Are there depth markings? ☐Yes ☐No
8. Are there daily maintenance processes and procedures in place? ☐Yes ☐No

E. Are there any other bodies of water present? ☐Yes ☐No
If yes, please provide the following:
1. Please describe the bodies of water present: _____
2. Are there any barriers, fences or other safeguards in place around the bodies of water? ☐Yes ☐No

F. Are there any saunas and/or hot tubs? ☐Yes ☐No
If yes, please provide the following:
1. How many? _____
2. Is there a lifeguard or attendant on duty? ☐Yes ☐No
If yes, how many hours per day is the lifeguard/attendant on duty? _____

G. Are there tennis/racquetball/handball courts? ☐Yes ☐No
If yes, how many courts? _____

H. Is there an exercise/weight room? ☐Yes ☐No
If yes, please provide the following:
1. How many different exercise/weight rooms? _____
2. Is there an attendant on duty? ☐Yes ☐No
If yes, how many hours per day is the attendant on duty? _____
3. Are there treadmills? ☐Yes ☐No

I. Are there covered parking facilities? ☐Yes ☐No
If yes, how many parking spaces? _____

J. Is there a community center? ☐Yes ☐No
If yes, what is the square footage? _____

K. Is the facility used by persons other than residents? ☐Yes ☐No
If yes, please describe: _____

L. 1. Is there a restaurant that is open to the public? ☐Yes ☐No
If yes, what are the gross receipts? $_____
2. Does the facility have a liquor license? ☐Yes ☐No
If yes,
a. Is alcohol served? ☐Yes ☐No
b. is there a per drink charge? ☐Yes ☐No
c. Is alcohol served only at dinner? ☐Yes ☐No
d. Is there a happy hour? ☐Yes ☐No

M. Are pets allowed in the facility? ☐Yes ☐No
If yes, are vaccinations required and documentation maintained by the Applicant? ☐Yes ☐No

VI. ADMINISTRATOR

A. Name of Administrator: _____ License Number: _____ State: _____

B. Length of time employed by, or working with, the Applicant: _____

C. How long has the Administrator been working as the Nursing Home Administrator (NHA)? _____

D. Does the Administrator work full time with the Applicant? ☐Yes ☐No

E. How many hours does the Administrator work at this facility per week? _____

VII. NURSE STAFFING

A. Name of the Director of Nursing (DON): _____ Professional credentials: ☐RN ☐LPN

Length of time employed by, or working with, the Applicant: _____ How long has the DON been working as the DON? _____

B. 1. What is the total number of employed nurses? _____
2. Please list the total number of employed nurses by category:

Category	1st shift	2nd shift	3rd shift	Turnover %
RN				%
LPN/LVN				%
CNA/Personal Caregiver				%
Agency				%
Pool				%
Nurse Practitioner				%

C. Does the Applicant require employed nurses to carry malpractice coverage? ☐Yes ☐No
If yes, does the Applicant obtain and review the employed nurses' certificates of malpractice insurance? ☐Yes ☐No

D. Does the Applicant verify the nursing licenses of employed nurses upon hire and annually thereafter? ☐Yes ☐No

E. Does the Application verify nursing assistant certifications of employed nursing assistants upon hire and annually thereafter? ☐Yes ☐No

F. Are background checks completed for agency and pool employees? ☐Yes ☐No

G. What was the Applicant's prior year's employee turnover rate? _____%

VIII. PHYSICIANS AND MEDICAL DIRECTOR

A. Number of physicians: Employed: _____ Affiliated: _____ Contracted: _____

B. Number of physician assistants: Employed: _____ Affiliated: _____ Contracted: _____

C. Does the Applicant request and review physicians' certificates of malpractice insurance? ☐Yes ☐No

D. Does the Applicant require that physicians maintain limits of liability equal to its own? ☐Yes ☐No
If no, please explain the differences in limits: _____

E. Are the physicians credentialed? ☐Yes ☐No
If yes, do credentialing activities include the following:
1. Verification of a current professional medical license? ☐Yes ☐No
2. Verification of a current DEA license? ☐Yes ☐No

F. Name of Medical Director: _____ License Number: _____ State: _____

G. Length of time as the Applicant's Medical Director: _____ Medical Specialty: _____

☐ Full time at this facility ☐ Part-time at this facility Number of hours at this facility per week: _____

H. Does the Medical Director also act as the attending physician to any residents? ☐Yes ☐No
If yes, how many residents? _____

I. Is there an annual evaluation of the Medical Director's performance? ☐Yes ☐No
If yes, please define: _____

J. Is the Medical Director:
1. Involved in credentialing the Applicant's medical staff? ☐Yes ☐No
2. An active participant in the Applicant's quality improvement program? ☐Yes ☐No
3. Involved with the peer review of physicians? ☐Yes ☐No

K. Is a physician on site or on call on a 24-hour basis? ☐Yes ☐No

IX. STAFF/EMPLOYEE SELECTION AND HIRING

A. Is there a formal, documented assessment process to measure the competency skills of staff members? ☐Yes ☐No

B. Does the Applicant conduct a new-hire orientation? ☐Yes ☐No

C. Does the Applicant conduct regularly scheduled in-service education programs for all staff/employees? ☐Yes ☐No

D. How are new employees recruited by the Applicant? _____

IX. STAFF/EMPLOYEE SELECTION AND HIRING (continued)

E. Does the background verification check performed by the Applicant on a new employee include a review of the following:

1. Work history? ☐Yes ☐No
2. Education? ☐Yes ☐No
3. Criminal record? ☐Yes ☐No
4. Driving record - Motor Vehicle Record (MVR) when appropriate? ☐Yes ☐No
5. Drug testing? ☐Yes ☐No
6. Abuse registry? ☐Yes ☐No
7. Other, please describe: _____

X. NON-RESIDENT AND ADDITIONAL SERVICES PROVIDED

A. **Home Health Care**

Is the Applicant a licensed home health care center? ☐Yes ☐No

If yes, please provide the following:

1. Gross receipts: $_____
2. Number of home health care visits or clients per year: _____
3. Is home health care provided by independent contractors? ☐Yes ☐No
4. Describe the home health care services provided by the Applicant: _____

B. **Adult Day Care**

Is the Applicant a licensed adult day care center? ☐Yes ☐No

If yes, please provide the following:

1. Total number of licensed centers: _____
2. Average occupancy: _____
3. Hours of operation: _____
4. Number of employees: _____
5. Does the Applicant provide transportation to and from the facility? ☐Yes ☐No
6. Does the Applicant provide transportation to and from events? ☐Yes ☐No
7. Does a physician perform a physical examination prior to admission? ☐Yes ☐No
   If yes, please describe: _____
8. Does the Applicant provide medical services? ☐Yes ☐No
   If yes, please describe: _____

C. **PACE (Program of All Inclusive Care for the Elderly)**

Is the Applicant a licensed PACE center? ☐Yes ☐No

If yes, how many participants? _____ *Please complete a PACE questionnaire.*

D. **Children Day Care**

Is the Applicant a licensed children day care center? ☐Yes ☐No

If yes, please provide the following:

1. Total number of licensed centers: _____
2. Average occupancy: _____
3. Hours of operation: _____
4. Number of employees: _____
5. Number of children: _____
6. Number of employee's children: _____
7. Does the Applicant provide any transportation for children? ☐Yes ☐No
   If yes, please describe: _____

E. **Respite Care**

Is the Applicant a licensed respite care center? ☐Yes ☐No

If yes, number of patients per year: ____

F. **Hospice Care**

Is the Applicant a licensed hospice care center? ☐Yes ☐No

If yes, please provide the following:

1. Gross receipts: $_____
2. Number of patients per year: ____

G. **Rehabilitation Services**

Is the Applicant a licensed rehabilitation services center? ☐Yes ☐No

If yes, please provide the following:

1. Number of patients per year: ____
2. Describe the in-house rehabilitation services provided by the Applicant: _____
3. Does the Applicant provide rehabilitation services to non-residents? ☐Yes ☐No

H. **Meals on Wheels**

Does the Applicant provide meals on wheels services? ☐Yes ☐No

If yes, please provide the following:

1. Gross receipts: $_____
2. Does the Applicant provide transportation to and from the facility? ☐Yes ☐No
3. Does the Applicant provide transportation to and from events? ☐Yes ☐No
4. Does the Applicant prepare meals at the facility? ☐Yes ☐No

X. NON-RESIDENT SERVICES (continued)

I. Does the Applicant provide the following services?

Service	Provided?	Number of Residents	Service	Provided?	Number of Residents
IV Infusion Therapy	☐Yes ☐No		Developmentally Disabled	☐Yes ☐No	
Ventilation Therapy	☐Yes ☐No		Alzheimer's/Dementia	☐Yes ☐No	
Physical Therapy	☐Yes ☐No		Psychiatric Care	☐Yes ☐No	
AIDS Treatment/ Therapy	☐Yes ☐No		Chemical Dependency Treatment	☐Yes ☐No	

J. Are any other services provided by the Applicant to its residents or the community? ☐Yes ☐No
If yes, please describe: _____

XI. CONSULTANTS/INDEPENDENT CONTRACTORS AND SERVICES

A. Indicate which of the following services are (1) provided to the Applicant by a consultant or independent contractor, (2) if a contract is in place and (3) the requested limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of Liability
Physicians	☐ Yes ☐No	☐ Yes ☐No	$
Dental	☐ Yes ☐No	☐ Yes ☐No	$
Nursing	☐ Yes ☐No	☐ Yes ☐No	$
Mental Health	☐ Yes ☐No	☐ Yes ☐No	$
Pharmaceutical	☐ Yes ☐No	☐ Yes ☐No	$
Physical Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Occupational Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Speech Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Dietary	☐ Yes ☐No	☐ Yes ☐No	$
X-Ray	☐ Yes ☐No	☐ Yes ☐No	$
Medical Records	☐ Yes ☐No	☐ Yes ☐No	$
Laboratory	☐ Yes ☐No	☐ Yes ☐No	$
Social Services	☐ Yes ☐No	☐ Yes ☐No	$
Recreational Services	☐ Yes ☐No	☐ Yes ☐No	$
Transportation	☐ Yes ☐No	☐ Yes ☐No	$
Barber/Beautician	☐ Yes ☐No	☐ Yes ☐No	$
Food	☐ Yes ☐No	☐ Yes ☐No	$
Laundry	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$

B. Has the Applicant received copies of certificates of insurance from independent contractors? ☐Yes ☐No
If yes, are the certificates of insurance reviewed annually? ☐Yes ☐No

C. Do the independent contractors have limits of liability equal to the Applicant's limits of liability? ☐Yes ☐No
If no, please explain: _____

XII. VOLUNTEERS

A. How many volunteers provide services for the Applicant? _____

B. What are the primary sources for obtaining new volunteers? _____

C. Is there a formal screening and orientation process for volunteers? ☐Yes ☐No
If yes, please explain: _____

D. Are roles and responsibilities of volunteers clearly communicated to staff and volunteers? ☐Yes ☐No

E. Do volunteers assist with resident feeding? ☐Yes ☐No

F. Are criminal background checks performed on volunteers? ☐Yes ☐No

XIII. RISK MANAGEMENT

A. Has a risk management program been implemented by the Applicant throughout all facilities? ☐Yes ☐No

B. Does the Applicant employ a full time, dedicated Risk Manager? ☐Yes ☐No
If yes, please provide the following:
1. Please indicate the Risk Manager's name: _____
2. How long has the Risk Manager been in that position with the Applicant? _____

XIII. RISK MANAGEMENT (continued)

C. Does the Applicant have an "incident reporting" policy? ☐Yes ☐No
If yes, please provide the following:
1. Are all incident reports reviewed by the Risk Manager and Medical Director? ☐Yes ☐No
2. Are incidents trended and presented to the quality/risk management committee? ☐Yes ☐No

D. Does the Applicant have a formal safety program? ☐Yes ☐No
If yes, does it include the evaluation and reduction of exposures relating to:
1. Life safety? ☐Yes ☐No
2. Employees? ☐Yes ☐No
3. Hazardous materials? ☐Yes ☐No
4. Environment? ☐Yes ☐No

E. Does the Applicant have a formal preventive maintenance program? ☐Yes ☐No
If yes, please provide the following:
1. Is one individual assigned responsibility for the program? ☐Yes ☐No
2. Does the program include the following:
   a. Evaluation of all electrical devices/equipment brought into the facility? ☐Yes ☐No
   b. Scheduled evaluations of equipment and devices including electrical supply? ☐Yes ☐No
   c. Retention of maintenance and inspection records? ☐Yes ☐No

F. What security measures are used to control unauthorized entrances and exits from the facility? _____

G. 1. Are Wander Guards or similar devices used as part of elopement prevention practices? ☐Yes ☐No
If yes, please provide the type of device: _____
1. Are Wander Guard devices for residents and buildings maintained and inspected according to manufacturer's specifications? ☐Yes ☐No
2. Number of elopements in the past three (3) years: _____

H. Does the Applicant have nursing assessment protocols in place to identify residents at risk for:
1. Elopement? ☐Yes ☐No
2. Falls? ☐Yes ☐No
3. Cognitive impairment? ☐Yes ☐No
4. Nutritional deficiency? ☐Yes ☐No

I. Does the Applicant perform a monthly review of drug regimens? ☐Yes ☐No
If yes, by whom? _____

J. 1. How are medications stored and distributed? _____
2. Are records kept on drug supplies and dispersal? ☐Yes ☐No
3. What is the maximum value of medications the Applicant keeps on hand at all facilities? $_____ Type: _____

K. 1. Does the Applicant have a licensed pharmacist on staff? ☐Yes ☐No
2. Does the Applicant use an outside pharmacy? ☐Yes ☐No
3. Does the Applicant use an onsite pharmacy? ☐Yes ☐No
If yes, please provide the following:
   a. What is the revenue per year: $_____
   b. Does the Applicant provide prescriptions to non-residents? ☐Yes ☐No

L. Does the Applicant have a dedicated special unit? ☐Yes ☐No
If yes, please provide the following:
1. Number of beds: _____
2. Describe type of beds: _____

M. Has the Applicant established admission, discharge and transfer criteria? ☐Yes ☐No
If yes, who ensures compliance with these established criteria? _____

N. Does the Applicant receive advance written consent from the resident or his or her guardian that allows medical care be provided when necessary? ☐Yes ☐No

O. Does the Applicant have a written policy addressing abuse? ☐Yes ☐No
If yes, please provide the following:
1. Does the policy include procedures for reporting and investigating alleged incidents of abuse? ☐Yes ☐No
2. Who is responsible for the investigation of abuse? _____
3. Are employees and volunteers educated about these reporting and investigating procedures? ☐Yes ☐No
4. Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse? ☐Yes ☐No
5. Are policies and procedures reviewed and updated as necessary at least every two (2) years? ☐Yes ☐No
6. What is the number of alleged abuse incidents investigated and/or reported in the last twelve (12) years? _____
7. Has the Applicant (including any employees or volunteers) had any claim or suit brought against them as a result of abuse within the last ten (10) years? ☐Yes ☐No
If yes, please explain the claim, the investigation and the outcome, including any corrective actions taken:
_____

P. Does the Applicant have a formal grievance procedure in place to address resident/family complaints? ☐Yes ☐No
If yes, please explain the process: _____

Q. Does the Applicant have arbitration agreements included in their Entrance Agreement? ☐Yes ☐No
If yes, what percentage of the Applicant's residents has executed the Entrance Agreement? _____%

XIV. ADDITIONAL PROPERTY/LIFE SAFETY INFORMATION

A. **Building Construction**

1. Type of building construction: _____ Year built: _____ Number of floors: _____ Number of elevators: _____
2. Date of last inspection: Electrical: _____ Plumbing: _____ HVAC: _____
3. Was the building constructed for this occupancy? ☐Yes ☐No
   If no, please explain: _____

B. **Occupancy**

1. Are there other occupancies in the building not related to resident care? ☐Yes ☐No
   If yes, please describe: _____
2. Is there a "no smoking" policy in effect throughout the facility? ☐Yes ☐No
3. Are smoking materials (including matches/lighters) allowed in a resident's room? ☐Yes ☐No
4. Are residents supervised and/or in restricted to designated areas while smoking? ☐Yes ☐No
5. How many exits (other than front entrance) are there? _____
6. Are the exits equipped with panic alarms? ☐Yes ☐No
7. Do panic alarms ring into the central security desk or nurses station? ☐Yes ☐No
8. Are there at least two remote exits on each floor? ☐Yes ☐No

C. **Protection**

1. Does the Applicant have an automatic sprinkler system protecting 100% of the building and have these systems been tested by a qualified contractor with results documented? ☐Yes ☐No
   a. If not 100%, please advise which areas are not protected: _____
   b. If not tested, please explain: _____
2. Are all alarm signals monitored by a UL-approved central station or the responding fire department? ☐Yes ☐No
3. Is there a written emergency plan covering fire, natural disasters and threats? ☐Yes ☐No
   If yes, do employees receive instruction training regarding this plan? ☐Yes ☐No
4. Has the fire department pre-planned emergency procedures? ☐Yes ☐No
   If yes, indicate the last date when these procedures were updated: _____
5. When was the Applicant's facility last inspected by local fire authorities? _____
6. Does the building have a bulk medical gas distribution system? ☐Yes ☐No
   If yes, are emergency shutoffs provided? ☐Yes ☐No
   If no, is there storage of individual tanks? ☐Yes ☐No
   If yes, are these tanks on rolling carts? ☐Yes ☐No
   If yes, are the tanks properly chained to the rolling carts? ☐Yes ☐No
7. Is there a fire suppression system in cooking areas (other than independent living units)? ☐Yes ☐No
   If yes, please provide the following:
   a. Is there a hood and grease filter? ☐Yes ☐No
   b. How often is the system cleaned (i.e. monthly/quarterly)? _____
   c. Is an outside contractor used for cleaning? ☐Yes ☐No
   d. Is the area equipped with an automatic fuel shutoff? ☐Yes ☐No
8. Do residents rooms/apartments have hardwire smoke detectors? ☐Yes ☐No
9. Are doors equipped with approved self-closing devices where required? ☐Yes ☐No
10. How many fire extinguishers are there throughout the Applicant's facilities? ____
11. If the Applicant has a multi-story building, do non-ambulatory residents reside on lower floors (1st/2nd)? ☐Yes ☐No
12. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? ☐Yes ☐No
13. Does the Applicant use video surveillance? ☐Yes ☐No
    If yes, please describe extent of use: _____
14. Does the Applicant conduct fire drills regularly? ☐Yes ☐No
    If yes, please describe: _____
15. Does each room/unit have an emergency call button? ☐Yes ☐No
16. Does each resident room have an intercom or bell? ☐Yes ☐No
17. Do hallways and bathrooms have handrails? ☐Yes ☐No
18. Do bathtubs/showers have non-slip surfaces? ☐Yes ☐No

XV. COMMERCIAL AUTOMOBILE

A. Does the Applicant have a contract with a transportation service (i.e. ambulance, buses, vans) to transport residents? ☐Yes ☐No
If yes, please provide the following:
a. What is the name of the transportation service? _____
b. Provide a contact name: _____
c. Telephone Number: _____-_____-_____

B. Do employees transport residents in their own automobiles? ☐Yes ☐No
If yes, please describe: _____ Average frequency:_____

C. Does the Applicant require employees to carry minimum insurance limits? ☐Yes ☐No
If yes, what limits are required? $_____

D. Does the Applicant have any Commercial Drivers Licensed vehicles? ☐Yes ☐No
If yes, how many? _____

E. Do volunteers operate any vehicles? ☐Yes ☐No

F. Are the driving records of any employee or volunteer operating a vehicle reviewed on an annual basis? ☐Yes ☐No

XVI. ATTACHMENTS

A. A copy of the following information must be submitted with this application. If not available, please explain.
1. Completed ACORD applications: ☐General Liability/Professional Liability ☐Umbrella
2. Schedule of Locations to be covered.
3. Five (5) years of currently valued loss reports from prior carriers.
4. Current audited Financial Statement (income, balance sheet, cash flow) with management notes.
5. A detailed narrative description for any claim, pending or closed, with total reserves or payments exceeding $100,000.
6. Copies of licenses for each location.
7. Facility web site address.
8. Organizational Chart.
9. CMS Long Form for quality of care surveys completed during the last twelve (12) months (includes complaint surveys).
10. Facility Quality Measures/Indicator Reports for a cumulative six-month period not older than 90 days.

B. Please include the following information for a Skilled/Assisted Living Facility:
1. Resumes for Administrator & Director of Nursing.
2. Any state survey reports. Please provide the last two (2) years (including any statement of deficiencies or corrective action plans).
3. A survey of any substantiated complaint made within the last two (2) years and any applicable Corrective Action Plans.

C. Please include the following information for a Skilled/Intermediate Care Facility:
1. Current CMS Forms 671 Facility Staffing & 672 Resident Census.
2. Copy of the Applicant's Skin/Wound Protocol.
3. Quality Indicator Report for the past two (2) six-month periods.

XVII. IMPORTANT NOTICE

This insurance may contain claims-made coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date. Please read and review the policy carefully.

XVIII. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ THE FOLLOWING:
Any person who knowingly and with intent to injure, deceive, or defraud any insurance company or other person files an application for insurance containing any materially false information or fails to provide complete information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may be prosecuted under state law and may be guilty of a felony and subject to criminal and civil penalties, fines, denial of insurance or confinement in prison.

XIX. STATE SPECIFIC NOTICES

If Delaware: National Fire & Marine Insurance Company and The Medical Protective Company recognize the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulleting No. 46 including the following: Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

XIX. STATE SPECICIF NOTICES (continued)

If Illinois: National Fire & Marine Insurance Company and The Medical Protective Company recognize the rights afforded to individuals under Illinois Bulletin 2011-06 And The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

If Rhode Island: **THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.**

XX. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association form any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Signature of Officer or Authorized Representative	Title	Date

XXI. SUPPLEMENTAL INFORMATION