

**OneBeacon Insurance Company
 Homeland Insurance Company of New York
 Traders and General Insurance Company
 York Insurance Company of Maine**

**LONG TERM CARE ORGANIZATION
 PROFESSIONAL LIABILITY APPLICATION**

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

A separate completed application is required for each facility.

A. Applicant Information

1. Legal name of facility: _____
 (Wherever used, the term "**Applicant**" shall mean the entity set forth in Section A1.)
2. Address: _____
 City: _____ State: _____ Zipcode: _____
3. Telephone Number: _____
4. Website: _____ E-mail Address: _____
5. Please list all affiliates and subsidiaries to which this insurance will apply. Include a complete description of the operations of each affiliate / subsidiary and its relationship to the **Applicant**. (Please attach a separate sheet if necessary.) (*Please note that coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)

<u>Name</u>	<u>Description of Operation</u>

6. How many years has the **Applicant** been in operation? _____
7. How many years has the **Applicant** been under present ownership? _____ Management? _____
8. **Applicant** is: (Please check all appropriate categories.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Individual Ownership | <input type="checkbox"/> Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Not For Profit | <input type="checkbox"/> Operated For Profit | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Charitable Organization | <input type="checkbox"/> Medicaid Certified | <input type="checkbox"/> Medicare Certified |
| <input type="checkbox"/> Accredited by CARF-CCAC | <input type="checkbox"/> Accredited by JCAHO | <input type="checkbox"/> Licensed By State |
| <input type="checkbox"/> Other _____ | | |

B. Description of Services

1. Bed Census

	Number of Licensed Beds	Number of Occupied Beds
Skilled Nursing Facility / Nursing Facility	_____	_____
Assisted Living / Residential Care	_____	_____
Independent Living (No Medical Professional Services Provided)	_____	_____

2. Contracted Professional Services None

Identify all contracted professional services performed for the **Applicant** and indicate the required professional liability insurance limit you require them to maintain.

<u>Type of Service</u>	<u>Required Limits</u>	<u>Type of Service</u>	<u>Required Limits</u>
Beautician / Barber.....	_____	Physical Therapy.....	_____
Dental.....	_____	Physician.....	_____
Dietary.....	_____	Radiology.....	_____
Laboratory.....	_____	Respiratory Therapy	_____
Occupational Therapy.....	_____	Speech Therapy.....	_____
Other: _____	_____	Pharmaceutical.....	_____

Do you obtain Certificates of Insurance for the contracted professional individuals? Yes No

3. Other Professional Services None

Indicate which of the following services are provided by **Applicant**:

- Adult Day Care Number of Daily Attendees _____
- Home Health Services Number of Annual Visits _____
- Other: _____

C. Resident Profile

1. Please state the percentage of payment / reimbursement in each category:

_____	_____	_____	_____
Medicare	Medicaid	Private Pay	Other

If Other, list payment source: _____

2. Number of patients restrained? _____

3. Are there any non-ambulatory residents above the first floor? Yes No

4. Do you have any non-geriatric residents whom you provide skilled care? Yes No

If yes, how many? _____

5. Resident Age Groups

<u>Age Group</u>	<u>Number of Residents</u>	<u>% of Non-Ambulatory</u>
Under the Age of 50	_____	_____
51 to 64 Years of Age	_____	_____
Over 65	_____	_____

6. Please indicate the number of residents in each category:

	<u>Number of Residents</u>
Residents Confined to Bed	_____
Residents Receiving Tube Feedings	_____
Residents Receiving Dialysis Care	_____
Residents In Need of Assistive Devices While Eating	_____
Residents Receiving Chemotherapy / Radiation Therapy ...	_____
Traumatic Brain Injured Residents	_____
Residents Receiving IV Therapy	_____
Residents Receiving Respiratory Treatment	_____
Residents Receiving Dementia Care	_____
Residents Receiving Specialized Rehabilitative Care	_____
Residents Receiving Hospice Care	_____
Residents Receiving Suctioning	_____

Number of residents receiving assistance with Activities of Daily Living:

	<u>Needing Assistance</u>	<u>Totally Dependent</u>
Bathing	_____	_____
Dressing	_____	_____
Transferring	_____	_____
Toilet Use	_____	_____
Eating	_____	_____

I. General Information

1. Has the **Applicant** or any other associated entity had its' Medicaid or Medicare certification limited, suspended or revoked within the last five years? Yes No

If yes, please explain: _____

2. Has the **Applicant** or any other associated entity ever had a license suspended, revoked, or placed under probation by any government licensing agency? Yes No

If yes, please explain: _____

3. Has the **Applicant** ever filed bankruptcy? Yes No

If yes, please explain: _____

4. Is any part of the **Applicant** operated / leased by a management corporation? Yes No

If yes, please explain: _____

5. Has the **Applicant** been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? Yes No

If yes, please explain: _____

6. Does the **Applicant** anticipate any facility expansions (increase in licensed beds or new facilities) within the next year? Yes No

If yes, please explain: _____

7. Does the **Applicant** have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next twelve months? Yes No

If yes, please explain: _____

E. Administration and Staff

1. Administrator

Name: _____

Full time at this facility? Part time at this facility? Number of Hours per week: _____

Number of years experience as an administrator? _____

Number of years as administrator at this facility? _____

Does the administrator have a current, unrestricted administrator's license? Yes No

Is the administrator a member or certified fellow of ACHCA? Yes No

2. Medical Director

Does **Applicant** employ or contract a medical director? Employ Contract

Name: _____

Medical Specialty: _____

Number of years experience as a Medical Director? _____

Number of years as a Medical Director at this facility? _____

Full time at this facility? Part time at this facility? Number of Hours per week: _____

Does the medical director also act as the attending physician for any residents? Yes No

If a medical director is not employed or contracted by **Applicant**, who is responsible for overseeing the delivery and quality of medical services provided?

3. Risk Manager

Name: _____

Full time at this facility? Part time at this facility? Number of Hours per week: _____

Number of years experience as a Risk Manager? _____

Number of years as a Risk Manager at this facility? _____

4. Director of Nursing

Name: _____

Full time at this facility? Part time at this facility? Number of Hours per week: _____

Does the Director of Nursing have a current, unrestricted license? Yes No

Is the Director of Nursing a member of NADONNA? Yes No

Number of years as a Registered Nurse? _____

Number of years experience as a Director of Nursing? _____

Number of years as Director of Nursing at this facility? _____

5. Other

For each classification below, show the total number of employees.

(Use full time equivalents. Only include direct care providers.)

	<u>1st Shift</u>	<u>2nd Shift</u>	<u>3rd Shift</u>	<u>Turnover %</u>
Certified Nursing Assistants.....	_____	_____	_____	_____
Dieticians.....	_____	_____	_____	_____
Licensed Practical Nurses.....	_____	_____	_____	_____
Maintenance / Security Personnel.....	_____	_____	_____	_____
Medication Aides.....	_____	_____	_____	_____
Physical Therapists.....	_____	_____	_____	_____
Podiatrists.....	_____	_____	_____	_____
Registered Nurses.....	_____	_____	_____	_____
Social Workers.....	_____	_____	_____	_____
Volunteers.....	_____	_____	_____	_____
Other : _____	_____	_____	_____	_____

Does the **Applicant** use any agency staffing for nursing positions? Yes No

If yes, are any shifts or units staffed exclusively by agency nurses?

Do members of the **Applicant's** nursing staff belong to any union? Yes No

6. Does **Applicant** provide staff monetary incentives for continuing education? Yes No

7. Does **Applicant** conduct formal, ongoing skill assessments and training of all staff providing resident care? Yes No

If yes, how often is this done? _____

How is this documented? _____

8. Staff Hiring Procedures:

Which of the following does the **Applicant** evaluate when hiring individuals to provide resident care services at the facility, check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Criminal Background | <input type="checkbox"/> Educational Background |
| <input type="checkbox"/> Drug Screening | <input type="checkbox"/> Sexual Offender Registry |
| <input type="checkbox"/> Personal References | <input type="checkbox"/> In Writing <input type="checkbox"/> By Telephone |
| <input type="checkbox"/> Previous Employer's Reference | <input type="checkbox"/> In Writing <input type="checkbox"/> By Telephone |

For physicians, oral surgeons and dentists: Are hospital privileges checked? Yes No

Are licenses checked? Yes No

Do you check for any disciplinary actions? Yes No

Are driver's license checked for anyone who transports residents? Yes No

Is the state Nurses Aides registry checked? Yes No

F. Policies and Procedures

1. Does the Applicant have a written emergency evacuation plan? Yes No
 - a. Are evacuation plans posted in all parts of the facility? Yes No
 - b. How often are evacuation / fire drills conducted each year for each shift? _____
 - c. Does the staff orientation plan include a review and "walk through" of any disaster plan? Yes No
 - d. Does the evacuation plan include advanced arrangements for transportation and temporary shelter? Yes No
2. Do you require evidence of acceptable health of all new residents admitted to your facility? Yes No
3. Is a comprehensive nursing assessment conducted for new residents? Yes No
How frequently is it repeated? _____
4. Is an inventory taken of residents' personal belongings on admittance with a copy maintained in the file? Yes No
5. Do all residents have their own attending physician? Yes No
If "No," who performs the role of attending physician? _____
6. How often are attending physicians required to update their patients' charts? # of days: _____
7. Are written orders from an attending physician required for:

All Drugs and Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other Specific Therapy / Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Facility or Hospital Transfers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restraints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Dietary Requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does **Applicant** retain a physician on-site or on-call on a 24-hour basis? Yes No
9. Do you obtain advance written consent from the resident or guardian that allows your facility to provide non-emergency medical care when it is needed? Yes No
10. Does **Applicant** have a "Do Not Resuscitate" policy in place? Yes No
11. Who determines if a resident must be transferred to another facility for further medical diagnosis or treatment?

12. How often do nurses perform total body skin assessments? _____
13. Does **Applicant** transfer patients with Stage III or IV pressure ulcers to another facility providing a higher level of care for treatment, or does **Applicant** provide treatment?
 Transfer to another Facility Treat at this Facility
14. Does **Applicant** have a policy regarding the use of physical and chemical restraints? Yes No
 If yes, please attach a copy.
15. Are physicians' orders verified as to restraints? Yes No
16. Does **Applicant** have a written policy / procedure to investigate alleged resident abuse and neglect? Yes No If yes, please attach a copy.
17. When and how often are fall risk assessments done? _____
 Please attach a copy of the policy and assessment tool.
18. When and how often are residents assessed for wandering and elopement? _____
 Please attach a copy of the policy and assessment tool.
19. Is a Wander Guard System (or similar system) in place? Yes No
20. Do you conduct elopement drills? Yes No If yes, how often? _____
21. Has any resident eloped from your facility? Yes No
 If yes, how many? _____ When? _____
22. Does your facility have a Resident/Family council? Yes No

G. Risk Management

1. Does **Applicant** have a formalized risk management program? Yes No
2. Is it a separate stand-alone program or integrated into the **Applicant's** Quality Management Program?
 Stand Alone Integrated
3. Who coordinates the **Applicant's** risk management activities? _____
4. What are the Risk Manager's accountabilities: (Check all that apply.)
 Loss Control Identification and Investigation of Potential Claims
 Safety / Security Insurance Purchase and Risk Financing
5. Does the **Applicant** monitor the effectiveness of its' risk management activities? Yes No
6. Does the risk management program include the following:
- | | | |
|---|------------------------------|-----------------------------|
| Claims Management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Contract Review and Evaluation at Facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Incident Reporting / Critical Indicator Screening | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient Complaint / Grievance Procedures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Safety Program at Corporate Level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tracking and Trending of Incidents at the: | | |
| Corporate Level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Facility Level | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

H. Physical Premises

1. Recreation Facilities None

	<u>Number</u>		<u>Number</u>
Exercise / Weight Room	_____	Sauna / Hot Tub	_____
Swimming Pool	_____	Tennis or Racquetball Court	_____
Other	_____		_____

2. Please list below all the buildings the **Applicant** owns, controls, leases or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. List additional facilities on a separate sheet of paper, if necessary.

Location # _____ Address: _____

City: _____ State: _____ Zip code: _____

Year Built: _____ # of Stories: _____ Total Square Feet: _____

Was this building originally designed and constructed for nursing home occupancy? Yes No

Does this building meet applicable current NFPA life safety codes? Yes No

When was the electric, heating or plumbing last inspected or updated?

	Electric	Heating	Plumbing
Inspected	_____	_____	_____
Updated	_____	_____	_____

Construction Type: Frame Brick Non-Combustible
 Masonry Non-Combustible Fire Resistive

Location of Smoke Detectors:

- None
- Entire Facility
- Hallways
- Common Areas
- Resident Rooms
- Other: _____

Areas Protected by Approved Automatic Sprinkler System:

- None
- Entire Facility
- Hallways
- Common Areas
- Resident Rooms
- Soiled Linen Chutes and Rooms
- Trash Collection Area

Location # _____ Address: _____

City: _____ State: _____ Zip code: _____

Year Built: _____ # of Stories: _____ Total Square Feet: _____

Was this building originally designed and constructed for nursing home occupancy? Yes No

Does this building meet applicable current NFPA life safety codes? Yes No

When was the electric, heating or plumbing last inspected or updated?

	Electric	Heating	Plumbing
Inspected	_____	_____	_____
Updated	_____	_____	_____

Construction Type: Frame Brick Non-Combustible
 Masonry Non-Combustible Fire Resistive

Location of Smoke Detectors:

- None
- Entire Facility
- Hallways
- Common Areas
- Resident Rooms
- Other: _____

Areas Protected by Approved Automatic Sprinkler System:

- None
- Entire Facility
- Hallways
- Common Areas
- Resident Rooms
- Soiled Linen Chutes and Rooms
- Trash Collection Area

H. Security and Life Safety

1. Is smoking permitted in resident rooms? Yes No

Is smoking permitted in common areas? Yes No

Describe rules applicable to smoking: _____

2. What security measures are used to control unauthorized entrance to the facility?

3. Are there any alarms on exit doors to alert the staff that residents may be leaving the building? Yes No

How often are they checked? _____ By whom? _____

How is this documented? _____

4. Are handrails provided in hallways and bathrooms? Yes No

5. Are bathtubs / showers equipped with non-slip surfaces? Yes No

J. Coverage Information

1. Current Professional Liability coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: _____

Claims-Made Retroactive Date: _____ Occurrence

Deductible _____ Self Insured Retention _____

Premium: _____

2. Current General Liability coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: _____

Claims-Made Retroactive Date: _____ Occurrence

Deductible _____ Self Insured Retention _____

Premium: _____

3. Current Excess coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: _____

Claims-Made Retroactive Date: _____ Occurrence

Deductible _____ Self Insured Retention _____

Premium: _____

MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER THIS QUESTION.

4. Has any insurer cancelled or declined to issue professional liability insurance for the **Applicant**? Yes No

If yes, explain: _____

5. Loss History:

Please attach a carrier produced currently valued loss history for the last 10 years from any and all previous carriers. The loss history should include current year and a breakdown of total incurred losses, paid losses, and outstanding losses separated by year for all coverages. Include primary and excess losses.

6. Is the applicant is aware of any fact, circumstance or situation that gives the applicant reason to believe that it might result in any future claim under the insurance for which this application is made? Yes No
If yes, explain: _____

7. Requested Quote: (Please note that coverage for this request is not automatically available; the terms and conditions of the Policy, if issued, will determine actual coverage.):

Requested total limits of liability: _____ / _____
Per Claim Annual Aggregate

Requested retention: _____ / _____
Per Claim Annual Aggregate

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THE RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

K. Requested Items

Please submit the following items:

- **Applicant's** most recent financial statement.
- **Applicant's** most recent JCAHO report or CCAC report if applicable.
- Copies of the most recent state survey with Plan of Correction.
- Current Quality Indicator Profile
- CMS Form 671 – Long term Care Facility Application
- CMS Form 672 – Resident Census and Conditions of Residents
- CMS Form 802 with redacted resident names

NOTICE TO APPLICANT - PLEASE READ CAREFULLY.

For the purposes of this Application, the undersigned authorized agent of the person(s) and the entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The Underwriter considers the Application, which is on file with the Underwriter, physically attached to any policy issued. The Underwriter will have relied upon this Application in issuing the policy.

The **Applicant** authorizes the Underwriter to make any inquiry in connection with this Application. Accepting this Application does not bind the Underwriter to complete, or the **Applicant** to purchase, the insurance.

If the information in this Application materially changes between the date of this Application and the policy effective date, the **Applicant** will notify the Underwriter which may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that the person(s) and entity(ies) applying for this insurance understand that:

- (i) certain insuring agreements apply only to "Claims" first made or deemed made during the "Policy Period" or any Extended Reporting Period; and
- (ii) "Defense Expenses" will be applied against the retention.

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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York 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 each 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.

