



SHAND MORAHAN & COMPANY, INC.

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(847) 572-6000 Fax (847) 572-6137

APPLICATION FOR
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 address: _____
- 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:
- | | Yes | No |
|--|-----|-----|
| (i) Certified for Medicare? | ___ | ___ |
| (ii) Certified for Medicaid? | ___ | ___ |
| (iii) Licensed and certified as required by state and/or federal law?..... | ___ | ___ |
| (iv) Accredited by JCAHO or CARF? | ___ | ___ |
| (v) A member of a state or national association? | ___ | ___ |
| If Yes, please identify: _____ | | |
| _____ | | |
| (vi) Affiliated or contracted with any HMO/PPO or Managed Care System? | ___ | ___ |
| 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 from surgery (i.e. hip or knee replacement). Sub-acute care is more nursing intensive than usual nursing home care and less intensive than 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. | _____ | _____ |

- Yes No**
- e. Is a nursing assessment conducted for new patients? _____
- If Yes, does this assessment include evaluation of:
- (i) Skin breakdown/Decubiti _____
 - (ii) Mobility limitations _____
 - (iii) History of prior injuries _____
 - (iv) Required assistance..... _____
 - (v) Disorientation _____
 - (vi) Current medications _____
- f. Are all medications kept in a secured (locked) location with limited key access? _____
- g. Is the dispensing of medications properly controlled with each patient dose recorded? _____
- h. Is a licensed pharmacist on staff or is there an agreement with an outside pharmacy? _____
 ? On 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.)

- Yes No**
- a. Do all patients have their own attending physician? _____
- If No, who performs the role of attending physician? _____
- b. (i) Are credential files maintained for physicians? _____
 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 _____
 - Special dietary requirements _____
 - Any other specific therapy/treatment _____
 - Use of restraints _____
- 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. _____
- f. Are there alarms or exit doors to prevent patients from leaving the premises without proper authorization? _____

5. STAFF

- a. (i) Are criminal record checks a part of pre-employment screening? _____
- (ii) Are state nurses aide registries checked for new hires? _____
- 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.

- | | Yes | No |
|---|---------|--------|
| a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? | ___ | ___ |
| b. Have you been the subject of any license suspension or revocation or been place under probation? | ___ | ___ |
| c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? | ___ | ___ |
| d. Are written procedures in effect for incident reporting? | ___ | ___ |
| 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? | ___ | ___ |
| g. Provide professional liability loss experience, currently valued, from your carrier for each of the last five (5) years. _____
_____ | | |
| h. Year 2,000 computer systems issue: | | |
| (i) Do your computer systems store a four-digit year? | ___ Yes | ___ No |
| (ii) If no, please attach a description of corrective measures taken and anticipated resolution date. | | |
| (iii) Are you, in the course of your business, working to solve the year 2,000 problem as a consultant/advisor or as a part of your employment? | ___ Yes | ___ No |
| (iv) If yes, what percentage of your work is involved? _____% | | |

i. 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?		Retro Date
						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: Areas protected by approved automatic sprinkler system:
- [] None [] None [] Hallways
 - [] Hallways [] Trash collection area [] Common Areas
 - [] Common Areas [] Soiled linen chutes & rooms [] Patient or resident rooms
 - [] Patient or resident rooms [] Other - Location: _____
 - [] Other - Location: _____

- 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?		Retro Date
						Yes	No	
_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	[]	[]	_____

PART III - ADDITIONAL ATTACHMENTS

- All Applicants
 - List of additional Insureds, description of their operations and relationship to you.
 - List of your additional locations.
 - Current, audited financial statement.
 - "Hold Harmless" agreement(s).
 - Professional Loss experience for past five years.
- For General Liability Coverage
 - Most recent property & boiler inspection reports.
 - Recent liability survey report.
 - Diagram of building
 - 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 Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

_____	_____
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.