

ASSISTED LIVING FACILITY LIABILITY APPLICATION

The purpose of this application form is for us to find out who you are and what material information is specific to your circumstances for this cover. Completion of this application form does not oblige either party to enter into a contract of insurance. Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed.

Whoever fills out the form must be principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered.

FACILITY DETAILS

1) Facility Name:

2) Street Address:

City

State

Zip Code

3) Facility Website Address:

4) Administrator's Name:

Telephone No.

5) Is the Facility licensed by the State?

When does the license expire?

6) Ownership of Facility:

7) If part of a chain, how many Facilities in the chain?

8) Number of licensed AL beds:

Number of AL Beds Occupied:

9) Is the Facility part of a CCRC?

If yes, number of SNG licensed beds?

SNF Occupied beds?

IL units:

10) Does the Facility provide any health care services to non-residents?

If yes, please explain below:

11) What is the number of new residents in the past 12 months?

12) Has the Facility traded at a profit in the last 3 years? If no, please attach financials.

13) Year Facility was built: Year of last renovation or upgrade:

14) Number of years in operation: Number of floors: Number of elevators:

15) Number of separate buildings: If more than 1, are the transfers between buildings secure?

CLAIMS/COMPLAINTS

16) Has the Facility had any regulatory actions or formal complaints against it in the last 5 years?
If yes, please attach details.

17) Has the Facility had any liability claims, or experienced any circumstances or incidents which could give rise to a liability claim in the last 5 years? If yes, please attach loss runs.

RESIDENT PROFILE

18) Please indicate the percentage of residents in the following age groups:

Less than 50 50 to 65 65 to 80 Greater than 80

Average percentage of residents diagnosed with Alzheimer's or Dementia:

BUILDING FIRE PROTECTION

19) Please detail the Facility's fire-protections below:

Common Areas:	Heat Detectors	Smoke Detectors	Sprinkler System
Hallways:	Heat Detectors	Smoke Detectors	Sprinkler System
Resident Rooms:	Heat Detectors	Smoke Detectors	Sprinkler System

20) Please indicate below how the fire detection system is routed:

Direct Notification of Fire Department: Central Onsite Monitoring:

Offsite Monitoring: No Monitoring:

21) Please indicate what the Facility's smoking policy is below:

Smoking permitted in designated indoor area(s):

Smoke-free building with smoking allowed in designated outdoor area(s):

No smoking allowed anywhere on the property:

EXIT CONTROLS

22) CCTV Wanderguard (or equivalent) Observed Exit

Electronic Door Monitoring Device Alarms

23) Number of elopements in the last 12 months:

STAFF DETAILS

24) Number of years of experience of administrator: Years with this Facility:

25) Are all new employees subject to criminal background checks?

If yes, please indicate the types of checks performed below:

Drug screening: Fingerprints: Sexual Offender Registry:

26) Is the licensure status of employees verified?

27) Are medication technicians used at the Facility? If yes, please answer the following:

Are the medication technicians trained in state-approved programs?

How many new employees not including contract staff) were added to the nursing staff in the last 12 months, broken down into the following categories?

RN LPN/LVN CNA/Personal Care Aides

28) How many hours per week of service are rendered by each of the following types of providers?

HOURS PER DAY (for all employees of each provider type)

- RNs
- LPNs/LVNs
- Certified Nursing Assistants
- Non-certified direct care staff (e.g. Personal Care Assistants)
- Medication Technicians (If applicable)

29) Does the Facility use contract (aka agency, registry) staff?

If yes, is evidence of Insurance requested from them?

30) If contract staff are used, what PERCENTAGE of all hours are provided by contract staff, broken down into the following categories?

RN

LPN/LVN

CNA/Personal Care Aides

Medication Technicians

CURRENT LIABILITY INSURANCE INFORMATION

31) Limit each loss:

Limit overall policy:

Deductible or self Insured retention:

Retroactive date:

Premium:

COMMENTS

Please add any additional information regarding the answers given above here:

SIGNATURES

PLEASE NOTE: COVERAGE IS WRITTEN WITH A NON-ADMITTED CARRIER. AGENT WARRANTS THAT ALL INSURANCE REQUIREMENTS OF APPLICANT'S HOME STATE HAVE BEEN OR WILL BE COMPLIED WITH, INCLUDING MAKING THE SURPLUS LINES FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.

Application must be signed and dated by Applicant:

Signed:

Name:

Title:

Date:

Application must be signed and dated by Agent for the Applicant:

Name of Agency:

Name of Agent:

Signature:

Date: