ProHealthCareMGA
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PROFESSIONAL AND GENERAL LIABILITY APPLICATION
For Nursing Care and Rehabilitation Facilities

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".** ***PLEASE READ THE POLICY CAREFULLY.*** *(*Please note that coverage is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.)*

A separate completed application is required for each location/facility.

A. Applicant Information **Requested Effective Date:**

1. Parent/ Holding Company/ Organization: _____

2. 2a. First Insured Legal name: _____
(Wherever used, the term **"Applicant"** shall mean the entity set forth in Section 2.)

2b. Official/legal mailing address: _____

City: _____ State: _____ Zip code: _____

3. **dba /** Name of insured facility: _____

4. Facility Address: _____

City: _____ State: _____ Zip code: _____

5. Website: www. _____

6. Inspection Contact Person: _____ Phone: _____

7. Contact person's E-mail Address: _____

8. **Additional Named Insureds**: Please list all affiliates and subsidiaries to which this insurance policy will apply. (Ownership, real estate, or management companies would be examples.) To list more than three additional insureds, or add more information, please attach a separate sheet and check this box: ☐ # of pages attached.

Name and Address	Description and Relationship

9. Insured facility contains these service types: (If there is separate management of any or all types then another application should be filled out for each, and insert letter value assigned to end of key number.)

☐ S: Skilled Nursing ☐ A: Assisted Living ☐ I: Independent Living ☐ C: CCRC (all three)

10. How many years has the **Applicant** been in operation? _____

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

If yes, please explain: _____

12. This facility also has been known as: _____

13. How many years has the **Applicant** been under present: Ownership? _____ Management? _____

14. **Applicant** is: (Please check <u>all</u> appropriate categories.)

☐ Individual Ownership	☐ Corporation	☐ Partnership
☐ Not For Profit	☐ For Profit	☐ Governmental
☐ Certified Eden Alternative	☐ Medicaid Certified	☐ Medicare Certified
☐ Accredited by CARF-CCAC	☐ Accredited by JCAHO	☐ Licensed By State
☐ Other: _____	☐ Other: _____	☐ Other: _____

B. 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 for bankruptcy protection? ☐ Yes ☐ No

If yes, please explain: _____

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

If yes, please explain: _____

5. Does the **Applicant** anticipate any facility expansions (increase in licensed beds or new facilities) within the next 12 months? ☐ Yes ☐ No

If yes, please explain: _____

6. Does the **Applicant** have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next 12 months? ☐ Yes ☐ No

If yes, please explain: _____

C. Description of Services

1. Bed Census: Total certified beds _____ Total Occupied beds _____

Bed type Breakdown:	Licensed Beds/Units	Occupied Beds/Units
SubAcute		
Skilled Nursing Facility / Dementia		
Intermediate Care / Rehabilitation		
Assisted Living / Residential Care		
Independent Living / Hospice / Respite (No Medical Professional Services Provided)		

2. Other Professional Services

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

☐ Adult Day Care Average Number of Daily Attendees _____

☐ Home Health Services Average Number of Annual Visits _____

☐ Child Day Care Services Average Number of Daily Attendees _____

☐ Other: _____

D. Administration and Staff

1. What is the annual average total number of employees? _____

2. 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

3. Medical Director

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

Name: _____

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

Medical Specialty: _____

Number of years experience as a Medical Director: _____

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

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

Does **Applicant** require the Medical Director to carry medical malpractice coverage? ☐ Yes ☐ No

If yes, what limit(s) of liability does **Applicant** require? _____

Does **Applicant** obtain/review the Medical Director's certificate of malpractice insurance? ☐ 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? _____

4. 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: _____

Who coordinates the **Applicant's** risk management activities? _____

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

Does the **Applicant** monitor the effectiveness of its risk management activities? ☐ Yes ☐ No

How? _____

5. 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 of experience as a DON: _____

Number of years as DON at this facility: _____

Does **Applicant** require the DON to carry medical malpractice coverage? ☐ Yes ☐ No

If yes, what limit(s) of liability does **Applicant** require? _____

Does **Applicant** obtain/review the DON's certificate of malpractice insurance? ☐ Yes ☐ No

6. Nursing Staff: For each classification below, show the total number of employees. (Use full time equivalents. For Health Care Providers include only those providing direct care.)

Skilled Nursing Facilities:	1st Shift	2nd Shift	3rd Shift	Turnover %
Registered Nurses……				
Licensed Practical Nurses……..				
Certified Nursing Assistants……..				

Intermediate Nursing Facilities:	1st Shift	2nd Shift	3rd Shift	Turnover %
Registered Nurses……				
Licensed Practical Nurses……...				
Certified Nursing Assistants……...				

Assisted Living Facilities	1st Shift	2nd Shift	3rd Shift	Turnover %
Registered Nurses……				
Licensed Practical Nurses……...				
Certified Nursing Assistants……...				

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

If yes: Are any shifts or units staffed exclusively by agency nurses? ☐ Yes ☐ No
Which shift(s)? _____

Under what circumstances do you use agency staffing?

_____

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

7. Staff Hiring and Volunteer Screening Procedures:

Which of the following does the **Applicant** evaluate when hiring/screening individuals to provide resident care services at the facility? (Check all that apply.)

☐ Criminal Background ☐ Educational Background

☐ Drug Screening ☐ Sexual Offender Registry

☐ Personal References ☐ In Writing ☐ By Telephone

☐ Previous Employer's Reference ☐ In Writing ☐ By Telephone

☐ Other _____

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

Do you require medical malpractice insurance? ☐ Yes ☐ No What limit(s)? 1M/6M

Do you obtain evidence of medical malpractice insurance? ☐ Yes ☐ No

Is a driver's license checked for anyone who transports residents? ☐ Yes ☐ No

Is the state Nurses Aides registry checked? ☐ Yes ☐ No

Do volunteers go through an orientation/training process? ☐ Yes ☐ No

E. Resident Profile – Skilled Nursing Facility only

1. Please state last year's average annual percentage of payment / reimbursement in each category:

Medicare _____ Medicaid _____ Private Pay _____ HMO _____

If Other, list payment source: _____

2. Do you have any non-geriatric residents for whom you provide **skilled** care? ☐ Yes ☐ No

If yes, how many? _____

3. Resident Age Groups

Age Group	Number of Residents	% of Non-Ambulatory
Under 21 Years		
22 to 49 Years		
50 to 64 Years		
65 Years and Over		

F. Policies and Procedures

1. Does the **Applicant** have a written emergency evacuation plan? ☐ Yes ☐ No

Are evacuation plans posted in all parts of the facility? ☐ Yes ☐ No

How often are evacuation /fire drills conducted each year for each shift? _____

Does the staff orientation plan include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

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?

Skilled Nursing Facility ☐ Yes ☐ No

Assisted Living Facility ☐ Yes ☐ No

Independent Living 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 to the skilled nursing facility 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? Every _____ days.

7. Are written orders from an attending physician required for:

All Drugs and Medications	☐ Yes ☐ No
Any other Specific Therapy / Treatment	☐ Yes ☐ No
Facility or Hospital Transfers	☐ Yes ☐ No
Restraints	☐ Yes ☐ No
Special Dietary Requirements	☐ Yes ☐ No

8. Does **Applicant** retain a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

9. Does **Applicant** 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? _____

What was the outcome? _____

22. Does the Applicant have a fall prevention policy? ☐ Yes ☐ No If "yes," please attach a copy.

23. Is there an ulcer prevention policy in place? ☐ Yes ☐ No

24. Does your facility have a Resident council? ☐ Yes ☐ No

25. Does yourfacility have a Family council? ☐ Yes ☐ No

26. Does **Applicant** have a formalized risk management program? ☐ Yes ☐ No

27. Is it a separate stand-alone program or integrated into the **Applicant's** Quality Management Program?

☐ Stand Alone ☐ Integrated

28. Does the risk management program include the following:

Claims Management	☐ Yes	☐ No
Incident Reporting / Critical Indicator Screening	☐ Yes	☐ No
Safety Program	☐ Yes	☐ No
Tracking and Trending of Incidents	☐ Yes	☐ No

G. Physical Premises

1. Recreation Facilities ☐ None

	Number		Number
Exercise / Weight Room		Sauna / Hot Tub	
Swimming Pool		Tennis or Racquetball Court	
Other			

2. Does the **Applicant** have a bar/lounge on the premises? ☐ Yes ☐ No

If "yes": Does the **Applicant** carry liquor liability insurance? ☐ Yes ☐ No

Does the **Applicant** operate the bar/lounge itself or subcontract operation to a third party? _____

3. Does the **Applicant** have a parking garage on the premises? ☐ Yes ☐ No

4. **Buildings:** Enter the following information for each building under the same legal name, administration, and management. List additional buildings on a separate sheet of paper, if necessary. (Buildings with separate facilities, management, or administrations should fill out another application. They can be included in same policy. Use same key number with added letter designation on end.) *If attaching additional forms be sure to give them all the same key number as this application.* _____ #of buildings to be covered under this policy.

Building #1 Name: _____ 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 ☐ NonCombustible ☐ Masonry NonCombustible ☐ Fire Resistive

Smoke Detectors:
- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Hard Wired?
- ☐ Central Station?

Approved Automatic Sprinkler System:
- ☐ None
- ☐ Entire Facility
- ☐ Hallways
- ☐ Common Areas
- ☐ Resident Rooms
- ☐ Soiled Linen Chutes and Rooms
- ☐ Central Station?

Building #2 Name: _____ 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 ☐ NonCombustible ☐ Masonry NonCombustible ☐ Fire Resistive

Location of Smoke Detectors:
- ☐ None
- ☐ Entire Facility
- ☐ Hallways

Areas Protected by Approved Automatic Sprinkler System:
- ☐ None
- ☐ Entire Facility
- ☐ Hallways

☐ Common Areas
☐ Resident Rooms
☐ Hard Wired?
☐ Central Station?

☐ Common Areas
☐ Resident Rooms
☐ Soiled Linen Chutes and Rooms
☐ Central Station?

H. Security and Life Safety

1. Smoking

	SNF	ALF	ILF
Is smoking permitted in resident rooms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is smoking permitted in common areas?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Describe the rules applicable to smoking: _____

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

3. Is the community gated? ☐ Yes ☐ No

4. 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? _____

5. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

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

I. Coverage Information

1. Current Professional Liability coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: _____

☐ Claims-Made with Retroactive Date: _____ ☐ Occurrence

☐ Deductible _____ ☐ Self Insured Retention _____

Premium: _____

2. Current General Liability coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: 2M/5M

☐ Claims-Made / Retroactive Date: _____ ☐ Occurrence

☐ Deductible _____ ☐ Self Insured Retention _____

Premium: _____

3. Current Excess coverage:

Carrier: _____

Policy Term: _____ to _____

Limits of Liability: 2M/5M _____

☐ Claims-Made with 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 5 to 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 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	

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.

I hereby declare that I am an authorized representative of the Applicant, that the above statements and particulars are true, and that I have not omitted or misstated any material facts. I agree that this Application shall be the basis for any insurance policy that is issued.

(PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.)

_____

Applicant's signature

OtherAuthorizedOfficer

Title

Date _____

_____

Name of Facility (type or print)

NOTE: THIS APPLICATION MUST BE SIGNED BY EITHER THE CHIEF EXECUTIVE OFFICER, PRESIDENT OR CHAIRMAN OR THE CHIEF FINANCIAL OFFICER OR EQUIVALENT OFFICER, WITH THE UNDERSTANDING AND AGREEMENT THAT SUCH SIGNER IS ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE. AN ELECTRONIC SIGNATURE MAY BE USED IF THIS APPLICATION IS TO BE SUBMITTED ONLINE.

PRODUCER INFORMATION

For Applicant:

Produced By: (person submitting this application)

Effective Date: _____

Please Print or Type Name

Please Sign Name

Insurance Agency:
Address:

Street City State Zip code

E-Mail Address:

Agent License Number:

Insurance Agency Taxpayer Id or Social Security Number:

Submitted By: (Wholesale Broker if A Retailer is listed above)

Name:
Address:

Street City State Zip code

E-Mail Address:

Agent License Number:

Insurance Agency Taxpayer Id or Social Security Number:

THERE ARE _____ TOTAL ADDITIONAL PAGES OF INFORMATION ATTACHED TO THIS APPLICATION. Please indicate number of pages of each type:

Loss History ___ Addl Insureds ___ Policies ___ Assessmnt Tools ___ Addl Facility Apps ___ Other ___

Date Submitted: _____

NOTES: