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

INSTRUCTIONS:

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

DOCUMENT CHECKLIST

- o **Loss History:** Loss history is not required unless prior coverage was on an occurrence form or there were previously open losses that may have developed. Inquire with your ASI underwriter for details
- o **HCFA Report:** Most recent 6-month Facility Quality Measure/Indicator Report showing percentile figures.
- o **Recent Survey:** A survey is not required unless ASI underwriter specifically requests
- o **Financials:** If your SIR is $25,000 or greater, please include 12-month financial statements, including balance sheet.

SECTION I: APPLICANT INFORMATION

1. Legal name of Applicant: _____

   { } check if no changes to billing address, or provide new information below

   Billing Address: _____

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

   Phone number: _____ Fax number: _____ Website: _____

2. Have any of the facilities that you wish to insure:

   a. Changed names in the last 12 months? **{ } 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 in the last 12 months? **{ } 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): _____

   { } check if no changes to facility address, or provide new information below

   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. Has the Applicant had this facility's license suspended, revoked, or placed under probation by any government licensing agency in the past 12 months? **{ } Yes { } No**

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

27865 Clemens Rd, Suite 3 ♦ Westlake, OH 44145
☎ (888) 331-3305 ♦ FAX ☎ (866) 827-6057

6. Does the Applicant anticipate any facility expansion within the next 12 months? **{ } Yes** **{ } No**

7. Any change in the current management contract in the past 12 months? **{ } N/A** **{ } Yes** **{ } No**

If "Yes", name of new Management Company: _____

SECTION III: DESCRIPTION OF SERVICES

1. Facility Classification and Bed Census:

Category	Total # of Licensed Beds	Average # of Occupied Beds
Sub Acute Care Post operative & trauma recovery, wound mgmt, ventilator care, IV antibiotic, hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), dialysis, blood plasma transfusion, Tracheotomy, central line care.	_____	_____
Skilled Care Services Professional nursing care, 24 hours, by licensed nurses. Skilled care services usually include some of all of the following; medical administration, order procedure ordered by physicians, injections, tube feedings, catheterization.	_____	_____
Intermediate Care Services Nursing care during day shift, 7 days per week. No complex nursing care (IVs, tube feeding, etc.). Assistance with activities of daily living. Some assistance with administering medications.	_____	_____
Residential/Assisted Living Services 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 Residents are at retirement age and in general good health; occupy apartment units that normally include cooking facilities. Residents do not receive any health care services directly from the operator.	**# of Apartment Units** _____	**# of Apartment Units** _____

2. Resident Diagnosis Characteristics (answer all parts):

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:	_____
4. Physical Rehab / Therapy	**{ } Yes** **{ } No**	If "Yes", # of annual visits:	_____

5. Does the facility provide any other off-site healthcare services? **{ } Yes** **{ } No**

6. Has the facility changed the admission criteria in the past 12 months? **{ } Yes** **{ } No**

If "Yes", provide details: _____

7. Does the facility maintain contract(s) with other healthcare entities to provide post operative rehab or Sub Acute Care? **{ } Yes { } No**

If "Yes", when did you first provide this service? _____

If "Yes", attach additional details of the contract(s) and the client referrals.

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%

4. Does the facility screen residents at admission and turn away if they are Registered Sex Offenders? **{ } Yes { } No**

5. Does the facility currently have any Registered Sex Offenders residing on the premises? **{ } Yes { } No**

SECTION V: STAFFING & PERSONNEL

1. Key staff information (if no change in the past 12 months, just check "No Change". Otherwise, please complete):

Staff Position	Check if No Change	Name	Hours / Week	# of Years Experience at Position	# of Years at Facility
Administrator	**{ }**				
Medical Director	**{ }**				
DON	**{ }**				
Risk Manager	**{ }**				

2. 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.)				

3. 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**

SECTION VI: RESIDENT CARE

1. Do you have a wound care specialist? **{ } No { } Yes – On Staff { } Yes – Contracted**

2. Residents with Stage III or IV pressure ulcers are either **{ } Transferred to another facility** or **{ } Treated at this facility**.

3. Number of resident falls ***related to lifting, moving and transporting*** with staff assistance in the past 12 months? _____

4. Number of incidents in the past 12 months that led to an allegation of **elder abuse**: _____

5. Number of incidents in the past 12 months that led to an allegation of **sexual abuse**: _____

6. What was your medication error ratio for the past 12 months? _____

7. Has any resident eloped from this facility in the past 12 months? **{ } Yes { } No**

If "Yes", please attach details of the event(s), including dates, outcome, and what corrective measures the facility has taken to avoid future elopements of similar circumstances.

SECTION VII: 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 VIII: 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 UNDERSTAND 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 LTC policy may 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 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