NAS INSURANCE SERVICES
16501 Ventura Blvd.
Suite 200
Encino, CA 91436
LIC #0677191
www.nasinsurance.com

APPLICATION for: LONG TERM CARE (formerly known as Elder Care)

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

THIS APPLICATION MUST BE COMPLETED, SIGNED AND DATED BY THE CEO, CFO, ADMINISTRATOR, DIRECTOR OF NURSING OR RISK MANAGER OF THE PROPOSED NAMED INSURED.

Please include the following information or documents as part of the Application, as they will be required to provide a firm quotation:

- The most recent state inspection reports and Complaint Surveys conducted within the last two (2) years (if any), including any statement of deficiencies and plan of correction; and
- The facility's current licenses; and
- Any marketing brochures; and
- Five (5) years currently valued loss runs for each coverage being requested, and by policy period.

APPLICANT'S INFORMATION

Desired Effective Date: _____/_____/_____

1. Applicant Name: _____

   DBA: _____

2. Physical Address: _____

3. City: _____ State: _____ Zip Code: _____

4. County: _____ Phone Number: (_____) _____

5. Website (if available): _____

6. Please list all subsidiaries to which this insurance will apply. Include a complete description of the operations of each subsidiary with confirmation that this Application reflects all exposures. (Please attach a separate sheet if necessary.)

   _____

   _____

OPERATION/BUSINESS INFORMATION

7. Date Established: _____ Years in Business Under Current Management: _____

8. Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality
   ☐ For Profit ☐ Joint Venture ☐ Other: _____

9. Revenues and Payroll:

   Total expected revenue for the upcoming year: _____

   Current Year Estimate: _____

   Last Year: _____

   Estimated payroll for the next twelve (12) months: _____

10. Type of Operation:
- ☐ Alzheimer's Adults
- ☐ Dementia Adults
- ☐ Group Home (Elderly)
- ☐ Group Home (non-Elderly)
- ☐ Independent Living (Elderly)
- ☐ Independent Living (non-Elderly)
- ☐ Skilled Nursing Facility
- ☐ Intermediate Nursing Facility
- ☐ Foster Care (Children)
- ☐ Other (specify): _____

11. Full description of services rendered: _____

_____

_____

COVERED FACILITY GENERAL INFORMATION

12. Covered Facility Business Name (dba): _____

a) Physical Address of Covered Facility (if different than #2): _____

b) Date Facility Opened (mm/yyyy): _____ Website (if different than #5): _____

c) Facility License Information:

License Number	Type	Expiration Date	Restrictions*	Provisions/Waivers**
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

* If "Yes" box is checked for Restrictions, please explain: _____

** If "Yes" box is checked for Provisions/Waivers, please explain:

a) Staffing related: _____

b) Line Safety Code related: _____

13. In the last five (5) years, has this facility ever:

a) Had its license suspended or revoked? ☐ Yes ☐ No

b) Been the subject of any federal or state sanctions? ☐ Yes ☐ No

c) Been the subject of any civil monetary penalty against it or any of its staff? ☐ Yes ☐ No

d) Entered into any Corporate Integrity Agreement ("CIA") with the Office of the Inspector General ("OIG")? ☐ Yes ☐ No

14. Total number of facilities or locations proposed for coverage: _____

15. Are all facilities licensed, as required, in all states where operating? ☐ Yes ☐ No

COVERED FACILITY OPERATIONAL EXPOSURE DATA

16. **Resident Count / Bed Census:**

Bed or Resident Type	Bed / Resident Type Description	Total Licensed Beds	# of Occupied Beds
Nursing Home	*Licensed as nursing facility where resident requires 24 hour nursing care (e.g. administration of medication by injection, catheter care, physical and occupational therapy, administration of oxygen, routine changing of dressings, tube feeding, etc.). An RN provides care during the day shift. LPN coverage is required during other shifts.*	#_____	#_____
Assisted Living / Intermediate Care (Level III)	*May be licensed as assisted living facility or nursing facility. Resident requires more nursing supervision than Assisted Living Level II, including assistance with ADL's and regular nursing services, depending upon resident acuity and number and type of nursing services provided and may require licensed nurses on all shifts. Included in this class is a resident with Alzheimer's who requires monitoring, for example, with Wander Guard system or locked units.*	#_____	#_____
Assisted Living (Level II)	*Licensed as assisted living facility but where resident has lower acuity, routinely receiving assistance with more than two ADL's as well as one or two episodic nursing services. Nursing supervision is provided during the day shift, seven days a week by either RN's or LPN's; no complex nursing care. No ventilator dependent residents and no residents who cannot re-position themselves in a bed or wheelchair. May include a high functioning Alzheimer's resident (Stage 3 or less).*	#_____	#_____
Assisted Living (Level I)	*Licensed as assisted living facility – social model. Possible nursing supervision during the day shift, seven days a week by either RN's or LPN's; no complex nursing care. Most services are provided by unlicensed staff such as nursing assistants. Resident requires assistance with ADL's. On average, resident receives assistance with two ADL's.*	#_____	#_____
Independent Living	*There are generally no nursing services or assistance with ADL's provided. Resident of retirement age, providing total self care, lives self sufficiently, occupies apartment/dwelling unit including cooking facilities, does not receive health care services, and administers their own medications. Residents may engage the services of home health providers similar to other individuals in their private homes.*	#_____	#_____

17. Please indicate the number of residents by age group:

<18 years old: #_____

18 – 54 years old: #_____

55+ years old: #_____

18. Please indicate the number of residents that exhibit each of the following conditions:

Bi-polar disorder: #_____

Schizophrenia: #_____

Significant dementia: #_____

Alzheimer's: #_____

CURRENT INSURANCE

19. Has Applicant had previous insurance for this enterprise? ☐ Yes ☐ No

If "Yes", complete the following:

GENERAL LIABILITY		PROFESSIONAL LIABILITY	
Current Carrier		Current Carrier	
Policy Term		Policy Term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro Date, if Claims Made		Retro date, if Claims Made	

20. Are all of this facility's expiring limits, coverage trigger(s) and retroactive date(s) the same as being requested in this submission? ☐ Yes ☐ No

21. Is requested Employee Benefits Liability Retroactive Date the same as Professional Liability Retroactive Date? ☐ Yes ☐ No

If "No", what is requested Employee Benefits Liability Retroactive Date: _____

22. Check Coverages and Limits that the Applicant would like quoted:

Limits: ☐ $100k/$300 ☐ $250k/$500k ☐ $500k/$1M ☐ $1M/$3M ☐ Excess above _____

23. Does the Applicant want physical abuse/sexual molestation coverage to protect the entity for alleged acts of its employees? ☐ Yes ☐ No

If "Yes", please specify limits: ☐ $100k/$300k ☐ $250k/$500k

EXPIRING INSURANCE INFORMATION

24. Has the Applicant ever had an insurance company cancel and/or refuse to renew coverage? ☐ Yes ☐ No

If "Yes", please indicate the reason for cancellation, non-renewal or restriction:

☐ Carrier withdrawal from state or line of business

☐ Carrier Insolvency

☐ Claims frequency and/or severity

☐ Misrepresentation or fraud by Applicant

☐ Applicant filed suit against carrier

☐ Other: _____

RESIDENT ASSESSMENTS

25. Is a nursing assessment conducted for new patients? ☐ Yes ☐ No

If "Yes", does this assessment include evaluation of:

- Full body skin breakdown/Decubitis Ulcer? ☐ Yes ☐ No
- Mobility Limitations? ☐ Yes ☐ No
- History of prior injuries? ☐ Yes ☐ No
- Required assistance? ☐ Yes ☐ No
- Disorientation? ☐ Yes ☐ No
- Current medications? ☐ Yes ☐ No

26. Bedsore Information: State "None", if none: _____ Reporting Date: _____/_____/_____

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

Please describe the protocols/procedures in place for treating bedsores: _____

_____

27. Who completes your pre-admission assessments? _____

28. Is assessment nurse a: ☐ RN ☐ LVN ☐ Other
If "Other", please describe qualifications: _____

29. Have you denied any possible admissions due to high acuity? ☐ Yes ☐ No
If "Yes", how many denials in the last two years? _____
What were the conditions that led you to deny them? _____

30. How often do you reassess your residents? _____

31. What system do you use to ensure timely reassessments? _____

32. What is the system for identifying when a resident needs to be transferred to another level of care (i.e., nursing home)?

_____

33. Do residents have their own attending physician? ☐ Yes ☐ No
If "No", who performs the role of the attending physician? _____
If "No", how many residents utilize the Medical Director as their attending physician? _____

ELOPEMENT

34. Do you conduct wandering risk assessments upon admit? ☐ Yes ☐ No
If "Yes", does this assessment include a cognitive assessment? ☐ Yes ☐ No

35. Does your facility have a policy clearly identifying the types of dementia residents your staff is capable of providing care to? ☐ Yes ☐ No
If "Yes", please explain the policy: _____

36. Are all exit doors alarmed at all locations? ☐ Yes ☐ No
If "No", please explain: _____

37. Does your facility have locked unit(s) for residents who are prone to wandering? ☐ Yes ☐ No
If "Yes", what system is in use? _____

38. How many residents have eloped from your facility in the last three (3) years? _____

39. What is the protocol or criteria for placing an alarm bracelet on a resident? _____

40. Is the family notified when an alarm bracelet is placed on a resident? ☐ Yes ☐ No

41. **SCHEDULE OF PHYSICIANS (employed or contracted)**

Name and Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted, or Employed	Has Malpractice Insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

42. **STAFF**

Staff - All Locations	1st Shift	2nd Shift	3rd Shift
MD			
RN			
LPN			
Nurse Aids			

Staff - All Locations	1st Shift	2nd Shift	3rd Shift
Psychologists			
Counselors			
Therapists			
Other: _____			

43. Does the facility maintain the same staffing levels on each shift on weekends as it does on weekdays? ☐ Yes ☐ No

If "No", please explain: _____

44. If the facility contains any bed type other than Independent Living, does the facility have at least one (1) "awake staff" on duty 24 hours per day? ☐ Yes ☐ No

45. If the facility renders any Nursing Services, does the facility meet minimum state staffing levels, including the number of LPN's on duty 24 hours per day? ☐ Yes ☐ No

46. Please check the hiring procedures that apply or are performed by this operation:

☐ Criminal background checks ☐ Verification of certification or professional licensing

☐ Drug, alcohol and sexual abuse screening or testing ☐ Reference checks

☐ Questioning of employees of their previous involvement as defendants in professional malpractice litigation

47. Director of Nursing:

a) Employment Status: ☐ Employee ☐ Independent Contractor

b) Professional Credentials: ☐ RN ☐ LPN ☐ Other: _____

c) Number of years experience as a Director of Nursing: _____

e) Number of years tenure at this facility: _____

48. Facility Administrator:

a) Employment Status: ☐ Employee ☐ Independent Contractor

b) Name: _____

c) License Number: _____ State of License: _____

d) Number of years experience as a Facility Administrator: _____

e) Number of years tenure at this facility: _____

MEDICATION ADMINISTRATION

49. Is the unit dose medication system used by the facility? ☐ Yes ☐ No
    If "No", what system is used? _____

50. Who is responsible for administering medications to the residents in the facility? ☐ Licensed Staff ☐ Medication Aide

51. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers' recommendations and Industry standards?

_____

_____

_____

_____

PREMISES INFORMATION

52. **Building(s)**

	Location 1	**Location 2**	**Location 3**
Building Construction (type)			
Year build/updated	_____/_____/_____	_____/_____/_____	_____/_____/_____
Square feet			
Number of floors			
Number of licensed beds			
Number of occupied beds			
Smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No ☐ Hardwire ☐ Battery	☐ Yes ☐ No ☐ Hardwire ☐ Battery	☐ Yes ☐ No ☐ Hardwire ☐ Battery
Fire Alarm?	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None	☐ Central ☐ Local ☐ None
Is building fully sprinklered? If not, what % is sprinklered?	☐ Yes ☐ No Sprinklered: _____%	☐ Yes ☐ No Sprinklered: _____%	☐ Yes ☐ No Sprinklered: _____%

53. If multi-story building(s), please indicate on which floor non-Ambulatory/Alzheimer's is located: _____

54. **Premises/Property**

a) Are there any animal exposures on the premises? ☐ Yes ☐ No
   If "Yes", please describe, including number of animals and type(s)/breed(s):

   _____

   _____

b) Are there any pools, lakes, ponds, rivers or other bodies of water on the premises? ☐ Yes ☐ No
   If "Yes", please describe: _____

d) If there is a pool or body of water, is it fenced? ☐ Yes ☐ No
   If "Yes", does it have a self-locking gate? ☐ Yes ☐ No

g) Are there any firearms on the premises? ☐ Yes ☐ No
   If "Yes", please describe: _____
   If "Yes", are the firearms locked in a secure place, away from the residents? ☐ Yes ☐ No
   If "No" to above, please explain: _____

STATE INSPECTION

55. Date of last State Inspection/Survey: _____/_____/_____

    a) Total Number of Deficiencies: _____

    b) Number of D, E, & F Deficiencies (Nursing Homes only): _____

    c) Number of G, H, & J Deficiencies (Nursing Homes only): _____

    d) Corrective Action Plan accepted by the State? ☐ Yes ☐ No
    If "Yes", date accepted: _____/_____/_____

    e) Number of complaints investigated by the State in the past 2 years: _____

    f) Number of substantiated complaints: _____

CLAIMS HISTORY

56. Has any application for Professional Liability or General Liability insurance made on behalf of the facility, any predecessors in business or present Partners ever been declined, or has the insurance ever been canceled or renewal refused? ☐ Yes ☐ No

    If "Yes", please provide details: _____

57. Has any claim, suit or regulatory proceeding ever been made against the facility or any of its employees during the past five (5) years? (Please attach a separate sheet if necessary.) ☐ Yes ☐ No

    If "Yes", please attach five (5) years currently valued loss runs from the facility's prior insurance carrier, by line of business, and by policy period. Alternatively, or if such loss runs are not available, please complete the following information on a first-dollar basis, without considering any deductibles. (Please attach a separate sheet if necessary.)

	Claimant Name	Type of Claim*	Date Claim Reported (mm/dd/yyyy)	Paid Loss Amount	Outstanding Loss Amount	Paid Expense Amount	Outstanding Expense Amount	State of Claim (open/ closed)
1.	_____	_____	_____	$_____	$_____	$_____	$_____	_____
2.	_____	_____	_____	$_____	$_____	$_____	$_____	_____
3.	_____	_____	_____	$_____	$_____	$_____	$_____	_____
4.	_____	_____	_____	$_____	$_____	$_____	$_____	_____
5.	_____	_____	_____	$_____	$_____	$_____	$_____	_____

* Type of Claim: Professional Liability = PL; General Liability = GL; Employee Benefits Liability = EBL; Sexual Misconduct Liability = SML

58. Has the Applicant ever been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ☐ Yes ☐ No

59. Has the Applicant ever been accused of errors by any government agency or commercial payer? ☐ Yes ☐ No

60. In the last five (5) years, have you experienced any claims or are you aware of any circumstances that may give rise to a claim that would have been covered by this policy? ☐ Yes ☐ No

61. Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☐ No

62. Of what professional association(s) is the Applicant a member in good standing? _____

DECLARATION AND SIGNATURE

The undersigned declares that to the best of his/her knowledge, the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained in the files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

Name of Applicant: _____ Title: _____
Please print

Signature: _____ Date: _____

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