Senior Living
Professional and General Liability
Covered Facility Supplemental Application

THIS SUPPLEMENTAL APPLICATION IS AN ATTACHMENT TO, AND NOT IN LIEU OF THE MAIN APPLICATION. THIS SUPPLEMENT PROVIDES THE NECESSARY UNDERWRITING AND RATING INFORMATION ON A PER COVERED FACILITY BASIS AND THIS SUPPLEMENTAL APPLICATIONS WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

Please type or print clearly.

- **Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **This form must be completed, dated and signed by the CEO, CFO, Administrator, Director of Nursing or Risk Manager of the proposed Named Insured.**

With respect to each facility for which coverage is sought, please answer the following questions.

(*Note: If more than one facility is proposed for coverage, please complete a separate Covered Facility Supplemental Application for each such facility*).

I. COVERED FACILITY GENERAL INFORMATION

A. Covered Facility Business Name (dba): ________________________________

B. Physical Address of Covered Facility: ________________________ ________________ ______

Street City, State ZIP

C. Date Facility Opened (mm/yyyy): __________ Website (if applicable): ____________________

D. 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):***
Staffing related: ________________________________
Life Safety Code related: ________________________________

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

(i)	Had its license suspended or revoked?	☐ Yes	☐ No
(ii)	Been the subject of any federal or state sanctions?	☐ Yes	☐ No
(iii)	Been the subject of any civil monetary penalty against it or any of its staff?	☐ Yes	☐ No
(iv)	Entered into any Corporate Integrity Agreement ("CIA") with the Office of the Inspector General ("OIG")?	☐ Yes	☐ No

F. Total Gross Revenue derived from this facility (Prior 12 months): $ ____________________

II. COVERED FACILITY OPERATIONAL EXPOSURE DATA

A. Resident Count / Bed Census:

Bed or Resident Type	Bed / Resident Type Description	Total Licensed or Available Beds of Type Described	Average Occupancy Past 12 months
Sub Acute	*Licensed to provide ventilator care, wound management, post operative / trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord / head injury, oncology, total parenteral nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, or dialysis.*	#________	#________
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.*	#________	#________
	Total Licensed or Available Beds / Total Avg. Occupancy:	#________	#________

B. Does the facility have any bed-bound assisted living residents above the second floor of the building? ☐ Yes ☐ No

C. Does the facility have any resident that is receiving ventilator care, or where the resident cannot reposition themselves in a bed or wheelchair, who is not in a licensed skilled bed? ☐ Yes ☐ No

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

< 18 yrs old	18 - 54 yrs old	*55+ yrs old*
#_______	#_______	#_______

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

Bi-polar disorder	Schizophrenia	Significant dementia	Alzheimer's
#_______	#_______	#_______	#_______

F. Additional Services Rendered:

		Number of Visits Performed in Prior 12 Months:	Gross Revenue Prior 12 Months:	Percentage of Service Rendered by Independent Contractors:
(i)	Home Health Care:	#________	$ ______________________	________%
(ii)	Respite Care:	#________	$ ______________________	________%
(iii)	Hospice Care:	#________	$ ______________________	________%

		Number of Residents / Participants Prior 12 Months:	Gross Revenue Prior 12 Months:	Percentage of Service Rendered by Independent Contractors:
(iv)	Adult Day Care (Social Model): *	#________	$ ______________________	________%
(v)	Adult Day Care (Medical Model): **	#________	$ ______________________	________%

** (Social Model) services include but are not limited to: recreational activities such as crafts, music, games, shopping trips, intergenerational programs, promotion of wellness and socialization programs, educational programs.*

*** (Medical Model) services include but are not limited to: those included in the Social Model, plus 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), and services for the mentally challenged, cognitively impaired, developmentally disabled, or chronically ill individuals.*

(v) Child Day Care: Does the facility provide any day care services for children? ☐ Yes ☐ No

G. Nursing Services Rendered / Activities of Daily Living Services (ADL's) Rendered:

(i) Please indicate the number of current residents who receive the following types of ***Nursing Services*** *(a resident may be receiving more than one)*:

(a)	Catheter care:	#_______
(b)	Ostomy care:	#_______
(c)	Tube feedings:	#_______
(d)	Diabetes care (including insulin injections):	#_______
(e)	Medication injections:	#_______
(f)	Medication administration:	#_______
(g)	Enemas or suppositories:	#_______
(h)	Continence care:	#_______
(i)	Wound care:	#_______
(j)	Decubitus care:	#_______
(k)	Oxygen / IPPB:	#_______
(l)	Anticoagulation monitoring:	#_______
(m)	Dialysis care:	#_______
(n)	Ventilator patient care:	#_______
(o)	2-person transfers:	#_______
(p)	Other: ____________________	#_______

(ii) Please indicate the number of current residents who receive the following types of ***Activities of Daily Living (ADL) Services*** *(a resident may be receiving more than one)*:

(a)	Mobility (ambulating, transferring to wheelchairs, etc.):	#_______
(b)	Communication:	#_______
(c)	Bowel and bladder management (toileting):	#_______
(d)	Eating and drinking:	#_______
(e)	Personal cleansing and grooming / bathing:	#_______
(f)	Dressing:	#_______
(g)	Medication management or assistance (but not administration):	#_______

H. (i) What Percentage of the above ***Nursing Services*** described in G. (i) are provided by independent contractors? ______%

(ii) What Percentage of the above ***ADL Services*** described in G. (ii) are provided by independent contractors? ______%

I. Key Staff:

(i) **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: ____________

(d) Number of years tenure at this facility: ____________

(ii) **Facility Administrator**:

(a) Employment Status: ☐ Employee ☐ Independent Contractor

(b) Name: ____

(c) License Number: _________________________ State of Licensure: ___________

(d) Number of years experience as a Facility Administrator: ____________

(e) Number of years tenure at this facility: ____________

(iii) **Medical Director**:

(a) Employment Status: ☐ Employee ☐ Independent Contractor

(b) License Number: _________________ State of Licensure: _______ Medical Specialty: ___________________

(c) Number of years experience as a Medical Director: ___________

(d) Number of years tenure at this facility: ___________

(e) Does the Medical Director also act as the attending physician to any residents? ☐ Yes ☐ No

(If the answer is "Yes" to above, how many residents: __________ , and what limits of Professional Liability insurance does the Medical Director carry: ______________________)

(f) Is the Medical Director involved in credentialing any licensed, professional staff utilized at the facility, whether such professional staff are employees or are independent contractors? ☐ Yes ☐ No

J. General Staffing:

(i) Total number of nursing / caregiver (whether employed or independent contractor) positions, by staff category:

Category	1st Shift:	2nd Shift:	3rd Shift:	Turnover Percentage Prior 12 Months:
RN:	#______	#______	#______	_____%
LPN / LVN:	#______	#______	#______	_____%
CNA / Personal Caregiver:	#______	#______	#______	_____%

J. General Staffing (continued):

(i) Total number of other staff (whether employed or independent contractor) by staff category:

Category	1st Shift	2nd Shift	3rd Shift	Comments
Dietician:	#______	#______	#______	______________________
Beautician / Barber:	#______	#______	#______	______________________
Administrative / Clerical:	#______	#______	#______	______________________
Maintenance / Security:	#______	#______	#______	______________________
Other Staff: (not described above)	#______	#______	#______	______________________
Volunteers:	#______	#______	#______	______________________

(ii) Does the facility maintain the same staffing levels on each shift on weekends as it does on weekdays? ☐ Yes ☐ No

(If the answer above is "No", please explain): ____

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

(iv) If the facility renders any ***Nursing Services***, as specified in Question G. (i) (a) through (p) of this Section, does the facility have a minimum of an LPN on duty 24 hours per day? ☐ Yes ☐ No

(v) Does the facility have a designated Risk Manager? ☐ Yes ☐ No

(If the answer above is "Yes", please indicate the number of years in that position): _________

(vi) Are background checks performed on all staff (both professional and non-professional, and including volunteers)? ☐ Yes ☐ No

(If the answer above is "Yes", do such background checks include verification of the following item?):

(a) Licensure type and status (including registry checks for CNA's and nurses): ☐ Yes ☐ No

(b) Work history and education: ☐ Yes ☐ No

(c) Criminal records: ☐ Yes ☐ No

(d) Driving records / MVRs (for any staff who will transport residents): ☐ Yes ☐ No

(e) Existence of their own professional liability insurance (for any staff who are licensed practitioners, including but not limited to: nurses, physicians, pharmacists): ☐ Yes ☐ No

(In the answer above is "Yes", what is minimum amount of such insurance the facility requires them to carry?) _______________________________

(vii) Does the facility conduct and document in-service training for all licensed and unlicensed staff in compliance with all state mandated training and education requirements, as appropriate to the facility's licensure? ☐ Yes ☐ No

K. Resident Assessments:

(i) Are resident pre-admission assessments for the facility done in person? ☐ Yes ☐ No

(ii) Are the procedures for admission, discharge and transfer of residents in writing and in compliance with all state and federal requirements? ☐ Yes ☐ No

(iii) Who completes admission assessments at the facility? ☐ RN ☐ LPN ☐ Other: ____________

(iv) In the past 12 months, has the admission of any potential resident been denied on the basis of acuity? ☐ Yes ☐ No

(v) Will the facility admit (or allow continued residency) any resident who is assessed to be a threat to self or others? ☐ Yes ☐ No

(vi) How often are residents reassessed? ☐ Monthly ☐ Quarterly ☐ Other: ____________

(vii) Does assessment of residents include evaluation of:

(a) Mobility limitations? ☐ Yes ☐ No

(b) History of prior injuries? ☐ Yes ☐ No

(c) Required assistance with ADLs? ☐ Yes ☐ No

(d) Disorientation? ☐ Yes ☐ No

(e) Risk of falls? ☐ Yes ☐ No

(f) Risk of wandering? ☐ Yes ☐ No

(g) Risk of pressure sores? ☐ Yes ☐ No

(h) Whether resident is threat to self or others? ☐ Yes ☐ No

(vii) Once a resident is assessed to be at risk for falls, what is the facility protocol for intervention? ____
____

(viii) Has any resident in this facility fallen within the last month and suffered a fracture or been hospitalized as a result of the fall? ☐ Yes ☐ No

(ix) Once a resident is assessed to be at risk for wandering, what is the facility protocol for prevention? ____
____

(x) Does the facility perform regular elopement drills? ☐ Yes ☐ No

(xi) Has the facility had any resident elope in the past year (where the resident was out of the facility and unaccounted for 1 hour or more)? ☐ Yes ☐ No

(If the answer is "Yes" to above, how many incidents of elopement have happened, whether or not a claim was made?): ______

(xii) Does the facility have a dedicated wound nurse? ☐ Yes ☐ No

L. Rules and Procedures:

(i) What security measures are used to control unauthorized entrance to the facility? ____
____

(ii) Are all staff required to have basic training in CPR? ☐ Yes ☐ No

(iii) If the facility admits any residents with risk of wandering, are alarms on all exit doors to prevent residents from wandering or leaving the premises without proper authorization? ☐ Yes ☐ No

(iv) Does the facility have locked unit(s) for residents prone to wandering? ☐ Yes ☐ No

*(If the answer is "Yes" to above, what system secures the unit?)*____________________________

(v) Does the facility have a "Wander Guard" system in place? ☐ Yes ☐ No

(vi) Can residents' door alarms be disabled or turned-off at a central location or station? ☐ Yes ☐ No

(vii) Does the facility have a written emergency or disaster plan? ☐ Yes ☐ No

(viii) Are evacuation directions posted in all parts of the facility? ☐ Yes ☐ No

(ix) Does the staff orientation / training include a review and "walk through" of any disaster plan? ☐ Yes ☐ No

(x) How often are evacuation / fire drills conducted each year for each shift? ☐ At least Monthly ☐ At least 4 times per year ☐ Less than 4 times per year

(xi) Are such evacuation / fire drills supervised by the local Fire Department? ☐ Yes ☐ No

(xii) Are written orders from an attending physician required for all drug or medicines or special dietary requirements? ☐ Yes ☐ No

(xiii) Is the unit dose medication system used by the facility? ☐ Yes ☐ No

(If the answer is "No" above, what system is used?): ______________________________________

(xiv) Who is responsible for administering medications to residents at the facility? ☐ Licensed Staff ☐ Medication Aide

(xv) Is smoking permitted in residents' rooms that are other than Independent Living beds? ☐ Yes ☐ No

(xvi) Does the facility contract with a transportation service (e.g., ambulance, bus, van) to transport residents? ☐ Yes ☐ No

(If the answer is "No" above, what carrier provides the coverage and what Limit of Liability does the facility's auto liability policy provide?)

Carrier: _____________________________ */ Limit:* _________________________

(xvii) Do any staff (including volunteers) transport residents in their own vehicles? ☐ Yes ☐ No

*(If the answer is "Yes" above, how many staff-owned autos are used to transport residents or are used in any other capacity on behalf of the facility's business?) #*____________

(xviii) Does the facility lease vehicles to transport residents? ☐ Yes ☐ No

*(If the answer is "Yes" above, how many leased vehicles are used to transport residents or in any other capacity on behalf of the facility's business?) #*___________

M. Facility Building and Equipment Features:

(i) Year building was built: _________________

(ii) Type of building construction: ☐ Frame ☐ Joined Masonry ☐ Masonry non-combustible ☐ Fire resistive

(iii) Is there an automatic sprinkler system installed in the building? ☐ Yes ☐ No

(If the answer is "Yes" to above, please check all areas that are protected):

☐ Residents rooms ☐ All common areas (corridors, lobbies, dining room, etc.) ☐ Concealed spaces above ceilings

☐ Rest rooms ☐ Attic areas ☐ Enclosed stairways

☐ Closets ☐ Basement, if any ☐ Exterior porches

(iv) If present, is the sprinkler system: ☐ NFPA 13 ☐ NFPA 13 R

(v) How often is the sprinkler system tested? __________________________ Date of last test: ______________

(vi) Are there at least two exits, located remotely from each other, on each floor and fire area? ☐ Yes ☐ No

(vii) Are doors to resident's rooms equipped with self-closing devices? ☐ Yes ☐ No

(viii) Does the facility have an auxiliary electrical supply system? ☐ Yes ☐ No

(ix) Does the facility have an emergency lighting system? ☐ Yes ☐ No

(x) Are all exit signs arranged to be illuminated in the event of power failure? ☐ Yes ☐ No

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

(xii) Are all bathtubs and showers equipped with non-slip surfaces? ☐ Yes ☐ No

(xiii) What types of recreational or dining facilities are provided at the facility (check all that apply)?

☐ Restaurant or dining room ☐ Health club or gym ☐ Other: ___________________

☐ Swimming pool ☐ Tennis, racketball or other courts or athletic fields ☐ None of these

(xiv) Are the general public or guests of residents allowed to use any of the above recreational or dining facilities? ☐ Yes ☐ No

III. COVERED FACILITY INSURANCE INFORMATION

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

Expiring Primary Professional Liability Policy Coverage Information

Effective Date (mm/dd/yyyy): ______________________ Expiration Date (mm/dd/yyyy): ______________________

Carrier Name: ________________________________

Per Claim Limit: ______________________ Aggregate Limit: ______________________

Each Claim Deductible: ______________________

Expiring Premium: ______________________

Coverage Trigger: ☐ Occurrence ☐ Claims Made Retroactive Date (mm/dd/yyyy): *(if Claims Made)* _________________

Expiring Primary General Liability Policy Coverage Information (*if applicable*)

Effective Date (mm/dd/yyyy): ____________________ Expiration Date (mm/dd/yyyy) : ____________________

Carrier Name: _____________________________

Per Claim Limit: ____________________ Aggregate Limit: ____________________

Each Claim Deductible: ____________________

Expiring Premium: ____________________

Coverage Trigger: ☐ Occurrence ☐ Claims Made Retroactive Date (mm/dd/yyyy): *(if Claims Made)* _________________

B. Requested Professional Liability Retroactive Date (mm/dd/yyyy): ____________________

C. Requested General Liability Retroactive Date (mm/dd/yyyy): ____________________

D. Is Requested Employee Benefits Liability Retroactive Date the same as Professional Liability Retroactive Date? ☐ Yes ☐ No

(If the answer to above question is "No", what is requested Employee Benefits Liability Retroactive Date?) ____________________

IV. COVERED FACILITY CLAIMS DATA

A. Has any claim, suit or regulatory proceeding been made against the facility during the past five (5) years? ☐ Yes ☐ No

(Note: If the answer to above question is "Yes", please attach five 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. If more than 5 claims for this facility, provide additional information on a separate sheet):

	Claimant Name	Type of Claim*	Date Claim Reported (mm/dd/yyyy)	Paid Loss Amount	Outstanding Loss Amount	Paid Expense Amount	Outstanding Expense Amount	Status 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

B. Is Applicant aware of any fact, circumstance, incident or loss which has occurred after the proposed retroactive date, which is not yet a claim but is likely to result in a claim under the coverage requested? ☐ Yes ☐ No

(Note: If the answer to above question is "Yes", please provide the following information):

	Date of Event (mm/dd/yyyy):	Potential Claimant Name:	Was prior Carrier Notified?
1.	____________	__________________	☐ Yes ☐ No
2.	____________	__________________	☐ Yes ☐ No
3.	____________	__________________	☐ Yes ☐ No
4.	____________	__________________	☐ Yes ☐ No
5.	____________	__________________	☐ Yes ☐ No

PLEASE NOTE, WITHOUT PREJUDICE TO ANY OTHER RIGHTS OF THE UNDERWRITER / INSURER, IT IS UNDERSTOOD AND AGREED THAT, ANY CLAIM OR RELATED CLAIM THAT ARISES OUT OF ANY CLAIM, SUIT, FACT, SITUATION, INCIDENT, CIRCUMSTANCE, INVESTIGATION OR PROCEEDING, THAT IS OR REASONABLY SHOULD HAVE BEEN DISCLOSED IN RESPONSE TO THE ABOVE QUESTIONS IS EXCLUDED FROM THE PROPOSED COVERAGE.

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

- If licensed as an assisted living facility or nursing facility, the most recent and immediately preceding state inspection reports (DHHS Standard Survey and LSC Survey), and Complaint Surveys conducted within the last 2 years (if any), including any statement of deficiencies and plan of correction; and
- The facility's current licenses; and
- A diagram of the facility (if available); and
- Samples of all types of applicable resident service contracts; and
- Any marketing brochures; and
- Five years currently valued loss runs for each coverage being requested, and by policy period; and
- The most recent audited financial statements (including balance sheet, income statement with expenses, and notes.

Signature of Applicant: ____________________________________
(Must be dated and signed by the CEO, CFO, Administrator, Director of Nursing or Risk Manager of the proposed Named Insured)

Printed Name: ____________________________________

Title: ____________________________________

Date: __________________