**Supplemental Questionnaire**
**Application**

# PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

In addition to the Acord Application for the General Liability coverage, we are asking that you complete the attached Supplemental Questionnaire. Please answer the questions carefully. If we are successful in writing your insurance, this questionnaire will become part of the policy.

We are further requesting that the APPLICANT'S SUPPLEMENTAL REPRESENTATIONS AND WARRANTIES statement below be placed on the Applicant's letterhead and signed by an authorized official or representative of Applicant.

APPLICAN'TS SUPPLEMENTAL REPRESENTATIONS AND WARRANTIES

I, _____, an authorized officer and representative of the Applicant, hereby make application for the General Liability and Professional Liability Policy (the "Policy") issued through the Program of All Inclusive Care for the Elderly (PACE). In order to persuade Columbia Casualty Company (the "Insurer") to consider issuance of the Policy, I hereby represent and warrant to Insurer that:

1. the application transmitted to me by Insurer was completed in full with respect to those questions that are relevant to my application to the Program;

2. the materials requested for attachment to the Supplemental Questionnaire and the responses to the questions are true, accurate, material, and complete;

3. the foregoing items in 1) and 2) are true, accurate, material, and complete and are the basis of the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy; and

4. a copy of my signature may be relied upon as if it were the original;

The Applicant declares that the foregoing representations and warranties are true and correct as of the date hereof.

The Applicant agrees that if after the date of this letter and any application submitted in conjunction herewith, and prior to the inception date of the Policy, any claim, suit, occurrence, event, incident or circumstance should render any of the answers or information contained in this Supplement and any application submitted in conjunction herewith, inaccurate or incomplete, then the Applicant shall notify the Insurer of such claim, suit, occurrence, event, incident or circumstance and shall provide the Insurer with answers and information that would complete, update, correct, or amend the answers and information contained in this Supplement and any application submitted in conjunction herewith. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.

This SUPPLEMENTAL REPRESENTATIONS AND WARRANTIES herein, as well as the responses to the Supplemental Questionnaire, shall attach to and become a part of the Policy.

Applicant's Signature: _____ Date: _____

Title: _____ Printed Name:_____

**Supplemental Questionnaire Application**

# PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

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

- **Copy of License**
- **Copy of Members Enrollment Agreement**
- **5 year company loss runs**
- **Audited financial statement**
- **Current Valued Loss Runs (Minimum 5 years)**
- **Copies of State Surveys with Plan of Correction**
- **Brochures and Marketing Materials**
- **Facility Web Site URL**
- **Copy of sample contracts with Vendors**
- **Evacuation Plan**
- **Resume of The Administrator/Director**

## Corporate Information

1. Corporate Name _____
2. Address_____
3. City _____ State _____ Zip _____
4. Contact Name _____
5. Contact Title _____
6. Phone _____
7. FAX _____
8. E-Mail _____
9. How many years has this organization been in business? _____
10. Effective Date _____
11. Prior Carrier_____
12. Expiring Premium $_____
13. Claims Made Retroactive Date _____
14. Has any insurance carrier cancelled or refused coverage that is similar to that being applied for in this Supplemental Questionnaire? Yes ☐ No☐
    If "Yes", please explain _____
15. In the past 5 years, has any claim or suit been filed against you for alleged medical professional malpractice, error or omission? Yes ☐ No☐
    If "Yes", explain_____

## General Information

1. For-profit: ☐ Not-for-Profit:☐
2. Is the facility affiliated with any other organization? Yes☐ No☐
   If yes, whom:_____

3. Annual Revenue: $_____ Number of Members: _____
4. Hours of operation: _____

**Supplemental Questionnaire**
**Application**

## Administrator

1. Name of Administrator/Director_____
   Length of service at this facility: _____ Total Experience:_____
2. Name of Medical Director_____
   Length of service at this facility: _____ Total Experience: _____

## Building Information

1. Is building 100% Sprinklered? Yes ☐ No ☐
   If not 100%, please list any unprotected areas_____
2. Has the sprinkler systems been tested by a qualified contractor? Yes ☐ No ☐
3. Does the building have heat and smoke detectors in all areas? Yes ☐ No☐
   If no, please explain_____
4. Are all alarms monitored by a UL approved central station or the responding fire department?
   Yes ☐No ☐
5. Are meals prepared at the center? Yes ☐ No ☐
   a. Is there a fire suppression system if meals are prepared at the center? Yes ☐ No ☐
   b. Is there a hood and grease filter? Yes ☐ No ☐
   c. What is the frequency of cleaning? _____
   d. Do you use an outside contractor for cleaning? Yes ☐ No ☐
   e. Is the area equipped with an automatic fuel shutoff? Yes ☐ No ☐
6. Are the meals prepared elsewhere? Yes ☐ No☐
   If yes, by whom?_____
7. Total number of fire extinguishers _____
8. Is video surveillance used? Yes ☐No☐
   If "yes", describe _____
9. Is the center, including the bathrooms, accessible to residents in a wheelchair? Yes☐ No☐
10. Is a written evacuation plan in place? Yes ☐ No ☐
11. How is the building secured? _____
12. Fully describe how are residents signed in and released:_____
    _____

## Member Census

1. Age of residents/number:
   55 to 65 years old: _____
   > 65 years old: _____
2. Number of developmentally disabled:
3. Number of Alzheimer or dementia residents:
   Is the center equipped with WanderGuard type device? Yes ☐ No☐
4. How are medical emergencies handled? If additional space is needed for this response, please attach the response to this Supplemental Questionnaire on your letterhead. _____
5. Number of Physicians Employed Affiliated Contracted
   If employed, is Medical Professional Insurance provided to the Physician?
   If 'Yes", Name of Physician_____ Medical Specialty
6. Number of Physician Assistants/ Nurse Practitioners Employed Affiliated Contracted
7. If Affiliated or Contracted, do you require limits of liability comparable to your own? Yes☐ No☐
   If No, define the differences in limits_____

8. Are the Physicians credentialed? Yes ☐ No☐
   Verification of License Yes ☐ No ☐
   Verification of DEA license Yes ☐ No ☐
9. Name of Medical Director_____
   a. Employed ☐Contracted ☐
   b. Length of service as the Medical Director_____
   c. Does the Medical Director have member contact? Yes ☐ No☐

## Staff

1. Provide number of the following who are employed:
   Physicians: _____RNs: _____LPNs: _____CNAs: _____Therapists: _____
   Social Workers: _____Others:_____
2. Staff to member ratio: _____
   a. Describe the background checks the facility performs for all employees of the facility:_____
   b. Do you verify licenses of professional staff upon hire and annually?
   c. Describe background verification checks on new employees?
      i. Work history? Yes ☐ No ☐
      ii. Education? Yes ☐ No ☐
      iii. Criminal Record? Yes ☐ No ☐
      iv. Drug Testing? Yes ☐ No ☐
      v. Motor Vehicle Records? Yes ☐ No ☐
3. Are volunteers used? Yes ☐ No☐
   If yes, how do you recruit them? _____

## Other

1. Are there any pets at the facility? Yes ☐No ☐
   If "Yes", are vaccination records kept on file? Yes ☐ No ☐
2. Is there a pool or other recreational equipment? Yes ☐ No ☐
   If "Yes" describe_____
3. Are children ever present in the facility? Yes ☐ No☐
   If "yes", describe_____
4. Describe any other operations/ services the facility provides to its residents or community_____

## Services Provided

| Service | PACE | Contractor | Name | Insurance Limit |
|---|---|---|---|---|
| Transportation | | | | |
| Adult Day Care | | | | |
| Meals on Wheels | | | | |
| Physician Care | | | | |
| Prescription Drugs | | | | |
| Meals | | | | |
| Physical Therapy | | | | |
| Occupational Therapy | | | | |
| Speech Therapy | | | | |
| Home Health Care | | | | |
| Dental | | | | |
| Podiatry | | | | |
| Optometry | | | | |
| Medical Equipment | | | | |
| Acute Care | | | | |
| Assisted Living | | | | |
| Skilled Care | | | | |
| Construction | | | | |
| Other | | | | |

**Supplemental Questionnaire Application**

**AUTHORIZATION** **DATE**

**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 complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued. It is agreed that this Application shall be on file with CNA and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy.**

**I hereby request that my Application for insurance coverage under the provisions of the PACE Program be submitted for consideration to CNA and its affiliates. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to CNA and its affiliates any and all information requested which may relate to insurability under the PACE Program.**

**I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.**

**FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

**WARNING – 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 DC 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 FL 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 LA 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 ME 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 NY residents only: 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 PA 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 TN and WA residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For VT 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.**