UNION GENERAL
Insurance Services, Inc.
We are the Market™ *Personal & Commercial Lines* AAMGA ciwa

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License Number: 0595325

CFC Underwriting

CareSurance™ Application Form

THE INSURANCE WE PROVIDE

We, at CFC, have tailored this CareSurance™ insurance policy for the specific needs of Nursing Homes.

We fully appreciate the value of your time and thank you for providing the important information which will allow us to accurately assess the risks which you face.

The purpose of our insurance is to indemnify you against your liability which arises from your breach of duty.

You must refer to our insurance policy which fully explains the rules governing the way we provide the cover, those things which are not covered and your obligations to us.

THIS PROPOSAL FORM

The purpose of this proposal form is for us to find out who you are and to obtain information relevant to the cover provided by the CareSurance™ policy. Completion of this proposal form does not oblige either party to enter into a contract of insurance.

Insurance is a contract of utmost good faith. This means that the information you provide in this proposal form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your proposal for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed.

If a contract of insurance is agreed between you and us this proposal form will form the basis of the contract.

Whoever fills out the form must be a principal, partner or director of the proposer and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered.

CareSurance™
Long Term Solutions For Long Term Care

APPLICATION FOR PROFESSIONAL AND COMMERCIAL GENERAL LIABILITY INSURANCE

I. **GENERAL INFORMATION (CORPORATE)**

A. Name: _____

Address: _____

_____

Telephone: _____ Facsimile: _____

E-Mail: _____ Web Address: _____

B. List all subsidiaries for which coverage is required, date acquired, description of operations and percentage of ownership. (Attach separate page if necessary)

Name	Percentage of Ownership	Date Acquired	Operations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Applicant is (check all that apply):

_____ Individual _____ For-Profit _____ Charitable

_____ Partnership _____ Not For Profit _____ Other (Describe:)

_____ Corporation _____ Government _____

D. Are all facilities:

Medicare Certified: ☐ Yes ☐ No

Accredited by JCAHO: ☐ Yes ☐ No

Licensed/Approved State Board of Health: ☐ Yes ☐ No

If "no" please explain: _____

_____

_____

SECTION II THROUGH AND INCLUDING SECTION VIII MUST BE COMPLETED FOR EACH FACILITY.

II. FACILITY INFORMATION

Name: _____

Address: _____

_____

County: _____

A. Number of Years:

- In operation: _____

- Owned by present owner: _____

- Managed by present management: _____

B. List all association memberships held:

_____

_____

_____

_____

C. **Attach copies of all licenses held.**

D. Provide facility classifications and bed census:

Skilled Care Services
Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following:

- Medical Administration
- Other procedures ordered by physician
- Injections
- Tube feeding
- Catheterizations

Intermediate Care Services
Nursing care during the day shift, 7 days, per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc). Assistance with activities of daily living (e.g., walking, bathing, dressing, eating). Some assistance with administering medications.

Residential Care Services / Assisted Living / Personal Care
Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs). Residents are eligible for incidental health care services, including assistance with medications.

Independent Living
Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.

	Total # Licensed Beds	Average # Occupied	
1)	_____	_____	Skilled Care Services
2)	_____	_____	Intermediate Care Services
3)	_____	_____	Residential Care Services
4)	Number of Residents: _____		Independent Living
5)	_____		Other – Define

E. Number of visits per year for all outpatient services provided or state "None". _____

Services	Visits
Adult Day Care	_____
Home Health Care, Personal Care, Chore or Companion Services	_____
Infusion Therapy	_____
Occupational Rehabilitation	_____
Physical Therapy	_____
Rehabilitation Therapy	_____
Respiratory Therapy	_____
Other _____	_____

F. Resident/Patient Profiles:

Age Group	Number	% Non Ambulatory
Under 50:	_____	_____
50 – 65:	_____	_____
Over 65	_____	_____

G. State number of employees in each classification. If none, state "None". Show number of employees in full time equivalents (FTE's) based on 40 hrs. per week. For example, 4 RN's each working 10 hrs. per week equals 1 FTE.

	1ST SHIFT	2ND SHIFT	3RD SHIFT
Administrative Personnel			
Beauticians/Barbers			
Dieticians			
Licensed Practical Nurses			
Maintenance/Security Personnel			
Nurse's Aides			
Physical Therapists			
Physicians			
Recreation Therapists			
Registered Nurses			
Social Workers			
Speech Pathologists			
Others – Describe:			

H. Administrator's name and summary of experience.

_____

_____

_____

I. Is there a full time employed medical director? ☐ Yes ☐ No

_____

_____

_____

_____

III. HIRING/STAFFING PROCEDURES

A. Check all procedures you use when hiring professional and para-professional staff:

[ ] Check of educational background or residency program, when applicable
[ ] Check of previous employers: [ ] in writing [ ] by telephone
[ ] Check on hospital privileges for physicians, oral surgeons and dentists.
How often do you update your list of specific privileges? _____
[ ] Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
[ ] Require information on any professional liability or work-related claim that has previously been made against the individual.

B. Do you have written job descriptions? ☐ Yes ☐ No

C. Are all employees required to attend an orientation program prior to beginning their employment? ☐ Yes ☐ No
Describe or attach the agenda for your orientation program.

_____

_____

D. Do you have a new employee preceptor, mentor or "buddy" program? ☐ Yes ☐ No
For which classes of Employees? How does it work? How long do you monitor new caregivers?

_____

_____

E. Provide full details of methods used to ensure you are fully and properly staffed at all times.

_____

_____

F. Do you have regularly scheduled inservices? ☐ Yes ☐ No
Describe and attach the type of inservices that have been conducted in the past six months.
By whom have they been conducted?

_____

_____

G. How do you ensure attendance at your inservices? Are they mandatory?

_____

_____

H. Do you perform criminal background investigations on all potential employees? ☐ Yes ☐ No

I. Annual staff turnover ratio for:

RN's ____% LPN's ____% CNA's ____%

J. Please provide ratios of staff to residents for RN's, LPN's and CNA's

_____

_____

IV. RISK MANAGEMENT

A. Are all new residents required to have evidence of acceptable health (physical examination)?
How is this assured?

_____

_____

B. Describe security measures to control unauthorized entrance: _____

_____

_____

C. Evacuation Procedures:

- Is there a written emergency evacuation plan? ☐ Yes ☐ No

- Does it include advance arrangements for transport and temporary shelter? ☐ Yes ☐ No

- Are evacuation directions posted in all areas? ☐ Yes ☐ No

- Is a review and "walk through" of disaster plans a part of staff orientation? ☐ Yes ☐ No

- How often are fire/evacuation drills conducted each year? _____

D. As respects skilled and intermediate care:

Do all residents have their own attending physician? ☐ Yes ☐ No
If "no", who performs that role? _____

_____

- Are written orders required from attending physician for:

  - All Drugs/Medicines ☐ Yes ☐ No
  - Dietary Special Requirements ☐ Yes ☐ No
  - Specific Therapy/Treatment ☐ Yes ☐ No

E. How often are resident's charts updated by the attending physician? _____ # of days

F. Do you conduct a nursing assessment for new residents? ☐ Yes ☐ No

Does it include:

- History of prior injury? ☐ Yes ☐ No
- Disorientation? ☐ Yes ☐ No
- Mobility limitations? ☐ Yes ☐ No
- Required assistance? ☐ Yes ☐ No

G. Is advance written consent obtained from resident or guardian allowing you to provide non-emergency medical care? ☐ Yes ☐ No

H. Is smoking permitted in resident rooms? ☐ Yes ☐ No

Describe other rules applying to smoking: _____

_____

_____

I. Is there a physician on site or on call on a 24 hour basis? ☐ Yes ☐ No

J. Who determines if a patient must be transferred elsewhere for medical diagnosis or treatment?

_____

_____

K. Medication Error Control

1) Do you employ _____ or contract _____ with a registered pharmacist to supervise pharmacy services?

2) How often does the pharmacist review every resident record?

_____

3) Describe the method used to prevent medication errors.

_____

_____

4) Does your consultant Pharmacist review your incident log? ☐ Yes ☐ No

5) Are any of your residents receiving 9 or more medications ☐ Yes ☐ No

If yes, how many: _____

L. Fall Prevention

1) How often and when are residents assessed for their risk of falls?

_____

_____

2) How are patients identified as “at risk” for falls?

_____

_____

3) Describe your fall prevention program. Attach a copy of your policy and procedures.

_____

_____

4) Describe other methods you have to prevent falls.

_____

_____

5) What percentage of your residents are physically restrained?

_____

_____

6) What techniques are utilized to reduce the use of restraints?

_____

_____

7) How many residents in the past year have had falls from bed or while ambulating, which required transport of the resident to a hospital or other facility for treatment or evaluation? What percentage of residents over a 12-month census does this represent? _____%

_____

_____

8) What other fall prevention strategies have you adopted?

_____

_____

M. Elopement/Wandering Prevention

1) How and when is your Elopement Prevention program implemented?

_____

_____

2) How are your entrances/exits secured?

_____

3) Is there a system in each facility to identify residents "at risk" for wandering?

☐ Yes ☐ No

4) Describe other methods you have to prevent patient elopements.

_____

_____

5) How many elopements occurred in your facilities <u>in the past 12 months</u> that required implementation of your elopement procedures?

_____

_____

N. Pressure Ulcer and Skin Care

1) Describe your program to prevent pressure ulcers. Attach a copy of your policy and procedures pertaining to this.

_____

_____

2) How often are resident skin assessments made? Provide the tool used to assess and document residents' skin condition.

_____

_____

3) How many residents in the past year developed pressure sores after admission? What percentage of residents over a 12-month census does this represent? _____%

_____

_____

4) Do you have a wound care team or designated individual responsible for this program?

☐ Yes ☐ No

If yes, describe the additional training or credentials of the team/individual.

_____

_____

5) Describe the staging system that you use when assessing a wound.

_____

6) On average, how many residents are receiving weekly special skin care?

_____

_____

7) Describe additional quality improvement efforts to reduce pressure ulcers.

_____

_____

O. Safety Committee Risk Management and Incident Reports

1) What criteria do you use for reporting incidents or occurrences?

_____

_____

2) Explain how you track and trend incident information.

_____

_____

3) How are substantial complaints addressed?

_____

_____

4) Describe the components of your Safety/Risk Management program as it pertains to professional liability issues. Attach a copy of your policy and procedures.

_____

_____

P. Physical/Sexual Abuse

1) Attach a copy of your policy and procedures related to physical and sexual abuse.

2) How many <u>reported</u> physical abuse incidents (upon residents) occurred in your facility in the past 12 months? _____

   a. How many involved allegations of resident-to-resident physical abuse? _____

b. How many involved allegations of employee-to-resident physical abuse? _____

c. How many of the reported physical abuse allegations were substantiated? _____

Provide complete details of substantiated physical abuse allegations.

_____

_____

3) How many reported sexual abuse incidents (upon residents) occurred in your facility in the past 12 months? _____

a. How many involved allegations of resident-to-resident sexual abuse? _____

b. How many involved allegations of employee-to-resident sexual abuse? _____

c. How many of the reported sexual abuse allegations were substantiated? _____

Provide complete details of substantiated sexual abuse allegations.

_____

_____

Q. Weight Loss Monitoring and Prevention Program

1) How often are your residents monitored for weight loss? Please attach a copy of your policy and procedures pertaining to this. _____

2) Does your facility employ a Registered Dietician to evaluate each resident's needs?

☐ Yes ☐ No

3) How many residents in the past year experienced a significant weight loss? (5% or > in the past 30 days; or 10% or > in the past 180 days.)

_____

_____

R. Additional Information

1) What is your facility's quality improvement team doing to improve quality (i.e.: pressure ulcers, fall prevention, B&B retraining, sentinel events [fecal impaction, dehydration, and pressure ulcers in low risk residents])?

_____

_____

2) How many complaints were investigated by the State in the past year? _____

a. How many were substantiated? _____

Provide complete details of substantiated complaints investigated by the State.

_____

_____

b. Has your facility ever had an immediate jeopardy determination? ☐ Yes ☐ No
If yes, please provide complete details.

_____

_____

3) Have you ever been de-licensed, de-certified, issued a restricted license, had reimbursement denied, or had new admissions restricted or denied? ☐ Yes ☐ No

If yes, provide full details and documentation.

V. CONTRACTUAL AGREEMENTS

A. Please list all contracted professional services provided for you and the minimum professional liability insurance limits you require of each provider: (Attach additional pages if necessary)

Services Contracted	Limits Required
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

B. Are there other service contracts in effect? ☐ Yes ☐ No
Please describe: _____

_____

VI. LOSS INFORMATION

A. Describe in detail each professional liability and general liability claim or suit made against you in the past 5 years. (Identify location if you have more than one facility).

1. Attach a currently dated loss summary from current and prior insurers (past 5 years).

2. If you do not have a loss summary, attach a separate sheet for each claim showing:
   - Date of event and date reported to you / to insurance carrier
   - Description of Cause of event
   - Current Status (Open or Closed matter)
   - Amounts Paid and/or Current Reserves. Specify indemnity payments and expenses.

VII. CURRENT INSURANCE INFORMATION

Current Professional Liability Insurer: _____

Policy Period: _____

Limits: $_____

Deductible or Self Insured Retention: $_____

Claims Made Form? _____ Occurrence Form?_____

If Claims Made, Retroactive Date: _____ Premium: $_____

Employee Benefits Liability Retroactive Date: _____

VIII. GENERAL LIABILITY/BUILDING INFORMATION (Complete for Each Facility.)

A. Construction/Protection

1. Name of facility _____

2. Address of facility _____

   _____

3. Year built _____

4. Construction type _____

5. Number of stories _____

6. Originally designed as long term care facility? ☐ Yes ☐ No

   If no, what was original purpose? _____

   _____

7. Sprinkler System

   - Is building completely sprinklered? ☐ Yes ☐ No

- If partially sprinklered, what areas are sprinklered? _____

_____

8. Smoke Detectors – Locations (check all that apply)

_____ None _____ Soiled Linen Chutes/Rooms

_____ Hallways _____ Trash Collection Areas

_____ Resident Rooms _____ Other _____

_____ Common Areas _____ Other _____

9. Electric/Plumbing/Heating System Inspections/Updating

	Electric	Plumbing	Heating
Qualified Inspection	_____	_____	_____
Replaced/Updated	_____	_____	_____

10. Does this location meet applicable 1994 NFPA Life Safety Codes? ☐ Yes ☐ No

If no, please explain _____

_____

_____

11. Are there at least two exits, located remotely from each other, on each floor and fire section? ☐ Yes ☐ No

12. When was this building last inspected by the:

Local fire authorities: _____ State Department of Health: _____
Month/Year Month/Year

13. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

14. Are bathtubs/showers equipped with nonslip surfaces? ☐ Yes ☐ No

15. Do you have any auxiliary electrical supply system? ☐ Yes ☐ No

16. Are all skilled or intermediate care patient beds equipped with side rails? ☐ Yes ☐ No

17. Are you planning any new construction for the next twelve months? ☐ Yes ☐ No

    If yes, use the comment section to describe the purpose, estimated costs and estimated completion date for such construction.

18. Recreation Facilities: Please check here if "None": ☐ or,

    Please indicate number corresponding to item below.

Swimming Pool _____ Exercise/Weight Room _____

Sauna/Hot Tub _____ Other: _____

Tennis or Racquetball Court _____ Other: _____

B. Please provide details of all General Liability claims or suits against you for the past 5 years which were not listed in Section VI as follows:

Policy Year	Date of Loss	Cause of Loss	Status: Open / Closed	Reserves	Amounts Paid
to					
to					
to					
to					
to					
to					
to					
to					
to					

IX. ATTACHMENTS

Attach the following:

1. Most recent audited financial statement
2. Most recent State Surveys including re-visits and compliance letters
3. Loss Runs for the last five years with a Loss Summary Sheet outlining the claims
4. Narrative by the Insured of all open claims and all claims closed over $25,000 in the last five years.
5. Fall Prevention Policy
6. Elopement/Wandering Policy
7. Pressure Ulcer/Skin Care Policy
8. Abuse (Physical/Sexual) Policy
9. Safety/Risk Management Policy
10. Orientation Program

11. Inservice Program
12. Admission Material and Agreements
13. Copy of all Licenses

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART THEREOF.

COMMENT SECTION

_____

_____

_____

_____

_____

Applicant Name: _____

_____ _____ _____
Applicant Signature Printed Name and Title Date

_____ _____ _____
Agent Signature Agent Printed Name Date

Agency: _____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP CODE

_____ _____ _____
TELEPHONE FAX EMAIL