Long-Term Care Facility
Professional Liability Application

PART I - PRODUCER INFORMATION

Agency Name		Address	Telephone
Agency License No.	State	Federal Tax ID	Email Address

PART II - APPLICANT INFORMATION

Name of Applicant (include a list of all subsidiaries)	Most Recent Carrier
Business Address	Mailing Address
Billing Address, if different	Email Address

Contact Person	Telephone	Fax Number

Date of Incorporation	Date Operations Began	State of Incorporation

State(s) Operating In (attach copies of each state license)	Federal Identification Number

Profit Status:

❑ For Profit ❑ Not for Profit ❑ Other (explain): ____________________

The Applicant is *(check all appropriate boxes)* :

❑ Individual ❑ Corporation ❑ Partnership ❑ Governmental
❑ Charitable ❑ Accredited by JCAHO ❑ Conditional Accreditation by JCAHO
❑ Medicaid Certified* ❑ Medicare Certified

*If not, please explain ____________________

Facility Construction: (coverage type)

❑ Multi-level Frame ❑ Single-level Frame ❑ Brick Veneer ❑ Masonry ❑ Fire-Resistive

(If more than one facility, enter # of facilities with construction in the box.)

PART III - COVERAGE AND LIMITS

Professional Liability: (coverage type)

❑ Occurrence
❑ Claims Made *For claims made, enter retroactive date desired* ______________

Limits of Liability: $ ______________ each claim $ ______________ annual aggregate

Coverage Effective Date

From: ____________

To: ______________

Commercial General Liability

Do you wish to purchase Commercial General Liability coverage? ❑ Yes ❑ No

If yes, please complete and submit **APP 007, Commercial General Liability** application.

PART IV - SERVICES PROVIDED

Facility Type and Bed Count

I. Skilled Care Services: Professional nursing care - 24 hours per day by licensed nurses. A registered nurse provides care during the day shift. LPN coverage required during other shifts. Skilled care services include some of the following:

a. Medical Administration
b. Tube feedings
c. Other procedures ordered by physician
d. Injections
e. Catheterization

Total Number of Beds: ______________ Average Occupancy: ______________

PART IV - SERVICES PROVIDED (continued)

Facility Type and Bed Count

II. Intermediate Care Services: Nursing care during the day shift, 7 days per week, by either RNs or LPNs. No complex nursing care (IVs, tube feedings, etc.) Assistance with activities of daily living (i.e., walking, bathing, eating). Some assistance with administering medications.

Total Number of Beds: __________ Average Occupancy: __________

III. Residential Care Services/Assisted Living: Residents are ambulatory with possible minor medical disorders, provided protective environments (meals, planned programs for social and/or spiritual needs) and/or personalized support services including assistance with activities of daily living (walking, bathing, dressing, eating). Residents are eligible for incidental healthcare services, including assistance with medications.

Total Number of Beds: __________ Average Occupancy: __________

IV. Independent Living: Residents are retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any healthcare services or assistance with medication, but do have access to skilled, intermediate or residential nursing care within the same facility complex.

Total Number of Beds: __________ Average Occupancy: __________

Total Number of Residents: ____________

V. Subacute Care Services: A comprehensive inpatient program for patients who have experienced a serious illness, injury or disease, but who will not require intensive hospital services. The range of services include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, postoperative recovery programs for knee and hip replacements and cancer, stroke and AIDS care.

Total Number of Beds: __________ Average Occupancy: __________

VI. Indicate type and number of outpatient services:

____

____

____

PART V - ADMINISTRATION & PERSONNEL

Indicate the Administrator's name and give a brief summary of administrative experience:

____

____

____

Do you employ or contract the medical director? ❑ Employ ❑ Contract

Briefly describe the director's medical qualifications:______________________________________

____

If there is not a medical director, who is responsible for overseeing the professional services and care provided? ___________________

____

Does the medical director also act as the attending physician for any residents? ❑ Yes ❑ No

If yes, indicate the medical professional liability limits required: $ _______________each claim $ ___________annual aggregate

Do you check hospital privileges for physicians, oral surgeons and dentists? ❑ Yes ❑ No

How often do you update your list of specific privileges? ____

Indicate total number of professional employees:

Physicians _____ Registered Nurses _____ Nurse Practitioners _____ Nurse Anesthetists_____

Licensed Practical Nurses ______ Nurse's Aids _____ Other Medical Personnel _____ Non-medical Personnel _____

Are employee's/contractor's references contacted before hiring/placement? ❑ Yes ❑ No

How are references checked?____

Do you question prospective employees as to any criminal record? ❑ Yes ❑ No

Do you question prospective employees on any prior professional malpractice claims? ❑ Yes ❑ No

Do you have continuing education for staff? ❑ Yes ❑ No

Are job descriptions provided for all professional and non-professional staff members? ❑ Yes ❑ No

Does the applicant utilize a formal written Quality Assurance and Risk Management Program? ❑ Yes ❑ No

---

Do patients have their own attending physician? ❑ Yes ❑ No

If no, who performs the role of attending physician? ________________________________

Do you require written orders from an attending physician for the following: ❑ Yes ❑ No

All drugs or medicines? ❑ Yes ❑ No

Special dietary requirements? ❑ Yes ❑ No

Any other specific therapy/treatment? ❑ Yes ❑ No

If yes, describe: ____

How often are attending physicians required to update their patients' charts? ______________________

Is a physician accessible, on-site or on-call on a 24-hour basis? ❑ Yes ❑ No

Is a nursing assessment conducted for new patients? ❑ Yes ❑ No

Who decides if the patient must be transferred to another facility for further medical diagnosis or treatment? __________________

____

Do you contract for medical professional services? ❑ Yes ❑ No

If yes, check all appropriate boxes:

❑ Physical Therapy ❑ Nursing Services ❑ Pharmacy ❑ Respiratory Therapy

❑ Speech Therapy ❑ Nutrition ❑ Skilled Therapy

❑ Others __________ __________ __________ __________

PART VI - PREVIOUS CARRIER INFORMATION

Please list all previous Insurers, starting with the most recent.

Company	Limits of Liability	Claims Made or Occurrence	Policy Period	Any Claims? Y/N	Premium

Is applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical record(s)?

If yes, please provide details on a separate sheet. ❑ Yes ❑ No

Has any insurance ever been declined, non-renewed, or cancelled? ❑ Yes ❑ No

If yes, please explain: ____

____

Read Carefully Before Signing

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATION IN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.*

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.*

No obligation to issue or purchase insurance

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

Authorization to obtain information

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

CALIFORNIA APPLICANTS: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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 POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATED AGENCIES.

DISTRICT OF COLUMBIA 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.

MAINE APPLICANTS: THE COMPANY WILL NOT RESCIND OR VOID ANY POLICY ISSUED IN MAINE DUE TO FRAUD OR A MISREPRESENTATION WITHOUT FIRST OBTAINING A COURT RULING THAT VOIDANCE OR RESCISSION OF THE POLICY IS PERMITTED. HOWEVER, IN THE EVENT OF A MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT IN THIS APPLICATION OR INFORMATION PROVIDED TO US TO OBTAIN INSURANCE, THE COMPANY MAY CANCEL THE POLICY AND/OR DENY COVERAGE FOR ANY CLAIM IF SUCH MISREPRESENTATION, OMISSION, CONCEALMENT OF FACT OR INCORRECT STATEMENT WAS FRAUDULENT OR MATERIAL.IN ACCORDANCE WITH 24-A M.R.S.A. 2186(3), IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

MARYLAND APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN MARYLAND. HOWEVER, COVERAGE WILL NOT BE PROVIDED IF WE DISCOVER CONCEALMENT, MISREPRESENTATION, OR FRAUD. ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NEW HAMPSHIRE APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY OR DENY COVERAGE TO ANY INSURED(S) IN NEW HAMPSHIRE IF THE INSURED(S) HAD NO KNOWLEDGE OF CONCEALMENT, MISREPRESENTATION OR FRAUD. HOWEVER, THE COMPANY WILL NOT COVER ANY CLAIMS AGAINST ONE OR MORE INSUREDS WHO HAS INTENTIONALLY CONCEALED OR MISREPRESENTED A MATERIAL FACT, ENGAGED IN FRAUDULENT CONDUCT, OR MADE A FALSE STATEMENT RELATING TO THIS INSURANCE.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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.

OREGON 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 MAY HAVE COMMITED A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.

VIRGINIA APPLICANTS: IN ACCORDANCE WITH VIRGINIA CODE 52-40, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

WASHINGTON APPLICANTS: THE COMPANY WILL NOT VOID ANY POLICY ISSUED IN WASHINGTON UNLESS THE INSURED(S) OR SOMEONE ACTING ON BEHALF OF THE INSURED(S) INTENTIONALLY CONCEALS OR MISREPRESENTS A MATERIAL FACT OR CIRCUMSTANCE RELATING TO THIS INSURANCE. 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.

ALABAMA, ALASKA, ARIZONA, ARKANSAS, DELAWARE, FLORIDA, IDAHO, INDIANA, KENTUCKY, LOUISIANA, MINNESOTA, NEW MEXICO, NEW YORK, OHIO, RHODE ISLAND, TENNESSEE, TEXAS, WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS MATERIALLY FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

______________________________ ______________________________

Applicant *(print name of entity)* Title

______________________________ ______________________________

By *(signature of duly authorized officer or employee)* Date

____

Printed Name of Applicant

______________________________ ______________________________

Signature of Producer *(signature is required for N.H. producers only)* Date

____

Printed Name of Producer