# Aon Affinity Insurance Service
# Senior Living Supplemental Application

## A. INSTRUCTIONS

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, attach a separate page.
4. This application must be completed, dated and signed by a principal officer of the business

## B. ATTACHMENTS

**Please include the following information with this application for all levels of care:**

1. Completed ACORD Applications:

   ☐ Property ☐ Auto ☐ General Liability/Professional Liability ☐ Crime ☐ Inland Marine ☐ Umbrella

2. Schedule of Locations to be covered.
3. Signed Statement of Values.
4. Five (5) years of currently valued loss reports from prior carriers.
5. Current audited Financial Statement (income, balance sheet, cash flow) with management notes
6. Photo and facility diagram/plot plan.
7. Copies of licenses for each location.
8. Facility web site URL.
9. Organizational Chart.
10. CMS Long Form for quality of care surveys completed during the last twelve (12) months (includes complaint surveys).
11. Facility Quality Measures/Indicator Reports for a cumulative six month period not older than 90 days.

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**Please include the following information for a Skilled/Assisted Living Facility:**

1. Resumes for Administrator & Director of Nursing.
2. State Survey reports- last two (2) years (include statement of deficiencies and Plan of Correction)
3. Substantiated Complaint Survey(s) and Plan of Correction if complaint is within the last two (2) years.

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**Please include the following information for a Skilled/Intermediate Care Facility:**

1. Current CMS Forms 671 Facility Staffing & 672 Resident Census
2. Copy of facility's Skin/Wound Protocol.
3. Quality Indicator Report for the past two six-month periods.

## C. CORPORATE/PARENT INFORMATION

1. Corporate/Parent Name: _____

   Corporate Address: _____

   City: _____ State: _____ Zip: _____

   Web Address: _____

2. Description of Corporate/Parent (check all that apply):

   ☐ For-Profit ☐ Not-for-Profi Religious Affiliated ☐ Yes ☐ No

   ☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital Affiliate ☐ CCRC / Life Plan Community

   ☐ JCAHO Accredited ☐ CARF-CCAC Accredited

3. Years parent company has been under present ownership: _____
4. Total number of facilities owned: _____
5. Is the parent company managed by a management company? ☐ Yes ☐ No

   if "Yes", provide the name of the management company: _____

How many years in place with this management company? _____

*Provide a copy of the management contract.*

6. List the Officers of the Operating Corporation or General Partners

| Name | Title | Status |
|---|---|---|
| | | ☐ Active ☐ Inactive |
| | | ☐ Active ☐ Inactive |
| | | ☐ Active ☐ Inactive |
| | | ☐ Active ☐ Inactive |

## D. APPLICANT INFORMATION

1. New Application: _____ If Renewal, please give policy number: _____
2. Applicant Name: _____
3. Facility Address: _____
4. Telephone: _____
5. Federal Employer ID #: _____ Provider ID: _____
6. Contact Person for Risk Management Survey: _____ Telephone: _____

   Email Address: _____ Fax: _____

7. Has any insurance carrier cancelled or refused coverage that is similar to that being applied for here?
   **(MISSOURI APPLICANTS NEED NOT REPLY)**

   ☐ Yes ☐ No

   If "Yes", explain: _____

8. Has the Applicant (including owners, managers, partners or administrators) ever (If "Yes", attach complete explanation):
   a) Been involved in any personal or business bankruptcy? ☐ Yes ☐ No
   b) Been arrested, charged or convicted of any civil or criminal violations? ☐ Yes ☐ No
   c) Been sued by, or had a request for records from the law firm of Wilkes & McHugh? ☐ Yes ☐ No
9. Is applicant aware of any recent circumstances which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? ☐ Yes ☐ No
   If "Yes", explain: _____
10. Loss History required. Submit insurance carrier currently valued hard copy loss data for last five (5) years
11. Are all applicable permits up to date? ☐ Yes ☐ No
    If "No", explain: _____
12. List all subsidiaries. Additional list attached? ☐ Yes ☐ No

| Name | Location | Description of Operations |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## E. CURRENT COVERAGE

1. Insurance Carrier: _____ Policy Expiration Date: _____ Annual Premium: $ _____
2. Professional Liability per Claim Limit: _____
   ☐ Occurrence Or ☐ Claims Made Retroactive Date: _____
3. General Liability Limit per Claim Limit: _____
   ☐ Occurrence Or ☐ Claims Made Retroactive Date: _____
4. Policy Aggregate: _____
5. Per Claim Deductible/SIR: _____
6. Employee Benefits Liability Limit _____ Policy Expiration Date: _____
7. Stop Gap Liability Limit: _____
   State: _____ Payroll: $ _____
8. Hired & Non-Owned Auto Liability Limit: _____
9. Excess / Umbrella Liability Limit: _____
   a) ☐ Occurrence Or ☐ Claims Made Retroactive Date: _____
   b) Insurance Carrier: _____ Annual Premium: _____

## F. FACILITY CREDENTIALS COVERAGE

1. List facility information below:
   a) License and Accreditation Information:

| | Type/Number | Expiration Date | Restrictions? | Provisions? |
|---|---|---|---|---|
| License: | | | | |
| License: | | | | |

b) Association memberships: _____

c) Date of last inspection/survey: _____ (Provide copy)

d) Number of deficiencies: Total: _____ D, E, F, G deficiencies _____ F, H, I, J, K, L deficiencies _____

e) Was a Plan of Correction accepted by the State? ☐ Yes ☐ No (Provide copy)

f) How many complaints were investigated in the past three (3) years? _____

How many complaints were substantiated? _____

g) Is facility approved for Medicare? ☐ Yes ☐ No If "Yes", # of beds: _____

h) Is facility approved for Medicaid? ☐ Yes ☐ No If "Yes", # of beds: _____

## G. CLASSIFICATION

1. **Select only the level of care reflected in the facility license** If the license is not specific with respect to type of care, select th one level that best reflects the primary medical services provided by this facilit .

Please indicate total licensed beds (If Independent Living, skip to "Independent Living" section).

| | |
|---|---|
| **Skilled Nursing:** | Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services<br><br>Total Licensed Beds: _____ Average Occupancy: _____ |
| **Assisted Living:** | Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's care and services<br><br>Total Licensed Beds: _____ Average Occupancy: _____ |
| **Independent Living:** | Residents of retirement age, total self care, live self-sufficientl , occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises.<br>a) What are the total numbers of units? _____<br>b) What are the total numbers of residents at full occupancy? _____<br>c) Are there common dining facilities? ☐ Yes ☐ No<br>d) Do individual units have cooking appliances (excluding microwaves)? ☐ Yes ☐ No<br>If "Yes", check type: ☐ Gas ☐ Electric<br>e) Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No<br>If "Yes", explain procedure: _____<br>f) Are Residents allowed to have home health care aides? ☐ Yes ☐ No<br>g) Are the aides contracted independently? ☐ Yes ☐ No<br>Through facility? ☐ Yes ☐ No<br>h) Are there licensed nursing personnel on staff? ☐ Yes ☐ No<br>What hours are they available? _____ What services do they provide? _____ |
| **Home and Community Based Services:** | Handyman services, durable medical equipment, homemaker, home care aids, hospice care, rehabilitation therapy, respiratory services, oxygen supplier, prosthetic/orthotic, skilled nursing care<br>Number of visits: _____ Receipts: _____ Attach a description of operations |

| **Adult Day Care:** | ☐ Social Total Participants: _____<br>☐ Enhanced (Mentally Challenged) Total Participants: _____<br>Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs<br>Medical – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision; medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT); the mentally challenged, cognitively impaired, developmentally disabled, chronically ill |
|---|---|

2. Show the percentage of residents by age range:

____< 30 ____= 30-64 ____= 65-74 ____= 75-84 ____= 85-94 ____>94

3. If any residents are under 64, please explain:_____

4. Additional general liability exposures.

a) Swimming Pools

1) Is there a swimming pool? ☐ Yes ☐ No
2) Is it open to the public? ☐ Yes ☐ No
3) Is the pool locked when not in use? ☐ Yes ☐ No
4) Is the pool fenced? ☐ Yes ☐ No
5) Is a full-time lifeguard on duty? ☐ Yes ☐ No
6) Is there a diving board/sliding board? ☐ Yes ☐ No
7) Are there depth markings? ☐ Yes ☐ No
8) Is there a daily maintenance procedure in place? ☐ Yes ☐ No
9) Is it an indoor or outdoor pool ☐ Yes ☐ No

b) Are there other bodies of water present? ☐ Yes ☐ No

If "Yes," describe: _____

c) Are there saunas and/or hot tubs? ☐ Yes ☐ No

If "Yes," how many?_____

Is there an attendant on duty? ☐ Yes ☐ No

If "Yes," how many hours per day is the attendant on duty _____

d) Are there tennis/racquetball/handball courts? ☐ Yes ☐ No

If "Yes," how many? _____

e) Are there exercise/weight rooms? ☐ Yes ☐ No

If "Yes," how many? _____

Is there an attendant on duty? ☐ Yes ☐ No

If "Yes," how many hours per day is the attendant on duty?_____

Are there treadmills? ☐ Yes ☐ No

f) Are there indoor parking facilities? ☐ Yes ☐ No

If "Yes," how many parking spaces:_____

g) Is there a Community Center? ☐ Yes ☐ No

If "Yes," how many square feet in area:_____

h) Is the facility used for activities other than by residents? ☐ Yes ☐ No

If "Yes," describe: _____

Is the restaurant open to the public? ☐ Yes ☐ No

Gross receipts: $ _____

Is liquor served? ☐ Yes ☐ No

## H. ADMINISTRATOR

1. Name of Administrator: _____ License Number: _____ State: _____
2. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA) _____

   Full time at this facility? ☐ Yes ☐ No Number of hours at this facility per week? _____

## I. NURSE STAFFING

1. Director of Nursing (DON):

   Name: _____ Professional credentials: ☐ Yes ☐ No

   Length of time at this facility: _____ Length of time as DON: _____

2. a) Total # of nurse employees: _____

   b) By category:

| Category | 1st shift | 2nd shift | 3rd shift | Turnover % |
|---|---|---|---|---|
| RN | | | | |
| LPN/LVN | | | | |
| CNA/Personal Caregiver | | | | |
| Agency | | | | |
| Pool | | | | |

   c) Do you require nurses to carry malpractice coverage? ☐ Yes ☐ No
   d) Do you obtain and review nurses' certificates of malpractice insurance? ☐ Yes ☐ No
   e) Do you verify nursing licenses upon hire and annually? ☐ Yes ☐ No
   f) Do you verify nursing assistant certification upon hire and annually ☐ Yes ☐ No
   g) Are background checks completed for agency and pool employees? ☐ Yes ☐ No

## J. PHYSICIANS AND MEDICAL DIRECTOR

1. Number of physicians: Employed: _____ Affiliated _____ Contracted: _____
2. Do you obtain and review physicians' certificates of malpractice insurance ☐ Yes ☐ No
3. Do you require limits of liability comparable to your own? ☐ Yes ☐ No

   If "No", define the differences in limits: _____
4. Do you require limits of liability comparable to your own? ☐ Yes ☐ No

   a) Do credentialing activities include:

      1) Verification of current professional license? ☐ Yes ☐ No
      2) Verification of current DEA license? ☐ Yes ☐ No

5. Name of Medical Director: _____ License Number: _____ State: _____
6. Length of time as Medical Director: _____ Medical Specialty: _____

   ☐ Full time at this facility ☐ Part-time at this facility

   Number of hours at this facility per week: _____

7. Does the Medical Director also act as the attending physician to any residents? ☐ Yes ☐ No
   If "Yes", how many: _____
8. Is there an evaluation of the Medical Director's performance? ☐ Yes ☐ No
   If "Yes", define _____
9. Is the Medical Director:
   a) involved in credentialing facility medical staff? ☐ Yes ☐ No
   b) an active participant in the facility quality improvement program? ☐ Yes ☐ No
   c) involved with peer review of physicians? ☐ Yes ☐ No
10. Is a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No

## K. STAFF/EMPLOYEE SELECTION AND HIRING

1. Is there a formal, documented assessment process to measure staff competency skills? ☐ Yes ☐ No
2. Do you conduct an orientation and regularly scheduled in-service education programs for all staff/employees? ☐ Yes ☐ No
3. How are employees recruited? _____
4. Describe background verification checks on new employees:
   a) work history? ☐ Yes ☐ No
   b) education? ☐ Yes ☐ No
   c) criminal record? ☐ Yes ☐ No
   d) driving record - Motor Vehicle Record (MVR) when appropriate? ☐ Yes ☐ No
   e) drug testing? ☐ Yes ☐ No
   f) Abuse Registry? ☐ Yes ☐ No
   g) Other (describe) ☐ Yes ☐ No

## L. NON-RESIDENT SERVICES

1. Please provide the following information for **NON-RESIDENT SERVICES ONLY:**

   **Home Health Care** ☐ Yes ☐ No
   If "Yes", Gross receipts: $ _____
   Describe home health care services: _____

   **Adult Day Care** total licensed #: _____ Average Occupancy: _____ Hours of Operation: _____
   Is this a licensed adult day care center? ☐ Yes ☐ No
   # of Employees: _____
   Do you provide transportation to and from your facility? ☐ Yes ☐ No
   Do you provide transportation to and from events? ☐ Yes ☐ No
   Is a physical examination performed by a physician prior to admission? ☐ Yes ☐ No
   If "Yes", describe: _____
   Are medical services provided? ☐ Yes ☐ No
   If "Yes", describe: _____

**Child Day Care** total licensed #: _____ Average Occupancy: _____ Hours of Operation: _____

# of Employees: _____ # of children: _____ # of employees' children: _____

Do you provide any transportation for children? ☐ Yes ☐ No

If "Yes", describe: _____

**Respite Care:** ☐ Yes ☐ No

If "Yes", # per year: _____

**Hospice Care:** ☐ Yes ☐ No

If "Yes", Gross receipts: $ _____

**Rehabilitation Services:** ☐ Yes ☐ No

If "Yes", # per year: _____

Describe in-house rehabilitation services: _____

**Meals on Wheels:** ☐ Yes ☐ No

If "Yes", Gross receipts: $ _____

Do you provide transportation to and from your facility? ☐ Yes ☐ No

Do you provide transportation to and from events? ☐ Yes ☐ No

Are the meals prepared at your facility? ☐ Yes ☐ No

2. Do you provide the following services?

| Service | Provided? | # of Residents | Service | Provided? | # of Residents |
|---|---|---|---|---|---|
| IV Infusion Therapy | ☐ Yes ☐ No | | Developmentally Disabled | ☐ Yes ☐ No | |
| Ventilation Therapy | ☐ Yes ☐ No | | Alzheimer's/Dementia | ☐ Yes ☐ No | |
| Physical Therapy | ☐ Yes ☐ No | | Psychiatric Care | ☐ Yes ☐ No | |
| AIDS | ☐ Yes ☐ No | | Chemical Dependency Treatment | ☐ Yes ☐ No | |

3. Do you provide any other services to your residents or the community? ☐ Yes ☐ No

If "Yes", describe: _____

## M. CONSULTANTS/INDEPENDENT CONTRACTORS AND SERVICES

1. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) limits of liability:

| Services | Is service provided? | Is a contract in place? | Limits of Liability |
|---|---|---|---|
| Physicians | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Dental | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Nursing | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Mental Health | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Pharmaceutical | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Physical Therapy | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Occupational Therapy | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Speech Therapy | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Dietary | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| X-Ray | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Medical Records | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Laboratory | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Social Services | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Recreational Services | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Transportation | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Barber/Beautician | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Food | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Laundry | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Home Health | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Other: | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |
| Other: | ☐ Yes ☐ No | ☐ Yes ☐ No | $ |

2. Have certificates of insurance been obtained from independent contractors ..... ☐ Yes ☐ No

   Are these reviewed annually? ..... ☐ Yes ☐ No

   If "Yes", are limits of liability the same as your limits of liability? ..... ☐ Yes ☐ No

   If "No", explain: _____

## N. VOLUNTEERS

1. What is the total number of volunteers? _____
2. What are the primary sources for volunteers? _____
3. Is there a formal screening and orientation process for volunteers? ..... ☐ Yes ☐ No
   a. Explain: _____
4. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? ..... ☐ Yes ☐ No
5. Do volunteers assist with resident feeding? ..... ☐ Yes ☐ No
6. Are criminal background checks run on volunteers? ..... ☐ Yes ☐ No

## O. RISK MANAGEMENT

1. Is there a risk management program implemented throughout this facility? ☐ Yes ☐ No
2. Is there a designated risk manager? ☐ Yes ☐ No

   If "Yes", indicate risk manager's name: _____

   How long has the risk manager been in that position? _____
3. Is there an "incident reporting" policy? ☐ Yes ☐ No
   a) Are all incident reports reviewed by the risk manager and medical director? ☐ Yes ☐ No
   b) Are incidents trended and presented to the quality/risk management committee? ☐ Yes ☐ No
4. Is there a formal safety program? ☐ Yes ☐ No
   a) Does it include evaluation and reduction of exposures relating to:
      1) Life safety? ☐ Yes ☐ No
      2) Employees? ☐ Yes ☐ No
      3) Hazardous materials? ☐ Yes ☐ No
      4) Environment? ☐ Yes ☐ No
5. Is there a formal preventive maintenance program? ☐ Yes ☐ No
   a) Is responsibility for the program assigned to one individual? ☐ Yes ☐ No
   b) Does the program include:
      1) Evaluation of all electrical devices/equipment brought into the facility? ☐ Yes ☐ No
      2) Scheduled evaluations of equipment and devices including electrical supply? ☐ Yes ☐ No
      3) Retention of maintenance and inspection records? ☐ Yes ☐ No
6. What security measures are used to control unauthorized entrances and exits from the facility? _____
7. Are Wander Guards or similar devices used as part of elopement prevention practices? ☐ Yes ☐ No

   If "Yes", provide type: _____
   a. Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications ☐ Yes ☐ No
   b. Number of elopements in past three years: _____
   c. If elopement(s) occurred, was harm caused to the resident(s) involved? ☐ Yes ☐ No
8. Are nursing assessment protocols in place to identify residents at risk for:
   a) Elopement? ☐ Yes ☐ No
   b) Falls? ☐ Yes ☐ No
   c) Cognitive Impairment? ☐ Yes ☐ No
   d) Nutritional Deficiency ☐ Yes ☐ No
9. Is monthly review of drug regimens performed? ☐ Yes ☐ No

   If "Yes", by whom? _____
10. How are medications stored? Distributed? _____
11. Are records kept on drug supplies and dispersal? ☐ Yes ☐ No
12. What is the maximum value of medications on hand? $_____ Type _____

13. Is a licensed pharmacist on staff? ☐ Yes ☐ No

a) Is an outside pharmacy used? ☐ Yes ☐ No

b) Is an onsite pharmacy used? ☐ Yes ☐ No

If "Yes", revenue per year: $ _____

If "Yes", do you provide prescriptions to non-residents? ☐ Yes ☐ No

14. Are admission, discharge and transfer criteria established? ☐ Yes ☐ No

a) Who ensures compliance with these established criteria? _____

15. Does facility have advance written consent from resident or guardian that allows medical care be provided when necessary? ☐ Yes ☐ No

16. Does facility have a written policy addressing abuse? ☐ Yes ☐ No

a) If "Yes", does the policy include procedures for reporting and investigating alleged incidents of abuse? ☐ Yes ☐ No

b) Are employees and volunteers educated about these procedures? ☐ Yes ☐ No

c) Are policies and procedures reviewed and updated as necessary at least every two (2) years? ☐ Yes ☐ No

d) Number of alleged abuse incidents investigated and/or reported in the last twelve (12) years? _____

e) Has the organization (including any employees or volunteer) had any claim or suit brought against them as a result of abuse within the last ten (10) years? ☐ Yes ☐ No

If "Yes", please explain the claim, the depth of the investigation and the outcome, including any corrective actions taken. _____

17. Does facility have a formal grievance procedure in place to address resident/family complaints? ☐ Yes ☐ No

If "Yes", explain how the process: _____

## P. ADDITIONAL PROPERTY/LIFE SAFETY INFORMATION

1. **Construction**

a) Type of construction: _____ Year built: _____ # of floors _____ # of elevators: _____

If the building is over 25 years old, have systems upgrades (such as roof, plumbing, heating, electrical) been completed in the past ten years? ☐ Yes ☐ No

If "Yes", describe: _____

b) Date of inspection: _____ Electrical: _____ Plumbing: _____ HVAC: _____

c) Was the building constructed for this occupancy? ☐ Yes ☐ No

If "No", please explain: _____

d) Have there been any water damage incidents in the past five (5) years ☐ Yes ☐ No

If "Yes", have they been corrected? ☐ Yes ☐ No

If "Yes", describe: _____

e) Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating ☐ Yes ☐ No

f) Type of wiring (copper or aluminum): _____ Type of roof: _____

Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____

g) Have there been any water damage incidents in the past five (5) years ☐ Yes ☐ No

If "Yes", describe: _____

h) Is there a scheduled service to clean heating and ventilation ducts? ☐ Yes ☐ No

1) How often are ducts cleaned? _____

## 2. Occupancy

a) Are there other occupancies in the building not related to resident care? ☐ Yes ☐ No

If "Yes", describe: _____

b) Is there a facility "no smoking" policy in effect? ☐ Yes ☐ No

c) Are smoking materials (including matches/lighters) restricted from a resident's room? ☐ Yes ☐ No

d) Are smoking residents supervised and/or in designated areas? ☐ Yes ☐ No

e) How many exits (other than front doorway) are there? _____

f) Are these equipped with panic alarms? ☐ Yes ☐ No

g) Do alarms ring into central security desk or nurses station? ☐ Yes ☐ No

h) Are there at least two remote exits on each floor ☐ Yes ☐ No

## 3. Protection

a) Is risk protected (100%) throughout by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? ☐ Yes ☐ No

If not 100%, please advise which areas are not protected: _____

If not tested, please explain: _____

b) Are all alarm signals monitored by a UL-approved central station or the responding fire department? ☐ Yes ☐ No

c) Is there a written emergency plan covering fire, natural disasters and threats: ☐ Yes ☐ No

If "Yes," do employees receive instruction training regarding this plan? ☐ Yes ☐ No

d) Has the fire department pre-planned emergency procedures at this location: ☐ Yes ☐ No

If "Yes", indicate the last date when these procedures were update: _____

e) When was facility last inspected by local fire authorities: _____

f) Is there a bulk medical gas distribution system piped in the building? ☐ Yes ☐ No

If "Yes," are emergency shutoffs provided? ☐ Yes ☐ No

If "No," is there storage of individual tanks? ☐ Yes ☐ No

If "Yes," are these tanks on rolling carts? ☐ Yes ☐ No

Are they properly chained? ☐ Yes ☐ No

g) In cooking areas (other than independent living units), is there a fire suppression system? ☐ Yes ☐ No

1) Is there a hood and grease filter? ☐ Yes ☐ No

2) What is the frequency of cleaning (i.e. monthly/quarterly)? _____

3) Do you use an outside contractor for cleaning? ☐ Yes ☐ No

4) Is the area equipped with an automatic fuel shutoff? ☐ Yes ☐ No

h) Are hardwire smoke detectors in resident rooms/apartments? ☐ Yes ☐ No

i) Are doors equipped with approved self-closing devices where required? ☐ Yes ☐ No

j) Total # of fire extinguishers: _____

k) Who is the sprinkler manufacturer and what type of sprinkler heads are used? _____

l) Is the building equipped with emergency lighting? ☐ Yes ☐ No

m) If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? ☐ Yes ☐ No

n) Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? ☐ Yes ☐ No

o) Is video surveillance used? ☐ Yes ☐ No

If "Yes", describe extent of use: _____

p) Are fire drills conducted regularly? ☐ Yes ☐ No

If "Yes", describe: _____

q) Is there an emergency evacuation plan in writing? ☐ Yes ☐ No

r) Are emergency call buttons in each room/unit? ☐ Yes ☐ No

s) Are intercoms or bells provided for each resident room? ☐ Yes ☐ No

t) Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

u) Are bathtubs/showers equipped with non-slip surfaces? ☐ Yes ☐ No

## Q. COMMERCIAL AUTOMOBILE

1. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? ☐ Yes ☐ No

   If "Yes", what is the name of the transport service? _____

   Contact Name: _____ Telephone Number: _____

2. Do employees transport residents in their own automobiles? ☐ Yes ☐ No

   If "Yes", describe: _____

   Average frequency _____

3. Do you require them to carry minimum insurance limits? ☐ Yes ☐ No

   If "Yes", what limits are required? $ _____

4. Do you have any Commercial Driver's License vehicles? ☐ Yes ☐ No

   a. How many: _____

5. Do volunteers operate any vehicles? ☐ Yes ☐ No

6. Are driving records reviewed annually? ☐ Yes ☐ No

**NOTICE: THIS IS A CLAIMS MADE POLICY. EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST YOU AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.**

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 FINES AND CONFINEMENT IN PRISON.**

**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 POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER 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 AUTHORITIES.**

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

**NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

**NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CON-TAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEAD-ING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.**

**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 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.**

**NOTICE TO LOUISIANA 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 FINES AND CONFINEMENT IN PRISON.**

**NOTICE TO MAINE 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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

**NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.**

**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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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.**

**NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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 MISLEAD-ING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).**

**NOTICE TO OREGON 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

**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.**

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.**

**NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.**

**WARRANTY:**

**I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO ISSUE AN INSURANCE POLICY, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CON-TRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICA-TION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.**

**NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

Signed **X** _____ Date _____
(Applicant)

Title _____ Organization _____
(must be signed by authorized officer (Organization's Seal)

Attest _____

Producer/Agent _____ License Number _____

Address _____

_____

_____

A-13055-0218