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APPLICATION FOR NURSING HOME, ASSISTED LIVING AND HEALTHCARE FACILITIES PROFESSIONAL AND GENERAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

PART I - ALL APPLICANTS MUST COMPLETE

1. APPLICANT INFORMATION

a. Full name of applicant: _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

c. [ ] Individual [ ] Partnership [ ] Corporation [ ] Governmental [ ] For Profit [ ] Not for Profit

d. Number of Employees: Full time _____ Part time _____ Total _____

e. Number of years this facility has been: Operating ___ Owned by current owner ___ Managed by current management ____

2. OPERATIONS

a. Are you:

(i) Certified for Medicare? ..... [ ] Yes [ ] No

(ii) Certified for Medicaid?..... [ ] Yes [ ] No

(iii) Licensed and certified as required by state and/or federal law? ..... [ ] Yes [ ] No

(iv) Accredited by JCAHO or CARF?..... [ ] Yes [ ] No

(v) A member of a state or national association? ..... [ ] Yes [ ] No
If Yes, please identify: _____
_____

(vi) Affiliated or contracted with any HMO/PPO or Managed Care System? ..... [ ] Yes [ ] No
If Yes, please describe:_____
_____

b. Facility Classification and Bed Census

	Total No. of Beds	Avg. No. Occupied
(i) Sub-acute/Rehabilitation Care Provides comprehensive inpatient care for someone who has an acute illness (i.e. stroke, heart attack) or recovery form surgery (i.e. hip or knee replacement). Sub-acute care is more nursing intensive than usual nursing home care and less intensive that hospital care.	_____	_____
(ii) Skilled Care Services Professional nursing care - 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following: Medical administration, tube feedings, injections, catheterizations. Other procedures ordered by physicians.	_____	_____

(iii) Intermediate Care Services
Nursing care during the day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feedings, etc.). Assistance with activities or daily living (i.e., walking, bathing, dressing, eating). Some assistance with medical administration. _____ _____

(iv) Assisted Living Services
Some nursing and/or health-related care to residents who do not require the degree of care and treatment described as skilled or intermediate. Residents may require some minor nursing care or help in activities such as washing, eating, bathing, dressing, walking, taking of medication, and preparation of special diets. _____ _____

(v) Residential Care Services
Residents are provided protective environments (meals and planned programs for social and/or spiritual needs). Residents responsible for their own medication. _____ _____

(vi) Independent Living Services
Retirement communities where residents live in apartments. Nursing or personal care is provided on an incidental or emergency basis only. More than 75% of the residents are over the age of 65. _____ _____

c. Resident/Patient Classifications (% of patient population): Medicaid _____ Medicare_____ Private Day _____

d. Resident/Patient Classifications by Age:

Age Group	No. of Residents/Patients% Non-ambulatory
Under 16	_____
17 - 21	_____
22 - 36	_____
37 - 50	_____
51 - 65	_____
Over 65	_____

e. Are you entered into any written indemnification agreements holding any other party harmless? ..... [ ] Yes [ ] No

f. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory? ..... [ ] Yes [ ] No

If Yes, attach a copy of ALL of your advertisements.

g. Annual Gross Receipts:

	Last 12 Months	Estimated next 12 months
Medicare	_____	_____
Medicaid	_____	_____
Charitable	_____	_____
Private Pay	_____	_____

h. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No
If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at https://www.markelcorp.com/en/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

3. SERVICES

a. Do you provide the following services?

		Yes	No	% of Patients
(i)	Subacute Care Rehabilitation	[ ]	[ ]	_____
(ii)	Alcohol abuse rehabilitation	[ ]	[ ]	_____
(iii)	Drug abuse rehabilitation	[ ]	[ ]	_____
(iv)	Methadone treatment	[ ]	[ ]	_____
(v)	Psychiatric care	[ ]	[ ]	_____
(vi)	Pet Therapy	[ ]	[ ]	_____
(vii)	Alzheimer/Dementia care	[ ]	[ ]	_____

b. Identify any outpatient services provided by your facility

	No. of Annual Visits/Revenues
Pharmacy for non-residents/patient	_____
Home Health Care	_____
Physical Rehabilitation/Therapy	_____
Mental Rehabilitation/Therapy	_____
Adult Day Care	_____
Child/Adolescent Day Care	_____

c. Are any offsite recreational, field trip or "challenge course" type activities undertaken? ..... [ ] Yes [ ] No
If Yes, please provide complete details

d. Are any athletic or recreational facilities contained on your premises, e.g., swimming pool, gymnasium, playing fields? If Yes, please describe in detail with particular attention to type of equipment present, i.e., high diving boards, trampolines, ropes, and level and quantity of supervision. ..... [ ] Yes [ ] No

e. Is a nursing assessment conducted for new patients?
If Yes, does this assessment include evaluation of:

(i) Skin breakdown/Decubiti ..... [ ] Yes [ ] No
(ii) Mobility limitations ..... [ ] Yes [ ] No
(iii) History of prior injuries ..... [ ] Yes [ ] No
(iv) Required assistance ..... [ ] Yes [ ] No
(v) Disorientation ..... [ ] Yes [ ] No
(vi) Current medications ..... [ ] Yes [ ] No

f. Are all medications kept in a secured (locked) location with limited key access? ..... [ ] Yes [ ] No

g. Is the dispensing of medications properly controlled with each patient dose recorded? ..... [ ] Yes [ ] No

h. Is a licensed pharmacist on staff or is there an agreement with an outside pharmacy? ..... [ ] Yes [ ] No
[ ] Staff [ ] Outside

i. How long are patient records kept? _____

j. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment? _____
_____

4. PROCEDURES

(Questions (a) through (f) apply only to facilities that provide either skilled or intermediate nursing home services.)

a. Do all patients have their own attending physician? ..... [ ] Yes [ ] No
If No, who performs the role of attending physician? _____
_____

b. (i) Are credential files maintained for physicians? ..... [ ] Yes [ ] No
What are minimum credential requirements? _____

(ii) Limits of liability physicians required to carry: _____

c. Are written attending physician orders required for:

All drugs or medicines ..... [ ] Yes [ ] No
Special dietary requirements ..... [ ] Yes [ ] No
Any other specific therapy/treatment ..... [ ] Yes [ ] No
Use of restraints ..... [ ] Yes [ ] No

d. How often are attending physicians required to update their patient charts? (No. of days) _____

e. Is smoking permitted in patient rooms? Describe any other rules applicable to smoking. ..... [ ] Yes [ ] No

f. Are there alarms or exit doors to prevent patients from leaving the premises without proper authorization? ..... [ ] Yes [ ] No

5. STAFF

a. (i) Are criminal record checks a part of pre-employment screening? ..... [ ] Yes [ ] No
(ii) Are state nurses aide registries checked for new hires? ..... [ ] Yes [ ] No

b. For each position listed below, please respond.

	Employed	Contracted	Full-Time	Part-Time	Years at This Facility	Years Experience
Director of Nursing						
Medical Director						
Administrator						

Please provide name and qualifications of Medical Director: _____

_____

c. For each classification listed below, show the number of full and part-time employees and/or independent contractors.

	1st Shift		2nd Shift		3rd Shift	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Physicians on Staff						
Physicians on Call						
Dentists						
Registered Nurses						
Licensed Practical Nurses						
Nurses Aides						
Physical Therapists						
Dieticians						
Beauticians/Barbers						
Administrative Personnel						
Maintenance/Security Personnel						
Social Workers						
Counselors						
Pharmacists						
Podiatrists						
Other – describe						
Total Number of Employees/ Independent Contractors						

d. Ratios of professional staff to occupied beds by shift: 1st_____:_____ 2nd _____:_____ 3rd _____:_____

6. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ..... [ ] Yes [ ] No

b. Have you been the subject of any license suspension or revocation or been place under probation? ..... [ ] Yes [ ] No

c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? ..... [ ] Yes [ ] No

d. Are written procedures in effect for incident reporting? ..... [ ] Yes [ ] No

e. Provide name and title of individual responsible for reviewing incident reports and determining whether corrective action is necessary: _____

_____

f. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you? ..... [ ] Yes [ ] No

g. Provide professional liability loss experience, currently valued, from your carrier for each of the last five (5) years. _____

_____

h. List prior professional liability insurance carried for each of the past five year. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	

i. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?.....[ ] Yes [ ] No

PART II: COMPLETE ONLY IF GENERAL LIABILITY COVERAGE DESIRED

1. PREMISES INFO

a. Building Description

	Buildings/Wing #1	#2	#3	#4
Type of Construction				
No. of Stories				
Total Beds				
Date Built				
Complete or Partial Sprinkler System				
Use of Building				

b. Are patient care facilities equipped with:

(i) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
(ii) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No
(iii) Exit doors of at least 42 inches width from all sleeping, diagnostic and treatment rooms? ..... [ ] Yes [ ] No
(iv) Automatic fire alarm system connected to local fire department? ..... [ ] Yes [ ] No

c. Location of smoke detectors:

[ ] None
[ ] Hallways
[ ] Common Areas
[ ] Patient or resident rooms
[ ] Other - Location: _____

Areas protected by approved automatic sprinkler system:

[ ] None
[ ] Trash collection area
[ ] Soiled linen chutes & rooms
[ ] Other - Location: _____
[ ] Hallways
[ ] Common Areas
[ ] Patient or resident rooms

d. Do you have any auxiliary electrical supply system? ..... [ ] Yes [ ] No

e. Are handrails provided in hallways and bathrooms? ..... [ ] Yes [ ] No

f. Are bathtubs/showers equipped with nonslip surfaces? ..... [ ] Yes [ ] No

g. Are all skilled or intermediate care patient beds equipped with siderails? ..... [ ] Yes [ ] No

2. PROCEDURES

a. Evacuation:

(i) Do you have a written emergency evacuation plan? ..... [ ] Yes [ ] No
(ii) Does your plan include advance arrangements for transportation and temporary shelter? ..... [ ] Yes [ ] No

(iii) Are evacuation directions posted in all parts of your facility? ..... [ ] Yes [ ] No

(iv) Does your staff orientation plan include a review and "walk through" of any disaster plan? ..... [ ] Yes [ ] No

(v) How often are evacuation/fire drills conducted each year for each shift?
Monthly/Quarterly/Annually/Other _____

b. Do you have a written patient safety policy? ..... [ ] Yes [ ] No
If Yes, attach a copy of this policy.

c. Is any real or personal property or equipment sold or leased to others? ..... [ ] Yes [ ] No
If Yes, please describe and advise estimated gross sales and/or receipts.

3. CLAIMS/HISTORY

a. Provide general liability loss experience, currently valued, from your carrier for reach of the last five (5) years.

b. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? ..... [ ] Yes [ ] No
If Yes, attach an explanation.

c. Please list general liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						[ ]	[ ]	
						[ ]	[ ]	
						[ ]	[ ]	

PART III - ADDITIONAL ATTACHMENTS

1. All Applicants

   a. List of additional Insureds, description of their operations and relationship to you.
   b. List of your additional locations.
   c. Current, audited financial statement.
   d. "Hold Harmless" agreement(s).
   e. Professional Loss experience for past five years.

2. For General Liability Coverage

   a. Most recent property & boiler inspection reports.
   b. Recent liability survey report.
   c. Diagram of building
   d. General Liability loss experience for past five years.

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.