



ACE USA

Long Term Care Professional and General Liability Policy Application

Along with this completed and signed application, prospective insureds must also submit the following information:

1. Past five (5) year loss run currently valued within the last three (3) months. Please provide detailed information on all claims with a \$25k incurred loss or greater.
2. Copies of State Inspection Reports for the last two (2) surveys. Include all statements of deficiencies and plans of correction.
3. Updated Form CMA 671 Facility Staffing and 672 Resident Census (SNF/ICF only) for each facility.
4. Copy of the most current audited financial statement.
5. Names and locations of all entities to be covered under this policy.
6. Current Quality Indicator Profile for the past 3 months.
7. Substantiated Complaint Survey if substantiated complaint is within last 2 years
8. Skin Care Policy and Procedure
9. Resident Admission Agreement
10. Elopement Policy and Procedure
11. Description of Fall Prevention Program
12. Physician Restraint/Device Policy
13. Abuse & Prevention Policy and Procedure
14. Copy of Current State License.
15. Diagram/Map of the facility.
16. Marketing brochures and advertising materials.
17. Resumes and Job Descriptions of the Administrator and Director of Nursing.

The requested information is necessary before a quotation can be obtained.

15. Is your organization planning for acquire or open any new locations in the next year? Yes No
 If yes, please provide details (location and # of licensed beds)

B. Prior Insurance History

Primary Coverage

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

Excess/Umbrella Coverage

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you? Yes No

If yes, please provide detailed descriptions on all claims with a \$25k incurred loss or greater.

2. In the last three (5) years, has any malpractice insurance carrier denied, restricted, limited or terminated coverage? Yes No

If yes, please explain:

3. Has the applicant facility, or any other person for whom insurance is being requested, aware of any fact(s), incidents(s), act(s), event(s), circumstance(s), or occurrence(s) that may result in a claim (s) being made against you? Yes No

If yes, explain (attach list with comments)

4. Has the applicant facility experienced any allegations or substantiated incidents of physical or sexual abuse (resident upon resident, staff upon resident, visitor upon resident) in the past three (3) years? Yes No

If yes, please provide full details

C. Licensing /Certification

1. Has your state license for any locations been revoked, suspended or limited with the last three (3) years? Yes No

If yes, please explain

2. Has your Medicare or Medicaid certification for any location been limited, suspended or revoked, for any reason, within the last three (3) years? Yes No

If yes, please explain

3. Has your facility been placed under Immediate Jeopardy during the past three (3) years? Yes No

If yes, please explain:

4. Date of last State Inspection/Survey: _____ Total # of Deficiencies: _____
Number of D, E & F Deficiencies: _____ Number of G, H & J Deficiencies: _____
Corrective Action Plan accepted by State: Yes No Date Accepted: _____

5. Number of complaints investigated by State the past three years: _____

Number of substantiated complaints: _____

D. Classification

Percent of residents

1. By age range: < 30 _____ 30-64 _____ 65-74 _____ 75-84 _____ 85-94 _____ >95 _____

If any residents below age 64, please explain: _____

2. Please state percentage of payment/reimbursement in each category:

Medicare: _____ Medicaid: _____ Private Pay: _____ Self Pay: _____ Other: _____

Sub-Acute: For Profit (80909) Not For Profit (80928)

Total Licensed beds: _____ Average Occupancy: _____

Ventilator care, post operative/trauma recovery, wound management, intravenous antibiotic &/or hydration therapy, spinal cord/head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, dialysis.

Skilled Nursing: For Profit (80908) Not For Profit (80929)

Total Licensed beds: _____ Average Occupancy: _____

Administration of medication by injection, catheter insertion and sterile irrigation, physical & occupational therapy, administration of oxygen & inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients.

Intermediate Care: For Profit (80907) Not For Profit (80914)

Total Licensed beds: _____ Average Occupancy: _____

Administration of oral medications, assistance with ADLs', preventive turning/positioning, restorative rehabilitation.

Assisted Living: For Profit (80920) Not For Profit (80932)

Total Licensed beds: _____ Average Occupancy: _____

Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Provides protective environment, meals, assistance with medications, group socials and spiritual activities, etc.

Personal Care: For Profit (80906) Not For Profit (80930)

Total Licensed beds: _____ Average Occupancy: _____

Security, transportation, nutritional meals, recreation, self administration/assistance with medications, guidance with activities of daily living (bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.

Independent Care: For Profit (80905) Not For Profit (80930)

Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises.

1. Total Number of Units: _____

2. Total Number of Residents at Full Occupancy: _____

3. Are there common dining facilities? Yes No

4. Do individual units have cooking appliances (excluding microwaves)? Yes No

If Yes, Please check type: Gas Electric

5. Are Residents checked every day? Yes No

If yes, explain procedure: _____

6. Are Residents allowed to have Home Health Care Aides? Yes No

If yes, do you require them to maintain professional liability insurance? Yes No

7. Are the aides contracted independently? Yes No Through Facility? Yes No

E. Administrator

1. Name: _____ License Number: _____ State: _____
2. Length of time at this facility: _____ Number of years as a NHA: _____

F. Nurse Staffing

1. Name of Director of Nursing: _____ Professional Credentials: RN LPN
2. Length of time at this facility: _____ Length of time as DON: _____
3. Total # of Nurse Employees: _____

	1 st Shift	2 nd Shift	3 ^d Shift	Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency Staff				

4. Does the facility utilize agency staff? Yes No
5. Do you verify nursing license upon hire and annually thereafter? Yes No
6. Do you obtain and review nurses' certificates of malpractice insurance? Yes No
7. Do you verify nursing assistant certification upon hire and annually thereafter? Yes No

G. Medical Director

1. Name of Medical Director: _____ License Number/State: _____
2. Length of time at this facility: _____ Medical Specialty: _____
3. Is the Medical Director:
 - Full Time at this facility Part Time at this facility
 - Employed Contracted (If contracted, please provide a copy of the contract)
4. How many hours does the Medical Director spend onsite per month: _____
5. How many the residents utilize the Medical Director as their attending physician? _____
6. Is there an evaluation of the Medical Director's performance? Yes No
If Yes, please define: _____
7. Is a Physician on site or on call on a 24 hour basis? Yes No

H. Medical Staff

1. Number Physicians Employed: On Staff _____ Affiliated _____ Contracted _____
2. Do you obtain and review physicians certificate's of malpractice insurance? Yes No
3. What limits do you require physicians to maintain? _____ per occurrence/_____ aggregate
4. Do you have a formal Medical Staff Credentialing Program?: Yes No

5. Do credentialing activities include:

- Physician criminal background checks: Yes No
Verification of current professional license: Yes No
DEA Certificate: Yes No
Past malpractice history Yes No

I. Human Resources/Employee Screening

1. Does the employee screening/hiring process include verification of the following?

- Educational Background _____
 Work History with at least two previous employers? _____ In Writing By Telephone
 Personal references In Writing By Telephone
 Criminal Background _____
 Drug Testing _____
 Abuse Registry
 Driving Record (MVR, when appropriate) _____
 Any pending license suspensions or revocations, or pending disciplinary actions

2. Are background checks conducted on Agency staff? Yes No
3. Are employee competencies assessed and documented? Yes No
4. Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees including agency staff? Yes No
5. Are volunteers utilized? Yes No

If yes, please describe selection process and training process: _____

J. Risk Management

1. Is there a risk management program at this facility? Yes No
2. Is there a designated Risk Manager? Yes No
3. Risk Managers Name: _____
4. Length of time at this facility: _____
5. Does the risk management program include the following?
 Incident Reporting Process
 Claims Management
 Resident Complaints and Grievances Process and Procedures
 Contract Review and Evaluation

6. Are incidents trended and presented to the quality/risk management committee? Yes No
7. How many formal complaints recorded by families, residents or advocates in the last 6 months? _____
8. Is there a formal safety program? Yes No

K. Policy and Procedures

Elopement

1. How and when are residents assessed for the potential to wander or elope? _____

2. What is the number of elopements in the past 12 months? _____
3. What is the number of elopements in the past 12 months that resulted in injury to resident? _____
4. What is the number of elopements in the past 12 months that resulted in death of resident? _____
5. Are Wander Guards or similar devices used as part of elopement prevention practices? Yes No
If yes, provide type: _____
6. Are Wander devices for residents and building maintained and inspected according to manufacturer's specifications? Yes No
7. What security measures are used to control unauthorized entrance/exits from facility? _____

Falls / Restraints

1. Do you have a Fall Prevention Program? Yes No
2. Are Nursing Assessment Protocols in place to identify residents at risk for Falls? Yes No
3. Are falls monitored and tracked to identify patterns or problems? Yes No
4. Is there a policy regarding the use of chemical and physical restraints? Yes No
5. Are families notified of use of Bed Rails? Yes No
6. Are handrails provided in halls and bathrooms? Yes No
7. Are call buttons operational in each room? Yes No
8. Are residents accounted for at least once every 24 hours? Yes No
9. What is the current number of residents with the following:

Lap Buddies/Seat belts or Waist Belts
Geriatric Chairs
Chest/Vest Restraints
Bed rails (any)

Abuse

1. Are policies in place for the immediate suspension/termination of staff suspected or involved in Resident Abuse? Yes No
2. Does facility have a written procedure for reporting Resident Abuse? Yes No
Who is responsible for the investigation? _____
3. Do you provide abuse training beyond the mandatory requirements? Yes No
4. Number of alleged abuse incidents investigated and/or reported in the 12 months year? _____

Skin Care and Decubitus Prevention

1. Are there written policy and procedures for the prevention and treatment of skin breakdown? Yes No
2. Are all residents evaluated for skin breakdown and risk of breakdown at the time of admission? Yes No
3. How often do nurses perform total body skin assessments? _____

4. Do you have a wound care team or designated individual responsible for this program? Yes No
5. What is your current resident population with Stage III or IV acquired Decubitus Ulcers? _____

Additional Services

1. Do you have a specialized Alzheimer's Unit within the facility? Yes No
If yes, please provide number or residents and capacity: _____
2. Do you have an in-house pharmacy Yes No
Who dispenses medications? _____
3. Is monthly review of drug regimens performed? Yes No
By Whom? _____
4. Is there a system in place to track medication errors? Yes No

L. Independent Contractors and Services

Below please address:

- Which of the following medical services are performed at your facility?
- Indicate Yes or No if the services provided are on a contractual basis?
- If yes, indicate the required limits of liability?

<u>Services Provided</u>	<u>Yes</u>	<u>No</u>	<u>Yes Contract</u>	<u>No Contract</u>	<u>Limits of Liability</u>
Physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharmaceutical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychologists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Podiatrists					
Chiropractors					
Physical Therapy					
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barber/Beautician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have Certificates of Insurance been obtained from Independent Contractors?
Are these reviewed annually?

Yes No
 Yes No

M. Non-Resident Services

Please indicate the annual number of visits or clients for the following.

Home Health Care Yes No # of Home Health Care Calls per year: _____

Home Health Care provided by Independent Contractors: Yes No

Describe Home Health Care Services Offered: _____

Day Care (total licensed #): _____ # of employees' children: _____ Hours of Operation: _____

Licensed Day Care Center: Yes No

Adult Day Care (total licensed #): _____ Hours of Operation: _____

Do you provide transportation to and from your facility(ies): Yes No

Do you provide transportation to and from events: Yes No

Respite Care: Yes No If Yes, # per year: _____

Hospice Care (80931): Yes No If Yes, # per year: _____

Describe **Rehabilitation Services** Offered: _____

Do you provide the following services?

			# of <u>Residents</u>				# of <u>Residents</u>
AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Alcohol Abuse Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Hospice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Drug Abuse Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	I V Infusion Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Ventilation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Alzheimer's/Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	Developmentally Disabled	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

N. Other Exposures

1. Recreational Offerings: Please check all that apply

- None
- Swimming Pool – If yes, please provide description including location, depth, supervision and maintenance

Is the pool: Please check all that apply:

- Open to the Public
- Locked when not in use
- Fenced
- Have a F/T Life Guard on Duty
- Have a Diving Board/Sliding Board:

- Saunas/Hot Tubs If Yes, how many? _____
- Exercise Weight Room
- Tennis/Racquetball/Handball Courts If Yes, how many: _____

Other bodies of water – If yes, please describe: _____

2. Is the applicant: Building Owner Tenant General Lessee

a) Year building was Built: _____ Number of Floors: _____ Number of Elevators: _____

b) Was the building designed and constructed for elder care occupancy? Yes No

If No, please explain: _____

Fire/Safety

1. Are smoke detectors hard wired to central station

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

a) Are these equipped with panic alarms: Yes No

3. Do alarms ring into central security desk or nurses station: Yes No

4. Total # of fire extinguishers: _____

5. If multi-story building, are non-ambulatory residents on lower floors (1st/2nd): Yes No

6. Is video surveillance used? Yes No If Yes, describe extent of use: _____

7. Are fire drills conducted regularly? Yes No If Yes, describe: _____

8. Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department:
 Yes No

9. Is there a written emergency plan covering fire, natural disasters and threats: Yes No

NOTICE TO ALL APPLICANTS:

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT. SUCH AN ACT IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant

Signature of Broker/Agent

Title

Date

Date

Signed by Licensed Resident Agent
(Where Required By Law)