Northland Insurance Companies
An Associates Company

APPLICATION - HEALTH CARE FACILITY

BUSINESS INFORMATION

1. Named Insured_____
2. Mailing Address_____
   Street City County State ZIP Code
3. Location of premises: ❑ Same as mailing address
   ❑ Other_____
4. Telephone (____) _____ Fax (____) _____
5. Contract person/phone #: Inspection_____
   Accounting/Records_____
6. Business type: ❑ Individual ❑ Partnership ❑ Corporation ❑ LLC ❑ Other_____
7. Operating as: ❑ For Profit ❑ Nonprofit ❑ Other_____
8. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other _____
9. Part occupied by Named Insured: ❑ Entire ❑ Portion(_____%) ❑ Other (Lessor's Risk Only)
10. Date business established_____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: ❑ General liability ❑ Professional Liability
2. Limit of Liability Desired: ❑ $100,000/$300,000 ❑ $300,000/$600,000 ❑ $500,000/$1,000,000
   ❑ $1,000,000/$2,000,000 ❑ Other_____
3. Physical/Sexual Abuse: ❑ $25,000/$50,000 ❑ $50,000/$100,000 ❑ $100,000/$300,000

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Medical Payments	$5,000
Personal and Advertising Injury	Same as Occurrence Limit

4. Contractual Liability: ❑ (Attach copy of contract) No separate limit
5. Effective Date Desired_____ Term Desired_____

TYPE OF FIRM

1. Type of firm:
   - ❑ Counseling Agency Type_____
   - ❑ Drug/Alcohol Rehab. Center Type _____
   - ❑ Foster Care Home
   - ❑ Halfway House Type_____
   - ❑ Mentally Ill Facility
   - ❑ Mentally Handicapped Facility
   - ❑ Physically Handicapped Facility
   - ❑ Other _____ Type _____
   - ❑ Group Home Type _____
   - ❑ Hospice
   - ❑ Mental Health Center
   - ❑ Physical/Occup. Rehab. Center
   - ❑ Shelter
2. Description of operations. _____

PREMISES

1. Age of building _____
2. Construction _____
3. Number of floors _____
4. Total square footage _____
5. Number of exits _____

	Yes	No
6. Central station alarm	❑	❑
7. Emergency lighting	❑	❑
8. Fully sprinklered	❑	❑

If no, describe extent of sprinklering:
_____
_____

9. Last update: Wiring_____ Plumbing_____

	Yes	No
10. Smoke detectors in: All sleeping rooms	❑	❑
Halls	❑	❑
11. Swimming pools	❑	❑
12. Has emergency evacuation plan been prepared?	❑	❑
13. Are both scheduled and unscheduled fire and emergency drills conducted?	❑	❑
14. Was building built for this purpose?	❑	❑
15. Are emergency facilities readily available?	❑	❑

If yes, describe. _____
_____
_____

OPERATIONS

1. Does your facility: Diagnose patients/residents? ❑ Yes ❑ No
   Prescribe treatment or medications to patients/residents? ❑ Yes ❑ No
2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*
   _____
   _____
3. Are outpatient services provided? ❑ Yes ❑ No Number of outpatient visits annually _____
4. Number of beds_____ Average Occupancy_____ Licensed # of beds _____
5. Resident age groups (give number for each): Under 18 years_____ 18-65 years_____ Over 65 Years_____
6. Patient admission is: ❑ Forced ❑ Voluntary

	Yes	No
7. Are patients/residents accepted on a court order?	❑	❑
8. Are there procedures in place for patient screening and acceptance?	❑	❑
9. Are current records and files maintained on each patient?	❑	❑
10. Have any patients/residents been given a probable diagnosis of having Alzheimer's?	❑	❑
If yes, how many and at what stage?_____ Stage 1_____ All other stages_____		
11. Have any patients/residents been diagnosed with a mental illness?	❑	❑
12. Average length of stay for patients/residents _____		
13. Are residents/patients allowed to leave premises unattended?	❑	❑
14. Number of non-ambulatory residents_____		
15. Any non-ambulatory patients above the second floor?	❑	❑
16. Describe management's/administrator's education and experience. _____		
_____		
17. Is there a record keeping system in place that documents: Operational procedures?	❑	❑
Incidents?	❑	❑
18. Do you train new paraprofessionals (e.g. aides, homemakers?)	❑	❑
If yes, explain. _____		
_____		
19. Do you provide ongoing training for paraprofessionals?	❑	❑

20. Describe the duties of volunteers or students. _____
    _____
21. Additional insureds (state their interests in insured's operation)._____
    _____
22. Total all locations: Receipts $_____ Outpatient Visits_____

23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.) _____

_____

24. Do you sell or lease any medical equipment or other products **to others**? ❑ Yes ❑ No
If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.

_____

_____ Receipts: _____

Do you require lessees to provide certificates of insurance? ❑ Yes ❑ No

25. Do you lease or rent any equipment **from others**? ❑ Yes ❑ No

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? ❑ Yes ❑ No

2.

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

	Yes	No
a. Do you comply with minimum required staff standards for each shift?	❑	❑
b. Are all staff certified/licensed according to federal, state, or local requirements?	❑	❑
c. Are any staff working on a contract basis?	❑	❑
If yes, do you require proof of separate professional liability insurance?	❑	❑

3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable	❑	❑	❑
b. Previous employers check	❑	❑	❑
c. Personal references check	❑	❑	❑
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals	❑	❑	❑
e. Criminal background check	❑	❑	❑

Are copies of background checks kept on file? ❑ Yes ❑ No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
❑ Yes ❑ No ❑ No licensing requirements
If no, state reasons for non-compliance and steps being taken to correct this.

_____

_____

Have you had any licensing or code violations in the past three years? ❑ Yes ❑ No
If yes, describe. _____

_____

Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?
❑ Yes ❑ No

2. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?
❑ Yes ❑ No ❑ No accreditation available
If yes, describe. _____

3. Are you a member of any professional association or organization? ❑ Yes ❑ No
   Name of association or organization. _____

RISK MANAGEMENT

		Yes	No
1.	Do you have a formal written risk management program?	❑	❑
2.	Is there a designated risk management person? If no, how are these duties delegated? _____	❑	❑
3.	Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage?	❑	❑
4.	Do you have: a. Written job descriptions?	❑	❑
	b. Policies and/or procedures manual?	❑	❑
	c. Full-time administrator or medical director on staff?	❑	❑
	d. Formalized loss control and claim prevention training program?	❑	❑
	e. Emergency shelter arrangements for residents?	❑	❑
5.	Have you entered into any other contractual agreements?	❑	❑
	a. If yes, is legal advice sought to write and approve?	❑	❑
	b. Does the agreement require you to hold any third party harmless?	❑	❑

PREVIOUS EXPERIENCE

		Yes	No
1.	Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? If yes, explain. _____	❑	❑
2.	**MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.** Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? *If yes, give name of company, date and reason.*	❑	❑

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				❑	
				❑	
				❑	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or 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 and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

_____
Signature of Applicant Title Date

_____
Signature of Producing Agent Date

_____
Agent Name and Address