Print Form

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

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 APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

- **Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If additional space is required for any response, please provide in a separate attachment, labeled with the 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.
If more than one facility is proposed for coverage, please complete a separate Covered Facility Supplemental Application for each facility.

Please include the following information or documents with this Supplemental Application, as it will be required by the Insurer in order to provide a quotation:

- **If licensed as an assisted living facility or skilled 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;**
- **The facility's current licenses;**
- **A diagram of the facility (if available);**
- **Samples of all types of resident service contracts;**
- **Any marketing brochures;**
- **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.**

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: _____

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	***Licensed as assisted living facility but where resident has lower acuity, routinely receiving assistance with more than***	#_____	#_____

(Level II)	***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. Additional Services Rendered:

	Number of Visits Performed in Prior 12 Months:	**Gross Revenue Prior 12 Months:**	**Percentage of Service Rendered by Independent Contractors:**
Home Health Care:	#_____	**$** _____	_____**%**
Respite Care:	#_____	**$** _____	_____**%**
Hospice Care:	#_____	**$** _____	_____**%**
	Number of Residents / Participants Prior 12 Months:	**Gross Revenue Prior 12 Months:**	**Percentage of Service Rendered by Independent Contractors:**
Adult Day Care (Social Model): *	#_____	**$** _____	_____**%**
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.***

C. Will the facility admit (or allow continued residency) any resident who is assessed to be a threat to self or others?	☐ **Yes**	☐ **No**
D. Does the facility have any resident that is receiving ventilator care, or where the resident cannot reposition themself in a bed or wheelchair, who is not in a licensed skilled bed?	☐ **Yes**	☐ **No**

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

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

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

Bi-polar Disorder	**Schizophrenia**	**Significant Dementia**	**Alzheimer's**
#_____	#_____	#_____	#_____

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)	**Continence care:**	#_____
(f)	**Decubitus care:**	#_____
(g)	**Oxygen / IPPB:**	#_____
(h)	**Anticoagulation monitoring:**	#_____
(i)	**Dialysis care:**	#_____
(j)	**Ventilator patient care:**	#_____
(k)	**2-person transfers:**	#_____
(l)	**IV Therapy, Parenteral Nutrition, or Blood:**	#_____
(m)	**Bedfast all or most of the time:**	#_____
(n)	**Physically Restrained:**	#_____
(o)	**Dementia: Multi-Infract, Senile, Alzheimer's or Other**	#_____
(p)	**Other: _____**	#_____

(ii) Please indicate the number of current residents who receive the following types of *Activities of Daily Living (ADL- ONLY) 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 *Nursing Services* described in Section G.(i) above are provided by independent contractors?** _____%	**(ii) What Percentage of the *ADL Services* described inSection G. (ii) above are provided by independent contractors?** _____%

I.	**Resident Care:**		
	Assessment		
	(i) Has the facility had any state reportable events within the last 90 days?	☐ **Yes**	☐ **No**
	(ii) Are resident pre-admission assessments for the facility done in person?	☐ **Yes**	☐ **No**
	(iii) Are the procedures for admission, discharge and transfer of residents in writing and in compliance with all state and federal requirements?	☐ **Yes**	☐ **No**
	(iv) Who completes admission assessments at the facility?	☐ **RN** ☐ **LPN** ☐ **Other: _____**	
	(v) In the past 12 months, has the admission of any potential resident been denied on the basis of acuity?	☐ **Yes**	☐ **No**
	(vi) How often are residents reassessed?	☐ **Monthly** ☐ **Quarterly** ☐ **Other:_____**	
	Falls		
	(i) Does the facility have a fall management program?	☐ **Yes**	☐ **No**
	(ii) Has any resident in this facility fallen within the last year and suffered a fracture or been hospitalized as a result of the fall?		
	Elopement		
	(i) Does the facility have a elopement prevention program in place?	☐ **Yes**	☐ **No**
	(ii) Does the facility perform regular elopement drills?	☐ **Yes**	☐ **No**
	(iii) 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)? *(If the answer is "Yes" to above, how many incidents of elopement have happened, whether or not a claim was made?):* _____	☐ **Yes**	☐ **No**
	(iv) 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**
	(v) Does the facility have an electronic wandering system such as Wander Guard in place?	☐ **Yes**	☐ **No**
	Resident Abuse/Neglect		
	(vi) Does the facility have a written procedure for reporting resident abuse?	☐ **Yes**	☐ **No**
	Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse?	☐ **Yes**	☐ **No**
	Skin/Wound		
	(i) Is there a program in place for all wounds?	☐ **Yes**	☐ **No**
	(ii) Does the facility have a dedicated wound nurse?	☐ **Yes**	☐ **No**
	(iii) Is there dietician involvement in the program?	☐ **Yes**	☐ **No**
	(iv) Are risk assessments performed at admission/quarterly/change of condition?	☐ **Yes**	☐ **No**
	(v) How often are skins checks performed?_____		

Medication Management			
(i)	**Who is responsible for administering medications?** _____	☐ **Licensed Staff**	☐ **Medication Aides**
(ii)	**Are policies and procedures in place for IV/tube feedings?**	☐ **Yes**	☐ **No**
(iii)	**How often does pharmacy review the medical record?** _____		
Restraints			
(i)	**Are policies and procedures in place for use of both physical and chemical restraints?**	☐ **Yes**	☐ **No**
(ii)	**What is the number of restrained residents?**	**#:** _____	
(iii)	**What types of restraints are utilized?** _____		

J.. 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**

K. 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:	#_____	#_____	#_____	_____%
Volunteers	#_____	#_____	#_____	_____%

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

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

_____

(ii) What is the minimum required number of nursing staff hours per resident per day in your state of operation? _____

(iii) What is your facility's number of nursing staff hours per resident per day? _____

(iv) 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

(v) 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

(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?)

_____

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

M. Facility Building and Equipment Features:

(i) Year building was built: _____

(ii) What is the number of stories in this facility? _____

(iii) Type of building construction:

☐ **Frame** ☐ **Joined Masonry** ☐ **Fire resistive** ☐ **Masonry non-combustible**

(iv) 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**

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 any bed-bound assisted living residents above the second floor of the building? ☐ **Yes** ☐ **No**

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

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

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

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

(xiv) 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**

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

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

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

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

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

☐ **Restaurant or dining room** ☐ **Health club or gym** ☐ **Swimming pool/Other body of water**

☐ **Other:**_____ _____ ☐ **None of these**

N. Transportation

(i) 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:***_____

(ii) 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?) #_____

(iii) 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?)
#_____

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?)
(mm/dd/yyyy): _____

IV. COVERED FACILITY CLAIMS HISTORY

A.	**Has any claim, suit or regulatory proceeding been made against the facility or any proposed Insured at the facility during the past five (5) years?** *(If the answer to above is Yes, please provide details in a separate attachment.)*	☐ **Yes**	☐ **No**
B.	**Is 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 reasonably likely to result in a claim under the coverage requested?** *(If the answer to above is Yes, please provide details in a separate attachment.)*	☐ **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.

V. IMPORTANT NOTICES AND FRAUD WARNINGS

THE IMPORTANT NOTICES AND FRAUD WARNINGS SET FORTH IN SECTION V. OF THE MAIN APPLICATION SHALL ALSO APPLY TO EACH AND EVERY SUPPLEMENTAL APPLICATION SUBMITTED BY THE APPLICANT.

VI. 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: _____