*This application must be completed and signed by the applicant. In addition, the following must be attached to the application.*

**The following are required for all levels of care:**

- Acord Applications: ☐ Property ☐ Auto ☐ General Liability ☐ Crime ☐ Inland Marine ☐ Electronic Data Processing ☐ Umbrella

- Signed Statement of Values
- Aging Services Business Interruption Worksheet (if applicable) or latest 12 month Profit & Loss statement
- Current valued loss reports of prior carriers (5 years minimum)
- Current audited financial statement (income, balance sheet, cash flow) with management notes

**The following are required for Subacute/Skilled/Intermediate/Assisted Living Facilities:**

- Resumes for Administrator & Director of Nursing (DON) if there were any changes within the last 12 months.
- State survey reports - last 12 months (Include all statements of deficiencies and Corrective Action Plans)
- Substantiated Complaint Survey(s) and Corrective Action Plans if complaint is within the last 12 months

**The following are required for Subacute/Skilled Nursing Facility/Intermediate Care Facilities:**

- Residents Utilization Guide Case Matrix Reports with number of hours by RUG category for last 12 month
- Current CMS Forms 671 Facility Staffing & 672 Resident Census
- Equip Quality Monitor Reports for the past two, six-month periods

Effective Date: _____

Claims-Made _____ Occurrence _____

Claims-Made Retro Date: _____

## I. Corporate/Parent Information

1. Corporate/Parent Name: _____

   Corporate Address: _____

   City: _____ State: __ Zip Code: _____

2. Has there been any change in the management company? ☐Yes ☐No

   If "Yes," provide the name of the new management company: _____

   *Provide a copy of the management contract.*



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## II. Applicant/Facility Information

3. Facility Name: _____

City: _____ State: __ Zip Code: _____

Contact Name: _____ Telephone: (___) ___-____

Email Address: _____ Fax: (___) ___-____

## III. Subsidiaries

4. List all new subsidiaries. Additional list attached? ☐Yes ☐No

| Name | Location | Description of Operations |
|---|---|---|
| | | |
| | | |
| | | |

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

## IV. Classification

6. **Select only the level of care reflected in the facility license**. If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.

Please indicate total licensed beds (If Independent Care, skip to "Independent Care" section).

| | |
|---|---|
| **Sub Acute:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Skilled Nursing:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Intermediate Care:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Assisted Living/Adult Care:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Memory Care:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Personal Care:** | Total Licensed Beds: ____ Average Occupancy: ____ |
| **Independent Care:** | |
| | a. What is the total numbers of units? _____<br>b. What is the total numbers of residents at full occupancy? _____ |



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7. Show the percentage of residents by age range:

___ < 30 ___ = 30-64 ___ = 65-74 ___ = 75-84 ___ = 85-94 ___ > 94

8. If any residents are under 64, please explain: _____

9. Number of elopement in the past twelve months: _____

## V. Administrator/Executive Director – *Complete only if there was a change in the past twelve months*:

10. Name of Administrator: _____ License Number: _____ State: __

11. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA): _____

Full-time at this facility? ☐Yes ☐No Number of hours at this facility per week? _____

## VI. Nurse Staffing

12. Director of Nursing (DON) – ***Complete only if there was a change in the past twelve months***:

Name: _____ Professional credentials: ☐RN ☐LPN

Length of time at this facility: ____ Length of time as DON: _____

13. a. Total # of nurse employees: _____

b. By category:

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

## VII. Medical Director – *Complete only if there was a change in the past twelve months*:

14. Name of Medical Director: _____ License Number: _____ State: __

15. Length of time as Medical Director: _____ Medical Specialty: _____

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

16. Does the Medical Director also act as the attending physician to any residents? ☐Yes ☐No

If "Yes," how many: _____

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



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## VIII. Non-Resident Services

18. Please complete the following

**Home Health Care** ☐Yes ☐No # of Home Health Care visits or clients per year: _____

Is home health care provided by independent contractors? ☐Yes ☐No

Describe home health care services: _____

Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic services, skilled nursing care

Number of visits: _____ Receipts: _____ Attach a description of operations.

**Adult Day Care:** Total Licensed #: _____

Average Occupancy: _____

Hours of Operation: _____

Is this a licensed adult day care center? ☐Yes ☐No # of Employees: _____

☐ Social (80911) Total Participants: _____

☐ Enhanced (Mentally Challenged) (80912) Total Participants: _____

Do you provide transportation to and from your facility? ☐Yes ☐No

Do you provide transportation to and from events? ☐Yes ☐No

Is a physical examination performed by a physician prior to admission? ☐Yes ☐No

If "Yes," describe: _____

Are medical services provided? ☐Yes ☐No

If "Yes," describe: _____

**PACE (Program of All Inclusive Care for the Elderly)** ☐ Yes ☐ No

If "Yes", how many participants? _____ (Please complete a PACE questionnaire.)

**Children Day Care:** Total Licensed #) _____ Average Occupancy: _____

Hours of Operation: _____

# of employees: _____ # of children: _____ # of employees' children: _____

Do you provide any transportation for children? ☐Yes ☐No

If "Yes," describe: _____

**Respite Care**: ☐Yes ☐No If "Yes," # per year: ____

**Hospice Care:** (80931): ☐Yes ☐No If "Yes," # per year: ____



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**Rehabilitation Services**: ☐Yes ☐No If "Yes," # per year: ____

Describe in-house rehabilitation services: _____

Are rehabilitation services available to non-residents? ☐ Yes ☐ No

**Occupancy**:

Are there any new occupancies in the building not related to resident care? ☐Yes ☐No

If "Yes," describe: _____

**Restaurant –** if open to the public, complete the following:

Gross receipts: $_____ Liquor receipts: $_____

**Liquor**

Is alcohol served with dinner or at a happy hour? ☐ Yes ☐ No

If "Yes", is there a charge?

**Pets**

Are pets allowed? ☐ Yes ☐ No

If "Yes", are vaccinations required and kept on record by the facility? ☐ Yes ☐ No

19. Do you provide the following services?

| Service | Provided? | # of Residents | Service | Provided? | # 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 | ☐Yes ☐No | | Chemical Dependency Treatment | ☐Yes ☐No | |

20. Do you provide any other new services to your residents or the community? ☐Yes ☐No

    If "Yes," describe**:** _____

## IX. Risk Management

21. Is there a new designated risk manager? ☐Yes ☐No
    If "Yes," indicate risk manager's name: _____
    How long has the risk manager been in that position? _____
    *Please attach a resume for the new risk manager.*

22. Please describe, if any, changes that have been made during the past year that have not already been addressed.



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**WARRANTY:**

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO ISSUE AN INSURANCE POLICY, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 OR INCOMPLETE 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 SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (FOR DISTRICT OF COLUMBIA RESIDENTS ONLY: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.) (FOR FLORIDA RESIDENTS ONLY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.) (FOR LOUISIANA RESIDENTS ONLY: 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 FINES AND CONFINEMENT IN PRISON.) (FOR MAINE RESIDENTS ONLY: 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.) (FOR NEW YORK RESIDENTS ONLY: 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 EACH SUCH VIOLATION.) (FOR OKLAHOMA RESIDENTS ONLY: WARNING: 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.) (FOR PENNSYLVANIA RESIDENTS ONLY: 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.) (FOR PUERTO RICO RESIDENTS ONLY: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD, PRESENTS FALSE INFORMATION IN AN INSURANCE REQUEST FORM, OR WHO PRESENTS, HELPS OR HAS PRESENTED A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, WILL INCUR A FELONY, AND UPON CONVICTION WILL BE PENALIZED FOR EACH VIOLATION WITH A FINE OF NO LESS THAN FIVE THOUSAND DOLLARS ($5,000) NOR MORE THAN TEN THOUSAND DOLLARS ($10,000); OR IMPRISONMENT FOR A FIXED TERM OF THREE (3) YEARS, OR BOTH PENALTIES. IF AGGRAVATED CIRCUMSTANCES PREVAIL, THE FIXED ESTABLISHED IMPRISONMENT MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IF ATTENUATING CIRCUMSTANCES PREVAIL, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.) (FOR TENNESSEE RESIDENTS ONLY: PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.) (FOR OREGON RESIDENTS ONLY: 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 OR INCOMPLETE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.) (FOR VERMONT RESIDENTS ONLY: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.) (FOR WASHINGTON RESIDENTS ONLY: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.)



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**Print : Applicant Name & Title** **Authorized Signature of Applicant** **Date**

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