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**K&B UNDERWRITERS**  
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**SUPPLEMENTAL INSURANCE APPLICATION**

**Please complete a separate application for each facility if multiple locations exist. In addition, please ensure we receive the following attachments with your application:**

**SUBMISSION REQUIREMENTS:** Please check all that have been included:

- Completed and signed Acord applications with signed statement of values
- Complete supplemental applications signed by insured and BI worksheet
- Resident service contract
- Five years currently valued loss runs by line of business and policy period
- Five years of premium history by line of business and policy period
- Most recent financial statements, including balance sheet, income and expense sheets, and notes
- Copy of licenses for each facility
- Brochures
- State inspection reports (SNF / ICF) - Last two years with any statement of deficiencies and plan of correction
- Resumes if business is less than 3 years old

**INSTRUCTIONS:**

1. Answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. "Applicant" refers to the company, its predecessors, and all proposed insureds, including subsidiaries.
3. PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.
4. For multiple locations, please complete a separate application for each.

**PART I – APPLICANT**

**A. Applicant information**

Named Insured: \_\_\_\_\_ Web Address: \_\_\_\_\_

Street Address: \_\_\_\_\_ P.O.Box: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ Coverage effective dates:

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Location name and address: \_\_\_\_\_ Additional subsidiaries and descriptions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Number of years this facility has been:

Operating: \_\_\_\_\_ Owned by present owners: \_\_\_\_\_ Managed by present management: \_\_\_\_\_

**B.** Please list the total annual gross sales for each of the last 3 years. However, on the GL Acord application, we must have the projected gross sales broken down per location:

\_\_\_\_\_

**C.** List all association memberships held by your facility:

\_\_\_\_\_

**D. BED CENSUS:**

	<b>Independent</b>	<b>Assisted</b>	<b>Skilled</b>
Total number of licensed beds			
Average number occupied			
Age range of residents			

If any residents age 59 or below, please provide the number and a description:

\_\_\_\_\_

\_\_\_\_\_

**E.** Please list the percentage of residents by degree of ambulation:

\_\_\_\_\_ % *bed bound*:                      \_\_\_\_\_ % *use wheelchairs all or most of the day*  
 \_\_\_\_\_ % *use canes/walkers*:            \_\_\_\_\_ % *are independently ambulatory*

**F.** Are any bed bound residents above the second floor?  Yes     No

**G.** Do you accept residents who are chemically dependent, physically impaired or mentally/emotionally disturbed?  Yes     No

**H.** If yes, describe the percentage of each as follows:

\_\_\_\_\_ % *bi-polar disorder*                      *Age ranges:* \_\_\_\_\_  
 \_\_\_\_\_ % *schizophrenia*                              *Age ranges:* \_\_\_\_\_  
 \_\_\_\_\_ % *significant dementia*                      *Age ranges:* \_\_\_\_\_  
 \_\_\_\_\_ % *Alzheimer's*                                      *Age ranges:* \_\_\_\_\_

**I.** Do any of the residents have a history of violent behavior?  Yes     No

**J.** Are procedures in place to ensure MI / DD residents are on the proper medication?  Yes     No

**PART II – ADMINISTRATION AND STAFF**

**A.** Administrator's name and brief summary of administrative experience: \_\_\_\_\_

\_\_\_\_\_

**B.** Describe the background checks done for the administrator: \_\_\_\_\_

\_\_\_\_\_

C. Total number of volunteers: \_\_\_\_\_ Primary source(s): \_\_\_\_\_

D. Is there a formal screening process for volunteers?  Yes  No

E. Is there a formal, documented competency process for all staff?  Yes  No

F. Do you conduct an orientation and regularly scheduled in-servicing for all staff?  Yes  No

G. How are workers recruited? \_\_\_\_\_

H. Describe background verification checks on new employees:

*Work history* \_\_\_\_\_

*Education* \_\_\_\_\_

*Criminal record* \_\_\_\_\_

*Driving record (when appropriate)* \_\_\_\_\_

*Drug testing* \_\_\_\_\_

*Does your facility keep proof of licensure or certification of employees?*  Yes  No

I. Does your facility require staff to have basic training in CPR and where are these files maintained?  
\_\_\_\_\_

J. Does your facility keep records of employee references?  Yes  No

K. How many workers compensation claims have been filed within the last 12 months and what were the types of claims? \_\_\_\_\_  
\_\_\_\_\_

L. Does your facility have a full time manager and what is the licensure requirement of the manager?  
\_\_\_\_\_

M. Do nurses carry their own separate limits of liability?  Yes  No  
What are the limits of liability? \_\_\_\_\_

N. In-service records

• *Does your facility have a designated staff educator?*  Yes  No

• *How does your facility determine the yearly educational plan or in-services for the staff?* \_\_\_\_\_  
\_\_\_\_\_

• *List the topics covered in the training program for direct care staff.* \_\_\_\_\_  
\_\_\_\_\_

• *What were the in-service topics for the last 6 months?* \_\_\_\_\_  
\_\_\_\_\_

O. Name of individual that our loss control services representative may contact for an on-site survey of your facility:

Name \_\_\_\_\_ Phone Number \_\_\_\_\_



**C. Fall Prevention:**

- *Does your facility assess each resident for fall risk upon admission?*  Yes  No
- *Once a resident is assessed to be at risk for falls, what is the facility protocol for interventions?*  
\_\_\_\_\_
- *Does your facility have a written Fall Program?*  Yes  No
- *What is the system for educating the staff on the Fall Program?* \_\_\_\_\_
- *Does your facility have a Fall Committee?*  Yes  No
- *If so, who is on the committee and what is the frequency of the meetings?* \_\_\_\_\_
- *Have you had any residents fall within the last month and receive a fracture or been hospitalized as a result of the fall?*  Yes  No
- *Does your facility have a "call alert" system?*  Yes  No
- *Where is the call alert sent and who is responsible for responding to the call alert system?*  
\_\_\_\_\_
- *What other interventions are used for residents who have fallen, and when are they used?*  
\_\_\_\_\_  
\_\_\_\_\_

**D. Elopement:**

- *Are alarms on exit doors to prevent residents from wandering or leaving the premises without proper authorization?*  Yes  No
- *If no, how is this controlled?* \_\_\_\_\_
- *Do you conduct wandering risk assessments on all residents upon admission, and does this include a cognitive assessment?*  Yes  No
- *If a resident is found to be at risk for wandering, what is your procedure for prevention?*  
\_\_\_\_\_
- *Does your facility have a policy to clearly identify the types of dementia residents that your staff are capable of providing care to?*  Yes  No
- *Does your facility have a locked unit(s) for residents prone to wandering?*  Yes  No
- *If so, what system secures the unit?* \_\_\_\_\_
- *Do you have a Wander Guard system in place?*  Yes  No
- *If not, how do you prevent elopements?* \_\_\_\_\_
- *Has your facility had any residents elope from the facility?*  Yes  No
- *Are residents allowed to sit or wander unsupervised in unsecured areas such as on the facility grounds?*  Yes  No

**E. Evacuation procedures:**

- *Do you have a written emergency plan?*  Yes  No
- *Are evacuation directions posted in all parts of your facility?*  Yes  No
- *Does your staff orientation plan include a review and "walk through" of any disaster plan?*  Yes  No
- *How often are evacuation/fire drills conducted each year for each shift?* \_\_\_\_\_
- *Are they fire department supervised?*  Yes  No

- F. Are written orders from an attending physician required for all drugs or medicines or special dietary requirements?  Yes  No
- G. Are physician orders recorded, maintained, and up-to-date?  Yes  No
- H. Is there a written resident agreement in place?  
Is your most recent copy attached? (required)  Yes  No  
 Yes  No
- I. Is smoking permitted in resident rooms?  Yes  No
- J. Medication administration
- *Is the unit dose medication system used by the facility?*  Yes  No
  - *If not, what system is used?* \_\_\_\_\_
  - *Who is responsible for administering medications to the residents in the facility:*  licensed staff  
 medication aide
  - *Where are medications stored?* \_\_\_\_\_
  - *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?*  
\_\_\_\_\_  
\_\_\_\_\_

**PART IV – CONTRACTUAL AGREEMENTS**

- A. Are Certificates of Insurance attached for all contracted professional services?  Yes  No
- B. If not, please explain: \_\_\_\_\_  
\_\_\_\_\_

**PART V – BUILDING AND EQUIPMENT FEATURES**  
(REQUIRED FOR EACH BUILDING)

The following information is needed for each building used for patient or resident occupancy. If you have more than one such building, you should either complete a copy of this section for each additional building or provide the information in the comments section.

- A. Building identification: \_\_\_\_\_ Year built: \_\_\_\_\_  
*Protection class:* \_\_\_\_\_ *Square footage:* \_\_\_\_\_ *Number of stories:* \_\_\_\_\_  
*Building construction:*  
 *Frame*     *Joisted masonry*     *Masonry non-combustible*     *Fire resistive*
- B. Was building originally designed and constructed for senior living?  Yes  No  
*If no, what was the original building occupancy?* \_\_\_\_\_  
*If applicable, what year was the building retrofitted for use as an senior living facility?* \_\_\_\_\_

C. When was this building's electric, heating or plumbing system last inspected or updated?

	Electric	Heating	Plumbing
Qualified inspection			
Replaced or updated			

D. When was this building last inspected by the:

Local Fire Authorities \_\_\_\_\_ State Department of Health \_\_\_\_\_

E. Are there at least two exits, located remotely from each other, on each floor and fire area?  Yes  No

F. 1. Are fire doors kept closed routinely or arranged to automatically close in the event of a fire alarm?  Yes  No

Explain: \_\_\_\_\_

2. Are doors to residents' rooms equipped with self-closing devices?  Yes  No

G. Is there an automatic sprinkler system installed in all buildings?  Yes  No

▪ If yes, please check areas that are protected:

- Resident rooms
- Rest rooms
- Closets
- All common areas (corridors, lobbies, dining room, etc.)
- Attic areas
- Basements, if any
- Concealed spaces above ceilings
- Enclosed stairways
- Exterior porches

▪ Is the sprinkler system:  NFPA 13  NFPA13 R

▪ Who was the sprinkler system contractor that installed the system?

Name \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_

▪ How often is the sprinkler system tested? \_\_\_\_\_ Date of last test: \_\_\_\_\_

H. Is there a smoke or heat detection system installed in all buildings?  Yes  No

▪ If yes, please check areas that are protected:

- All common areas
- Concealed areas above ceilings
- Resident rooms
- Elevator lobbies only
- Attic areas

▪ Is the system:

- Hard wired to building electric service
- Battery units only
- Combination (Explain): \_\_\_\_\_

▪ What happens upon activation of system? Check all that apply:

- Alarm sent to off-site central station. Name: \_\_\_\_\_
- Alarm sent automatically to fire department.
- Local signal at front desk/nurses station.
- Local alarm sounded throughout facility.

▪ How often is smoke/heat detection system tested? \_\_\_\_\_

▪ Date of last test: \_\_\_\_\_

▪ Who tested: \_\_\_\_\_

- I. 1. Do you have an auxiliary electrical supply system?  Yes  No  
 2. Is there an emergency lighting system?  Yes  No  
 3. Are all exit signs arranged to be illuminated in the event of power failure?  Yes  No

J. Are handrails provided in hallways and bathrooms?  Yes  No

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

L. Are you planning any new construction for the next 12 months?  Yes  No

*If yes, use the comment section to describe the purpose, estimated cost and estimated completion date for such construction.*

M. Does facility have a formal safety program in place?  Yes  No

If no, please describe: \_\_\_\_\_

N. Recreational facilities

▪ *Swimming pool*  Yes  No

▪ *Health club, gym, or other (please describe controls and monitoring):*

\_\_\_\_\_

O. Describe management's commitment to resident and employee safety. Attach copies of any safety policies.

\_\_\_\_\_

\_\_\_\_\_

## PART VI – CLAIMS HISTORY

A. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance?  Yes  No

*If yes, please describe:*

\_\_\_\_\_

\_\_\_\_\_

B. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association?  Yes  No

*If yes, please describe:*

\_\_\_\_\_

\_\_\_\_\_

C. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you?  Yes  No

*If yes, please fill out Appendix A at the end of this application.*

## PART VII – COVERAGE HISTORY

### A. Professional/General liability coverage history:

**Present insurance company:** \_\_\_\_\_

Policy period: From: \_\_\_\_\_ To: \_\_\_\_\_

Limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_

Is present coverage:  Occurrence  Claims-made

Retro date: \_\_\_\_\_

**First year prior carrier:** \_\_\_\_\_

Policy period: From: \_\_\_\_\_ To: \_\_\_\_\_

Limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_

Occurrence  Claims-made

Retro date: \_\_\_\_\_

**Second year prior carrier:** \_\_\_\_\_

Policy period: From: \_\_\_\_\_ To: \_\_\_\_\_

Limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_

Occurrence  Claims-made

Retro date: \_\_\_\_\_

Comments: \_\_\_\_\_

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 FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (NOT APPLICABLE IN CO, HI, NE, OH, OK, OR; IN ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED.)

**The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:**

**Please ensure that additional information is attached where applicable.**

**The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.**

**The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.**

**\*PLEASE NOTE THAT THIS APPLICATION WILL NOT BE REVIEWED UNLESS IT IS SIGNED AND DATED.\***

Insured signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Title: \_\_\_\_\_

