Print Form

ALLIED WORLD ASSURANCE COMPANY (U.S.) INC.
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LONG TERM CARE
MAIN APPLICATION FOR
PROFESSIONAL AND GENERAL LIABILTY POLICY

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY, EMPLOYEE BENEFITS LIABILITY AND SEXUAL MISCONDUCT LIABILITY COVERAGE WRITTEN ON A CLAIMS-MADE BASIS; AND GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THIS APPLICATION AND THE POLICY CAREFULLY AND DISCUSS WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THIS APPLICATION AND ANY APPLICABLE SUPPLEMENTAL APPLICATIONS WILL BECOME PART OF THE POLICY, AS IF PHYSICALLY ATTACHED.

- **Answer ALL questions completely, leaving no blanks, including any Supplemental Application(s) as may be required. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **All questions referring to the "Applicant" means the Named Insured or any facility proposed for coverage.**
- **If additional space is required for any response, please provide in a separate attachment, labeled with the question number.**
- **Certain questions apply on a per facility or per location basis – whether you operate only a single facility or multiple facilities or locations, please provide such data separately for each facility or location on a *COVERED FACILITIES SUPPLEMENTAL APPLICATION*.**
- **This form must be completed, dated and signed by the CEO, CFO, Administrator, Director of Nursing, or Risk Manager of the proposed Named Insured.**

I. GENERAL BUSINESS INFORMATION

A. Proposed Named Insured: _____

B. DBA: _____ Federal Tax ID: _____

C. Is Applicant a management company? ☐ Yes ☐ No

D. Mailing Address of Named Insured: _____ (Street) _____ (City, State) _____ (ZIP)

E. Telephone #: _____

F. Website: (if applicable) _____

G. Proposed Policy Effective Date: _____ Proposed Policy Expiration Date: _____

II. GENERAL EXPOSURE INFORMATION

A. Total Number of facilities or locations proposed for coverage? _____

(i) Is the proposed coverage intended to satisfy, either for any facility or for any additional insured, the coverage required by any state Patient Compensation Fund? ☐ Yes ☐ No

(ii) If only one (1) facility is proposed for coverage, what is the Named Insured's ownership percentage in such facility? If more than one (1) facility is proposed for coverage, what is the *smallest* percentage ownership interest in any such facility? _____ %

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

C. Are any facilities proposed for coverage contained within, operated by, affiliated with or owned by a licensed hospital or mental health facility? ☐ Yes ☐ No

D. In the last three years, have any facilities been designated a special focus facility? ☐ Yes ☐ No

E. In the last five (5) years, has any 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

(v) Had any billing sanctions or suspensions? ☐ Yes ☐ No

If the answer is "Yes" to above, please attach details separately.

F. Total Gross Revenue (Prior 12 months): $_____

G. APPLICANT IS (Check all that applies):

Organizational Structure:	Accreditation / Memberships:	All facilities are:
☐ Limited Liability Company	☐ Accredited by JCAHO	☐ For-profit
☐ Partnership	☐ Accredited by CCAC	☐ Not-for-profit
☐ Joint Venture	☐ Member of association: _____	☐ Mixed / Both
☐ Other: _____	☐ None	

H. COVERAGE(S) REQUESTED:

Professional Liability (select one): ☐ Claims Made

General Liability (select one): ☐ Claims Made ☐ Occurrence Based

- Bodily Injury and Property Damage
- Personal and Advertising Injury
- Products Completed Operations Hazard
- Fire Damage

Employee Benefit Liability (select one): ☐ Claims Made ☐ No Coverage

Sexual Misconduct Liability (select one): ☐ Claims Made ☐ No Coverage

I. PRIOR CLAIMS HISTORY OR PRIOR KNOWN INCIDENTS:

A. Has any claim, suit or regulatory proceeding been made against the Applicant, or any Insured or facility proposed for coverage, at any time during the past five (5) years? ☐ Yes ☐ No
(If the answer to above is Yes, please provide details in a separate attachment.)

B. Is the Applicant or any Insured proposed for coverage 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 that would be subject to the coverage requested? ☐ Yes ☐ No
(If the answer to above is Yes, please provide details in a separate attachment.)

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.

III. EXPIRING INSURANCE INFORMATION

A. Has Applicant ever had an insurance company cancel, refuse to renew or restrict coverage through endorsements to the policy? ☐ Yes ☐ No

If the answer above is "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: _____

IV. REQUESTED COVERAGE INFORMATION

A. Are all facilities proposed for coverage requesting the same limits and deductibles? ☐ Yes ☐ No
(Note: If "No", please provide details of the different limits and deductibles on the COVERED FACILITIES SUPPLEMENTAL APPLICATION)

B. REQUESTED PROFESSIONAL LIABILITY PRIMARY LIMITS:

- ☐ $500,000 Per Claim / $1,500,000 Aggregate
- ☐ $1,000,000 Per Claim / $3,000,000 Aggregate
- ☐ $2,000,000 Per Claim / $4,000,000 Aggregate
- ☐ Other: _____

C. REQUESTED PROFESSIONAL LIABILITY EACH CLAIM DEDUCTIBLE:

☐ $1,000 ☐ $10,000 ☐ $25,000 ☐ $100,000 ☐ Other: _____
☐ $5,000 ☐ $15,000 ☐ $50,000 ☐ $250,000

D. REQUESTED GENERAL LIABILITY PRIMARY LIMITS:

- ☐ $1,000,000 Per Claim / $1,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $3,000,000 Aggregate
- ☐ $2,000,000 Per Claim / $4,000,000 Aggregate
- ☐ Other: _____

E. REQUESTED GENERAL LIABILITY EACH CLAIM DEDUCTIBLE:

☐ $1,000 ☐ $10,000 ☐ $25,000 ☐ $100,000 ☐ Other: _____
☐ $5,000 ☐ $15,000 ☐ $50,000 ☐ $250,000

F. REQUESTED EMPLOYEE BENEFITS LIABILITY PRIMARY LIMITS:

☐ $1,000,000 Per Claim / $1,000,000 Aggregate ☐ Other: _____
☐ $1,000,000 Per Claim / $3,000,000 Aggregate

G. REQUESTED EMPLOYEE BENEFITS LIABILITY EACH CLAIM DEDUCTIBLE:

☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: _____

H. REQUESTED SEXUAL MISCONDUCT LIABILITY PRIMARY LIMITS:

☐ $250,000 Per Claim / $500,000 Aggregate ☐ $1,000,000 Per Claim / $1,000,000 Aggregate
☐ $500,000 Per Claim / $1,000,000 Aggregate

I. REQUESTED SEXUAL MISCONDUCT EACH CLAIM DEDUCTIBLE:

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other: _____

J. REQUESTED DEFENSE EXPENSE TREATMENT:

☐ Defense Expenses Erode Limit (for all Coverage Parts)

☐ Defense Expenses in addition to Limit (for all Coverage Parts other than Sexual Misconduct)

V. IMPORTANT NOTICES AND FRAUD WARNINGS

IMPORTANT NOTICES TO APPLICANT

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

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.

INSURANCE FRAUD WARNINGS

NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, DISTIRCT OF COLUMBIA AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR

KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMING WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONEFINEMENT IN PRISON.

NOTICE TO MAINE, MISSOURI, TENNESSEE, VIRGINIA, AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

NOTICE TO NEW YORK APPLICANTS: 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.

VI. CONTACT INFORMATION

Key Contact of the Proposed Named Insured for Insurance Matters:

_____

Position of Key Contact is: ☐ **Risk Manager** ☐ **CFO** ☐ **CEO** ☐ **Other: _____**

Telephone Number: **_____**

Email Address: **_____**

VII. ATTESTATION AND SIGNATURE

THE UNDERSIGNED REPRESENTATIVE HEREBY ACKNOWEDGES THAT HE OR SHE IS AUTHORIZED TO MAKE THE REPRESENTATIONS IN THIS APPLICATION ON BEHALF OF THE PROPOSED NAMED INSURED AND ALL ENTITIES OR PERSONS PROPOSED FOR COVERAGE UNDER THE POLICY, AND THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Signature of Authorized Representative:

(Must be signed by the CEO, CFO, Administrator, Director of Nursing or Risk Manager of the proposed Named Insured)

Printed Name:

Title:

Date: