UNDERWRITERS DIRECT ACCESS

Salt Lake City Area Office
8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
800-257-5590 • Fax 800-478-9880

Chicago Office
303 W. Madison Street Suite 2075
Chicago, IL 60606
800-456-4576 • Fax 312-408-8081

SENIOR CARE

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

Is this a new business? **o** Yes **o** No If no, how many years have you been in business? _____

Applicant is: **o** Individual **o** Corporation **o** Partnership **o** Joint Venture

o Other (please describe): _____

Annual Payroll: $ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? **o** Yes **o** No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? **o** Yes **o** No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? **o** Yes **o** No

If yes, please explain: _____

_____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?

o Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

2. Desired Insurance

Limit of Liability - Professional Liability Coverage:

	Per Act/Aggregate		Per Person/Per Act/Aggregate
o	$50,000/$100,000	**o**	$25,000/$50,000/$100,000
o	$150,000/$300,000	**o**	$75,000/$150,000/$300,000
o	$250,000/$1,000,000	**o**	$100,000/$250,000/$1,000,000
o	$500,000/$1,000,000	**o**	$250,000/$500,000/$1,000,000
o	Other: _____	**o**	Other: _____

Self Insured Retention (SIR): **o** $1,000 (Minimum) **o** $1,500 **o** $2,500 **o** $5,000 **o** $10,000

3. Hiring Practices and Employee Information

1. How are workers recruited? _____

_____

2. Check any of the procedures you follow when hiring technical administration and staff employees:

o Applications **o** Experience references checked

o Drug testing **o** Education and competency

o Criminal background check **o** Annual license confirmation

3. Are any physicians employed? **o** Yes **o** No

If yes, explain: _____

_____

4. Identify the number of employees by type:

	NUMBER
RNs	

LVNs	
All other Employees	

5. Is a medical director required in your state? **o** Yes **o** No

   If yes, identify details: _____

6. Please provide the following information for each separate location:

	YEARS EXPERIENCE	YEARS AT LOCATION
Administrator		
Director of Nursing		
Assistant Director of Nursing		
Medical Director		

7. Identify the patient-to-caregiver ratio required in your state: _____ Patient(s) to one caregiver

8. Identify the resident-to-assistance provider ratio recommended in your state:

   _____ Resident(s) to one assistance provider

9. Staff assignment by work shift:

	FIRST	SECOND	THIRD
Physicians Employed			
Dentists Employed			
Registered Nurses			
LVN, LPN's			
Respiratory Therapist			
Certified Nurses Aides			
Medication Aides			
Restorative Aides			
Physical Therapists			
Dieticians			
Food Service Staff			
Beauticians/Barbers			
Administrative Personnel			
Maintenance/Laundry/ Housekeeping			
Social Workers			
Others - Describe			
Total Number Employees			

4. Facility Information

Definitions

Skilled Nursing Facility – Patients require 24-hour nursing services by Registered Nurses and Licensed Practical Nurses, which may provide medications, catherization, internal feeding, Class IV therapy, and other special care services as may be ordered by a Physician.
Assisted Living and Personal Care Facility – Residents require "support" services with daily living routine including meal preparation, eating, dressing, bathing, walking, taking medication, room cleaning, and laundry services.
Residential Independent Living Facility – Residents do not require special care or services. Facility provides meal services, recreation activities, social coordination, transportation and other similar everyday conveniences.

10. Does your facility provide exit security? **o** Yes **o** No

If yes, check what systems are operating: **o** Exit alarms **o** Panic doors **o** Cameras installed

o Electronic personal devices used to monitor wandering

If you use these devices, what type do you use? _____

11. Identify the number of patients or residents that wander: _____

12. Do you provide nursing services at locations other than in facilities? **o** Yes **o** No

If yes, please identify:

o Home Health Care **o** Adult Day Care **o** Home for the Aged

o Meals on Wheels **o** Adult Sitters **o** Child Care

o Counseling **o** Other: _____

If any are checked above, please provide the combined annual gross receipts from all services noted:

$ _____

13. If your facility offers retirement and adult apartment residential living facilities, do you provide:

a. A pharmacy that is used by non-residents? **o** Yes **o** No

b. A beauty shop that is used by non-residents? **o** Yes **o** No

c. A swimming pool? **o** Yes **o** No

If yes, does the pool have a jump board? **o** Yes **o** No

Is the pool area fenced? **o** Yes **o** No

d. An emergency lighting system? **o** Yes **o** No

e. Medical personnel on staff? **o** Yes **o** No

f. Assistance in medication? **o** Yes **o** No

g. A common dining facility? **o** Yes **o** No

h. Each private unit:

1. Has an emergency call button? **o** Yes **o** No

2. Can be communicated with directly? **o** Yes **o** No

14. Are you licensed for:

Medicare **o** Yes **o** No Medicaid **o** Yes **o** No

State-assisted programs of reimbursement: **o** Yes **o** No

15. Identify beds or apartments by use:

	NUMBER	NUMBER OCCUPIED
Licensed Nursing Home Patient's Beds		
Licensed Assisted living Resident Beds		
Adult Resident Apartments		
Other Beds (MN, MR, DD, etc.)		
Total Patient or Resident Beds and Apartments		

5. Licensing Requirements

16. Is your operation licensed in your state? **o** Yes **o** No

If yes, identify what type of licenses you hold, and the date first licensed:

Type: _____ Date First Licensed: _____

Type: _____ Date First Licensed: _____

Type: _____ Date First Licensed: _____

17. Are you approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO)?

o Yes **o** No

18. State licensing, inspection and/or registration:

a. If your state provides a rating, indicate last rating: _____

Please provide a copy of your most recent state inspection.

b. In the past three years, has any location or facility been placed under vendor hold, recommended contract cancellation, or proposed desertification; or had any other sanction or fines imposed by the state or any other licensing agency? **o** Yes **o** No

If yes, describe reason and corrective action taken, if any: _____

_____

_____

19. Is any operation or location now under any waivers from an agency, standard board, or regulatory department? **o** Yes **o** No

If yes, explain: _____

_____

6. Patient Demographics

20. Identify residents or patients by type and level of care:

	NUMBER
Ambulatory (including walkers and canes)	
Non-Ambulatory (wheelchairs / geriatric)	
Bedfast (immobile)—First floor	
Bedfast (immobile)—Upper floors	
AIDS / HIV	
Spine / Head Injuries	

	NUMBER
Wound management / Short stay / Post operation	
Mental illness (schizophrenia, etc.)	
Decubitus (pressure sores)	
Tube feeding	
Ventilator or respirator	
Developmentally disabled	
Alzheimer's and wanderers	
General geriatric and dementia	
Assisted living residents	
Independent living apartments or rooms	
Dialysis	
Other (please explain):	
Total	

21. Indicate the number of Decubitus ulcers reported within the past 12 months:

	ACQUIRED ULCERS	INHERITED ULCERS
Stage #1		
Stage #2		
Stage #3		
Stage #4		

22. Indicate the number of patients or residents by type of reimbursement:

	NUMBER
Medicaid	
Medicare	
Private pay	
Veteran's Administration	
Other state programs	
Other (please explain):	
Total	

23. Identify patients by category in the table below. Use the following definitions of patient categories:

Category I (201/203) Heavy Care Group - A patient must have one of the following conditions or be receiving at least one of the following treatments: coma; quadriplegia; stage 3 or 4 Decubitus with Decubitus care and/or wound dressing twice daily; non-oral nourishment; daily oral/nasal suctioning; or daily tracheotomy care. Patient must also require at minimal, frequent assistance with activities of daily living (eating, toileting and transfer).

Category II (202) Rehabilitation Group - Patient must be receiving physical or occupational therapy at least three times per week. The therapy must be ordered by a licensed physician and must be rehabilitative/restorative in intent.

Category III (204, 206, 208) Clinically Unstable Group - Patient must have at least one of the following conditions or be receiving at least one of the following treatments: recent amputation of a limb; seizures; dehydration with intake/output monitoring at least two times per day; incontinence with bowel and bladder management at least three times per day; urinary tract infection with intake/output monitoring at least three times per day; daily oxygen administration; respiratory therapy at least three times per day; or wound dressing at least two times per day.

Category IV (205, 207, 209, 210, 211) Clinically Stable Group - This Group includes all Patients who do not qualify for the heavy-care, rehabilitation, or clinically unstable groups. Patients in this group are included in a mental/behavioral condition subgroup if they do not require minimal/frequent assistance with activities of daily living (eating, toileting and transferring) and they have at least one of the following cognitive or behavioral characteristics: incoherent/ frequent disorientation, daily disruptive behavior or daily aggressive behavior.

Medicare Skilled Patient who meets the requirements of the Title XVIII of the Social Security Act is eligible for service and resides in a Medicare certified nursing facility or in a distinct part of a nursing facility.

Enter the number of patients for each category and age group:

	AGE GROUP 0-22	**AGE GROUP 23-54**	**AGE GROUP 55-64**	**AGE GROUP 65 +**	**TOTAL**
Category I					
Category II					
Category III					
Category IV					
Medicare Skilled					
Total					

7. Services and Patient Care

24. Do you complete regular skin assessment reports? **o** Yes **o** No

If yes, please note:

a. How often are reports completed? **o** Yes **o** No

b. Who reviews such reports? **o** Yes **o** No

c. Are photographs taken and entered in patient's or resident's medical records? **o** Yes **o** No

25. Do you have a written policy and procedure for use of physical and chemical restraints? **o** Yes **o** No

If no, would you agree to effect one of the same? **o** Yes **o** No

26. Do you have a written policy and procedure to investigate and resolve alleged patient or resident abuse and neglect? **o** Yes **o** No

If no, would you agree to effect one of the same? **o** Yes **o** No

8. Other

27. Please provide a copy of the latest "Department of Health and Human Services Health Care Financing Administration" form HCFA 672 (10/98), or its equivalent, which was completed by an independent inspector, as a resident census and condition of residents.

28. Use the space below for any comments: _____

_____

_____

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name