



INSURANCE AGENCY, INC.
 PRIMARY / EXCESS AND SURPLUS LINES BROKERS
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Convalescent Homes/Residential Care/Homes for the Aged General Liability Application

Applicant's Name _____
 Mailing Address _____

 Location _____

 (Please complete a separate application for each location.)

Agent Name _____
 Address _____

PROPOSED EFFECTIVE DATE:

From _____ To _____
 12:01 A.M., Standard Time at the address of the Applicant

Applicant is: Individual Corporation Partnership Joint Venture
 Limited Liability Company Other (Specify) _____

LIMITS OF LIABILITY REQUESTED

PREMIUMS

| | | |
|--|-------------|-------------------------------|
| General Aggregate | \$ | Premises/Operations |
| Products & Completed Operations Aggregate | \$ | \$ |
| Personal & Advertising Injury | \$ | Products/Completed Operations |
| Each Occurrence | \$ | \$ |
| Fire Damage (any one fire) | \$ | Other |
| Medical Expense (any one person) | \$ Excluded | \$ |
| Professional Limit | \$ | Professional |
| Each Medical Incident | \$ | \$ |
| Aggregate | \$ | |
| Other Coverages, Restrictions, and/or Endorsements | | Total |
| Deductible | \$ | \$ |

Definitions:

“Residential/Personal Care Facility (RCF)”:

A facility that provides personal care, residential and social care with some routine health care, but not continuous skilled nursing care. Residents of homes for the aged must be ambulatory; group homes are for trainable developmentally disabled. (There is no daily medical attention.) Patients are responsible for their own medication.

“Intermediate Nursing Care or Intermediate Care Facility (ICF)”:

A facility where the residents' physiological and psychological functions are stable, but require individually planned treatment and services under the direction of a licensed nurse and supervision of a licensed physician (not on staff). Emphasis is on maintenance of maximum independence and return to the community as soon as possible. Some assistance in medication administration.

“Skilled Nursing Care or Skilled Care Facility (SCF)”:

A facility where the residents' conditions, needs, and/or services are of such complexity and sophistication so as to require the frequent or continuous observation and intervention of a registered nurse, and the supervision of a licensed physician (not on staff). Skilled nursing care includes some or all of the following: medication administration, injections, tube feedings, catheterizations, or other procedures ordered by physician.

1. **Full Named Insured*:** _____

*Note: If more than one Named Insured, explain the ownership/operational interest of each.

2. **Operating as:** Profit Non-Profit

Number of licensed beds: _____ How long under present management? _____

3. **Named Insured is:** Building owner Tenant General lessee

4. **Building owner** (if other than Named Insured): _____

5. **Are there any other occupants of the premises?** Yes No If yes, identify: _____

6. **Officers and general partners**

Titles

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

7. **How many years has the facility been in business under the current ownership?** _____

8. **How many years experience does the current ownership have in health facilities?** _____

How many years does the current management have in health facilities? _____

9. **In what professional or industry association(s) is the facility a member in good standing?** _____

10. **Name of administrator:** _____

(a) How long at this facility? _____

(b) Experience as administrator or assistant administrator: _____ years

11. **Who is in charge when administrator is absent?** (name and title) _____

12. **Number of administrators at the facility during the prior 10 years:** _____

13. **Does the facility have a medical director?** Yes No

Does the medical director have his/her own professional liability insurance? Yes No

14. **Is facility certified for:** Medicare? Yes No

Medicaid? Yes No

Other? Yes No

15. **Number of patients in each category:** Private Pay _____

Title 18 _____

Title 19 _____

Other _____

16. **Gross annual receipts of the facility** (including Medicare and Medicaid): \$ _____

17. **Please attach the most recent copies of state and county inspections.** Are there any deficiencies uncorrected? Yes No

If yes, what? _____

18. **License Information:**

(a) Please attach all licenses required for this facility's operation.

(b) Is license conditional, provisional, probationary or temporary? Yes No If yes, explain: _____

(c) Has license ever been revoked? Yes No If yes, explain: _____

(v) Cooking: Gas Electric None If none, describe food service: _____

1. Is stove vented outside with hood and grease filter? Yes No
2. Are filters clean? Yes No
3. Are hood and cooking surfaces protected with automatic extinguishing system? Yes No
4. Are all cooking surfaces directly protected? Yes No
5. Is automatic fuel shutdown interlocked to system? Yes No
6. Is there any deep fat frying? Yes No

23. Emergency Procedures:

- (a) Written emergency evacuation plan? Yes No
- (b) Does plan include advance arrangement including transportation and temporary shelter? Yes No
- (c) Are evacuation procedures posted in all parts of your facility? Yes No
- (d) Are drills conducted regularly for each shift? Yes No
- (e) Is the entire staff familiar with the emergency evacuation plan? Yes No
- (f) Is the plan filed with the local fire department? Yes No

24. Classify number of employees by shift:

| | 1st Shift | 2nd Shift | 3rd Shift | Laundry | _____ | _____ | _____ |
|--------------------------------|-----------|-----------|-----------|------------------|-------|-------|-------|
| Physicians, interns, residents | _____ | _____ | _____ | Other (describe) | _____ | _____ | _____ |
| Graduate nurses—RN | _____ | _____ | _____ | | _____ | _____ | _____ |
| Practical nurses—LPN | _____ | _____ | _____ | | _____ | _____ | _____ |
| Nurses' aides | _____ | _____ | _____ | | _____ | _____ | _____ |
| Student nurses | _____ | _____ | _____ | | _____ | _____ | _____ |
| Physical therapists | _____ | _____ | _____ | | _____ | _____ | _____ |
| Inhalation therapists | _____ | _____ | _____ | | _____ | _____ | _____ |
| Dieticians | _____ | _____ | _____ | | _____ | _____ | _____ |
| Beauticians/barbers | _____ | _____ | _____ | | _____ | _____ | _____ |
| Dentists | _____ | _____ | _____ | | _____ | _____ | _____ |
| Administrative | _____ | _____ | _____ | | _____ | _____ | _____ |
| Kitchen | _____ | _____ | _____ | | _____ | _____ | _____ |

| | 1st Shift | 2nd Shift | 3rd Shift |
|-------------------------|-----------|-----------|-----------|
| Respiratory therapists | _____ | _____ | _____ |
| Social workers | _____ | _____ | _____ |
| Speech therapists | _____ | _____ | _____ |
| Recreational therapists | _____ | _____ | _____ |
| Occupational therapists | _____ | _____ | _____ |
| X-ray technicians | _____ | _____ | _____ |
| Lab technicians | _____ | _____ | _____ |
| Maintenance/security | _____ | _____ | _____ |
| Special technicians | _____ | _____ | _____ |
| Housekeeping | _____ | _____ | _____ |

Total number of employees: _____ Full-time: _____ Part-time: _____

25. Physicians:

(a) Residents are expected required to have their own physician.

(b) Does facility employ or contract any of the following:

EMPLOYED

CONTRACTED

| | | | | | | |
|---------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|-------------------------|
| Psychologists | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| Dentists | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| Psychiatrists | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |
| Physicians | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how many? _____ |

(c) What are the duties of the contracted physicians? _____

(d) What are the average hours per week for all contracted physicians? _____

(e) Does insured obtain and maintain evidence of Professional Liability coverage for contracted professionals? Yes No

(f) What minimum limits are required? _____

26. Are pre-employment physicals required? Yes No

27. Is prior employment history checked? Yes No Attach a copy of the facility's hiring guidelines.

28. Is English the primary language of all professional staff? Yes No If no, what procedures does the insured have in place to ensure the staff is fluent enough in English to provide adequate care? _____

Does the facility provide in-service training in languages other than English? Yes No

29. Does applicant have Workers' Compensation coverage in force? Yes No

30. Does applicant lease employees? Yes No If yes, explain: _____

31. Does the facility ever use a nurses' registry or other temporary services to provide any staff?..... Yes No

(a) If yes, are they covered by their own Workers' Compensation? Yes No

(b) If yes, do they have their own Professional Liability Coverage? Yes No

(c) Are certificates of insurance obtained? Yes No

What are the limits? _____

(d) Is the registry or service licensed? Yes No

32. Do nurses make outside calls? Yes No If yes, number per week: _____

33. Does applicant provide outpatient hospice care? Yes No Attach application GLS-APP-32g.

If yes, describe: _____

34. Does applicant provide outpatient home care? Yes No If yes, describe: _____

35. Are physicians or RNs private practitioners (independent contractors) or actual employees of insured? _____

36. Does the facility maintain its own: Barber/beauty shop Yes No

Pharmacy Yes No

Gift Shop..... Yes No

(a) Do the operators have their own professional liability? Yes No

(b) If no, complete and return Professional Application.

37. **Are there any volunteers or volunteer programs?** Yes No Types of tasks performed: _____

Number of volunteers by shift: 1st _____ 2nd _____ 3rd _____

38. **Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.):** _____

39. **Patient ages:** From _____ (youngest) to _____ (eldest)

40. **Is there a safety committee?** Yes No How often does it meet? _____

41. **Are employees taught to lift using proper techniques?** Yes No

(a) Are Hoyer Lifts being used? Yes No

(b) Are Gate Belts being used? Yes No

42. **Are all wheelchairs equipped with locks for the wheels?** Yes No

43. **Is there a regular extermination program by an outside firm?** Yes No

(a) If yes, who? _____

(b) How often? _____

(c) Is certificate of insurance on file? Yes No

44. **Does the facility control the possession of smoking materials?** Yes No If yes, how? _____

Provide a copy of the facility's smoking policy.

45. **Are there established visiting hours?** Yes No If yes, what are they? _____

46. **Are the medications kept under locked conditions?** Yes No

Do only authorized personnel have keys? Yes No

47. **Does the facility have a policy on restraint usage?** Yes No If yes, please attach a copy of the policy.

48. **Any other premises or operations exposures not stated in this application?** Yes No

If yes, attach a complete description and underwriting/rating information.

49. **Number of AIDS/HIV patients:** _____

(a) Are patients isolated? Yes No If yes, how? _____

(b) What training is provided to new/existing staff? _____

(c) Is staff informed of all patients with AIDS/HIV? Yes No

(d) Does insured do any blood testing? Yes No

(e) Attach a copy of the insured's written infection control plan.

(f) How is infectious waste stored and disposed of? _____

(g) Are employees tested for AIDS/HIV? Yes No How often? _____

(h) Describe how the laundry from the AIDS/HIV patients is handled: _____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

| YEAR | COMPANY | POL. # | PREMIUM | LOSSES PAID | LOSSES RESERVED | DESCRIPTION |
|------|---------|--------|---------|-------------|-----------------|-------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |

50. Have any claims during the past five years ever been made or suit brought against the applicant because of any alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation? Yes No

If yes, date: _____ Brief description: _____

51. During the past three years has any company ever cancelled, declined or refused to issue similar insurance to the applicant? (Not applicable in Missouri) Yes No

If yes, explain: _____

| SCHEDULE OF HAZARDS | | | | | | | | | |
|---------------------|----------------|-------------|-----------------------------|--|-------|------------|-------------------------|------------|-------------------------|
| Loc. No. | Classification | Class. Code | Premium Bases: | | Terr. | Rate | | Premium | |
| | | | (s) Gross Sales (a) Area | (p) Payroll (c) Total Cost (t) Other | | Prem./Ops. | Products/ Comp. Ops. | Prem./Ops. | Products/ Comp. Ops. |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

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.

FRAUD WARNING:

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.

APPLICANT'S SIGNATURE _____ Date _____

AGENT NAME _____ AGENT LICENSE NUMBER: _____
(Applicable to Florida Agents Only.)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE