Affinity Global INSURANCE

# PROFESSIONAL & GENERAL LIABILITY INSURANCE APPLICATION FOR LONG TERM CARE FACILITIES

**Desired Effective Date:** _____

## INSTRUCTIONS:

1. **Answer all questions; do not leave any question blank. If the question does not apply write "N/A" in the space provided. If an answer requires more detail, please attach a separate sheet of paper.**
2. **Application must be signed and dated by owner, partner, or officer.**
3. **Return application along with all required items listed in the Document Checklist below.**
4. **A separate application is required for each facility. For additional locations, you may start with Section II.**
5. **Once completed, this application is valid for 120 days.**

## DOCUMENT CHECKLIST

- o **Loss History:** Currently valued, carrier produced loss runs for current policy and preceding 4 years; five (5) total years of history.
- o **HCFA Report:** Most recent 6-month Facility Quality Measure/Indicator report showing percentile figures.
- o **Financials:** Please include the most recent 12-month financial statements including a balance sheet and income statement.
- o **Recent Survey:** A survey is not required unless ASI underwriter specifically requests

## SECTION I: APPLICANT INFORMATION

1. Legal name of Applicant: _____

   Billing Address: _____

   City: _____ State: _____ Zip code: _____ County: _____

   Phone number: _____ Fax number: _____ Website: _____

2. Applicant is (check all that apply):

   ☐ For profit ☐ Governmental ☐ Partnership

   ☐ Not for profit ☐ Individual ☐ Corporation

3. List all other additional insureds to be considered for coverage (attach a separate sheet if necessary):

| Additional Insured | Address | Insurable Interest |
|---|---|---|
| 1. | | |
| 2. | | |

4. Date business started: ____ _____
5. Number of Long Term Care facilities owned and/or operated: _____
6. Number of Long Term Care facilities that you are applying for coverage for: _____
7. Number of years experience operating Long Term Care facilities: ____ _____
8. Have any of the facilities that you wish to insure:
   a. Changed names in the last 5 years? ◯ **Yes** ◯ **No**
   b. Been purchased in the last 12 months? ◯ **Yes** ◯ **No**
   c. Been considered for sale in the next 12 months? ◯ **Yes** ◯ **No**
   d. Filed bankruptcy? ◯ **Yes** ◯ **No**
   e. If yes to any of the above questions, please explain:

_____

## SECTION II: FACILITY INFORMATION

1. Legal name of facility (if different than Section I): _____

   Facility address: _____

   City: _____ State: _____ Zip code: _____ County: _____

2. Facility contact : ___ _____ Title: _____

   Facility phone number: _____ Facility fax: _____ Email: _____

3. Facility funding is:

   Medicare: _____% Medicaid: _____% Private Pay _____%

4. Number of years owned by the Applicant listed in Section I: _____

5. Has the Applicant had it's license suspended, revoked, or placed under probation by any government licensing agency? ◯ **Yes** ◯ **No**

6. What date was the facility last inspected/surveyed? ____ _____

7. Does the Applicant anticipate any facility expansions within the next 12 months? ◯ **Yes** ◯ **No**

8. Is the facility run under a management contract? ◯ **Yes** ◯ **No**

   If "Yes", name of Management Company: _____

   If "Yes", number of years under current contract: _____ & number of facilities operated by management company _____

9. If state law permits, does the facility admission process include an Arbitration Agreement? ◯ **Yes** ◯ **No**

10. If facility was acquired in the past 3 years, was it acquired from a **large** nursing home chain? ◯ **Yes** ◯ **No**

11. Is the owner involved in the daily operations of this facility? ◯ **Yes** ◯ **No**

## SECTION III: DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census:

| Category | Total # of Licensed Beds | Average # of Occupied Beds |
|---|---|---|
| **Skilled Care Services**<br>Professional nursing care, 24 hours, by licensed nurses. RN coverage during day shifts at a minimum. LPN coverage during other shifts. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization.<br>(SNF beds) | _____ | _____ |
| **Intermediate Care Services**<br>Nursing care during day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feeding, etc.). Assistance with activities of daily living (i.e., walking, baths, dressing, eating). Some assistance with administering medications. | _____ | _____ |
| **Residential/Assisted Living Services**<br>Residents are ambulatory with possible minor disorders, provided protected environments (meals and planned programs). Residents are eligible for incidental health care services, including assistance with medications. | _____ | _____ |
| **Independent Living Services**<br>Residents are at retirement age and in general good health; occupy apartment/dwelling units that normally include cooking facilities. Residents do not receive any health care services, but have access to skilled or intermediate care within the same facility complex. | **# of Apartment Units**<br>_____ | **# of Apartment Units**<br>_____ |

2. Re sident Diagnosis Characteristics:

a. Indicate the percentage of residents whose primary diagnosis is Alzheimer's / Dementia: _____%

b. Indicate the percentage of residents whose primary diagnosis is Psychiatric related: _____%

c. Indicate the percentage of residents whose primary diagnosis is Sub Acute Care: _____%

d. Indicate the percentage of residents whose primary diagnosis is Developmentally Disabled: _____%

e. Indicate the percentage of residents whose primary diagnosis is Drug Abuse related: _____%

f. Indicate the percentage of residents whose primary diagnosis is Alcohol Abuse Rehabilitation: _____%

3. Do you provide any of the following services for non-residents?

| | | | |
|---|---|---|---|
| Adult Day Care | ◯ **Yes** | ◯ **No** | If "Yes", # of annual visits: _____ |
| Child / Adolescent Day Care | ◯ **Yes** | ◯ **No** | If "Yes", # of annual visits: _____ |
| Off-Site Home Health Care | ◯ **Yes** | ◯ **No** | If "Yes", # of annual visits: _____ |
| Off-Site Hospice Care | ◯ **Yes** | ◯ **No** | If "Yes", # of annual visits: _____ |
| Physical Rehab / Therapy | ◯ **Yes** | ◯ **No** | If "Yes", # of annual visits: _____ |

4. Does the facility provide any other off-site healthcare services? ◯ **Yes** ◯ **No**

If "Yes", provide details: _____

5. Does the facility use restraints? ◯ **Yes** ◯ **No**

if "Yes", provide the current # of residents physically restrained: _____ and # of residents chemically restrained: _____

6. Does the facility have an open pharmacy available to non-residents? ◯ **Yes** ◯ **No**

If "Yes", does the applicant own and operate the pharmacy? ◯ **Yes** ◯ **No**

If "Yes", does the pharmacy maintain an in-force liability policy? ◯ **Yes** ◯ **No**

## SECTION IV: RESIDENT PROFILE INFORMATION

1. Number of residents by class:

Total # of Residents: _____ Geriatric (55+): _____ Adolescent (12-18): _____

Non-Geriatric (19-54): _____ Pediatric (0-11): _____

2. Percentage of residents whose average length of stay is:

0–60 Days : _____% 61–180 Days: _____% Over 180 Days: _____%

3. Percentage of residents with a Legal Conservator: ◯ 0 - 15% ◯ 16 - 25% ◯ 26 - 50% ◯ > 50%

## SECTION V: STAFFING & PERSONNEL

1. Key staff information:

| Staff Position | Name | Hours / Week | # of Years at Position | # of Years at Facility |
|---|---|---|---|---|
| **Administrator** | | | | |
| **Medical Director** | | | | |
| **DON** | | | | |
| **Risk Manager** | | | | |

2. Key staff turnover information:

# of Administrators at facility over past 5 years? _____ # of Medical Directors at facility over past 5 years? _____

# of DONs at facility over past 5 years? _____ # of Risk Managers at facility over past 5 years? _____

3. Does the facility Medical Director ever perform the role of attending physician? ◯ **Yes** ◯ **No**

   If "Yes", how many? _____

4. Scheduling & turnover (show the total # of employees for each shift using full time equivalents):

| Staff Position | 1st Shift | 2nd Shift | 3rd Shift | Turnover % |
|---|---|---|---|---|
| **Nurses (RNs)** | | | | |
| **Licensed Practical Nurses (L.P.N.)** | | | | |
| **Certified Nursing Assistants (C.N.A.)** | | | | |

5. Does the Applicant use any agency staffing for nursing positions? ◯ **Yes** ◯ **No**

   If "Yes", are any shifts or units staffed exclusively by agency nurses? ◯ **Yes** ◯ **No**

6. Does the Applicant contract professional services? ◯ **Yes** ◯ **No**

   If "Yes", do you require ALL independent service contractors (i.e. physicians, nurses, etc.) to carry liability insurance with limits comparable to your own? ◯ **Yes** ◯ **No**

7. Hiring practices (check all that apply):

   ☐ Criminal Background ☐ Educational Background ☐ Sexual Offender Registry ☐ Personal References
   ☐ Employer References ☐ Drug Screening

## SECTION VI: LIFE SAFETY

1. Does the Applicant have a written emergency evacuation plan? ◯ **Yes** ◯ **No**
   a. Are evacuation plans posted in all parts of the facility? ◯ **Yes** ◯ **No**
   b. Does new staff orientation include a walk through review of any disaster plan? ◯ **Yes** ◯ **No**
   c. Does plan include advanced arrangements for transportation & temporary shelter? ◯ **Yes** ◯ **No**
   d. How often are evacuation / fire drills conducted each year for each shift? _____
2. Is smoking permitted in the facility? ◯ **Yes** ◯ **No**
3. Are residents allowed to keep smoking materials in their possession? ◯ **Yes** ◯ **No**
4. Are non-ambulatory residents located above the 1st floor? ☐ **Single Story** ◯ **Yes** ◯ **No**
5. Check the following recreation areas that apply to this facility. ☐ None ☐ Swimming Pool ☐ Hot Tub
   ☐ Sauna ☐ Exercise / Weight Room ☐ Other: _____
6. Smoke detector locations (check all that apply): ☐ Every Resident Room ☐ Common Areas ☐ Hallways ☐ Restrooms
7. Fire sprinkler locations (check all that apply): ☐ Every Resident Room ☐ Common Areas ☐ Hallways ☐ Restrooms
8. Approximate distance to nearest: Hospital? _____miles Fire Station? _____miles

## SECTION VII: RESIDENT CARE

1. Is a comprehensive nursing assessment conducted for new residents? ◯ **Yes** ◯ **No**

   How frequently is it repeated? _____

2. Are written orders from an attending physician required for the following?

   Drugs & Medications ◯ **Yes** ◯ **No** Special Diet Needs ◯ **Yes** ◯ **No**
   Facility Transfers ◯ **Yes** ◯ **No** Specific Therapy ◯ **Yes** ◯ **No**
   Restraints ◯ **Yes** ◯ **No**

3. Do you have a wound care specialist? ◯ **No** ◯ **Yes – On Staff** ◯ **Yes – Contracted**

4. Are photos and/or measurements taken of wounds on admission or re-admission? ◯ **Yes** ◯ **No**
5. Residents with Stage III or IV pressure ulcers are either ◯ **Transferred to another facility** or ◯ **Treated at this facility**.
6. How often do nurses perform total body skin assessments? _____
7. When and how often are fall assessments done? _____
8. Number of resident falls related to lifting, moving and transporting (including Hoyer lifts) in the past 12 months? _____
9. Skilled and intermediate care beds equipped with side rails? ◯ **Yes** ◯ **No**
   If "No", does the facility utilize low profile beds? ◯ **Yes** ◯ **No**
10. Are there handrails in both hallways and bathrooms? ◯ **Yes** ◯ **No**
11. Bathrooms, tubs, showers equipped with non-slip surfaces? ◯ **Yes** ◯ **No**
12. Are Hoyer lifts or other mechanical lifting devices used? ◯ **Yes** ◯ **No**
13. Are there tempering valves that control the temperature of resident's water? ◯ **Yes** ◯ **No**
14. Do you assess for wandering/elopement? ◯ **Yes** ◯ **No**
15. Has any resident eloped from this facility in the past 5 years? ◯ **Yes** ◯ **No**
    If "Yes", how many? _____ When? _____
16. Is Wander Guard System or similar security system operational? ◯ **Yes** ◯ **No**
17. Does Applicant have a policy to investigate alleged resident abuse & neglect? ◯ **Yes** ◯ **No**
18. Number of incidents in the past 12 months that led to an allegation of **elder abuse**: ____ _____
19. Number of incidents in the past 12 months that led to an allegation of **sexual abuse**: ____ _____
20. Have any elder or sexual abuse allegations developed into a claim during the past 5 years? ◯ **Yes** ◯ **No**
21. What was your medication error ratio for the past 12 months? _____

## SECTION VIII: INSURANCE HISTORY

1. **Current** Professional & General Liability Carrier: _____ Effective Date: _____/_____/_____
   Type of Policy Form: ◯ Claims Made, Retro Date: _____/_____/_____ (or) ◯ Occurrence
   Per occurrence limit: $_____ Aggregate limit: $_____ Retention: $_____
   Sexual Abuse / Misconduct Coverage Included? ◯ Yes, Limits: $_____ (or) ◯ No
   Premium: $_____
2. Is Risk Management Provided? ◯ Yes, Cost: $_____ ◯ No
3. Do you have any Excess Coverage or an Umbrella Policy? ◯ **Yes** ◯ **No**
   If "Yes", please provide details: _____
4. Is your Professional & General Liability Insurance currently "packaged" with other coverage? ◯ **Yes** ◯ **No**
5. Please provide details about your insurance history for the two years **prior to your current coverage**:

| Carrier | Policy Term | Limits | Claims Made? | If Claims Made, Retro Date |
|---|---|---|---|---|
| | | | ◯ Yes ◯ No | |
| | | | ◯ Yes ◯ No | |

6. Has the Applicant had their PL/GL insurance cancelled or non-renewed in the last three years? ◯ **Yes** ◯ **No**

## SECTION IX: CLAIMS HISTORY

1. Have you had any professional or general liability claims at this facility during the past 5 years? ◯ **Yes** ◯ **No**
   **If "Yes", please provide details on any claim with a paid or reserved value that is greater than $50,000.** The loss runs required in the document checklist on page one of this application should the current year and a breakdown of total incurred losses, paid losses, and outstanding reserves separated by year for all coverages. Include primary and excess losses.
2. Are you aware of any incident(s) or occurrence(s) at this facility during the past 5 years that may give rise to a professional or general liability claim? ◯ **Yes** ◯ **No**
   If "Yes", please provide details: _____

## SECTION X: REPRESENTATIONS & WARRANTIES

The undersigned authorized officer of the applicant declares that the statements set forth herein are true to the best of my knowledge and that no material fact has been omitted or misstated. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such change, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant to purchase or the insurer to provide the insurance. Acceptance of the applicant by the company is required prior to quotation or binding of coverage or the issuance of a policy. It is agreed that this application and the reliance upon its contents shall be the basis of the issuance of a policy and shall be attached and made part of said policy.

**FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY SUBMITS AN APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE, OR MISLEADING INFORMATION MAY BE SUBJECT TO CIVIL OR CRIMINAL PENALTIES.**

**NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

**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 DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND 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 MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**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 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 AND 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 MARYLAND APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

**NOTICE TO NEW JERSEY 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 ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

**NOTICE TO OKLAHOMA APPLICANTS:** 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 OREGON AND TEXAS APPLICANTS:** ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

**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. A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

**I HAVE READ AND FULLY UNERSTAND THE QUESTIONS AND MY ANSWERS ON THIS APPLICATION. UNDERSTAND THAT ANY OMISSION OR MISSTATEMENT OF ANY OF THE RESPONSES THAT ARE MATERIAL TO THE RISK ASSUMED (AS WELL AS ATTACHED TO THIS APPLICATION), MAY CAUSE THIS POLICY TO BECOME NULL AND VOID AND/OR MAY GIVE RISE TO RESCISSION OF THE POLICY.**

The Signatory hereby acknowledges that he/she is aware that the Aggregate Limit in the CPL policy shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Company shall not be liable for the costs of legal defense or for the amount of any judgment or settlement or cleanup costs to the extent that such exceeds the limit of liability of this policy.

The Signatory hereby further acknowledges that legal defense costs that are incurred shall be applied against the deductible amount.

Should the signatory become aware of any change or omission relative to the information provided herein subsequent to the completion of this application and precedent to the effecting of insurance, the undersigned promissorily warrants that he will submit to American Safety Insurance Services, Inc. supplementary advice specifying such change or omission. Notwithstanding the immediate foregoing, however, the signatory further promissorily warrants that he will inform American Safety Insurance Services, Inc. of any change or omission with respect to any answers given in this application at any time subsequent to the completion thereof, provided insurance has been effected. It is agreed that the duty imposed upon the signatory by virtue of the foregoing promissory warranties, shall be non-delegable. It is further agreed that this application shall be the basis of any insurance as may be subsequently effected by American Safety Insurance Services, Inc. and that American Safety Insurance Services, Inc. will rely upon the veracity of all responses thereto in causing such insurance to be effected. It is further understood and agreed that all representations and warranties made to American Safety Insurance Services, Inc. also are made to the issuing carrier.

It is finally agreed that the completion of this application neither obligates the Applicant to purchase insurance nor binds American Safety Insurance Services, Inc. or the issuing carrier to affect insurance.

I have read the Required Fraud Warnings and further agree to the signatory statement.

**APPLICANT**: _____ _____ _____

Signature | Print Name | Date

**PRODUCER**: _____ _____ _____

Signature | Print Name | Date