AMWINS™

PROGRAM UNDERWRITERS

LONG- TERM CARE FACILITIES INSURANCE PROGRAM
NEW BUSINESS APPLICATION

INSTRUCTIONS:

1 Please complete all sections (General, Facility, Staffing-RM, Ins. Coverage, Claims & Warranty)
2 Sections C - H should be completed for all insured locations
3 Please sign and date the application on the Warranty page
4 Please complete the Claims Supplement if the Applicant answers "Yes" to Question 3 in Section M. Claims

CORPORATE INFORMATION:

A. Applicant Information

1 Corporate Name: _____
2 Address: _____
3 Website: _____

4 Ownership Type: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture

5 Profit Status: ☐ For Profit ☐ Not For Profit

6 Number of facilities: _____

B. General Information

1 Is any part of the applicant operated / leased by a management corporation? _____ Yes _____ No
If "Yes" please explain and/or provide an organization chart: _____

2 Has the Applicant or any associated entity ever had a license suspended, revoked, or placed under probation by any government licensing agency? _____ Yes _____ No

3 Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? _____ Yes _____ No

4 Has the applicant ever filed for bankruptcy? _____ Yes _____ No

5 Does the Applicant anticipate any facility expansions (increase in licensed beds or new facilities) within the next 12 months? _____ Yes _____ No

6 Does Applicant have any plans for mergers, acquisitions, new services, sale of assets or business, or any similar corporate plans within the next 12 months? _____ Yes _____ No

7 Please explain any "Yes" answer for questions 1-6: _____

FACILITY INFORMATION:
Please complete a separate copy of sections C - H for each facility or building location.

Facility Name: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

C. Description of Services

1 Exposures:

	Licensed Beds / Units	Occupied Beds / Units
Skilled Nursing / Intermediate:		
Sub Acute / Rehabilitation:		
Assisted Living:		
Independent Living:		
Dementia / Alzheimer:		

Home Health Services: _____ number of annual visits

Adult Daycare: _____ number of daily attendees

Is there a separate Alzheimer unit? _____ Yes _____ No

2 Resident Groups:

Age of Resident: Under 21: _____ residents 21 to 64: _____ residents 65 Yrs + _____ residents

Length of Stay: 0 - 60 days: _____ residents 61 - 180 days: _____ residents 181 + days: _____ residents

D. Physical Premises

1 Number of stories: _____ Square feet: _____ Year built: _____

2 Construction Type: Fire Resistive _____ Frame _____ Brick _____ Masonry Non-Combustible _____ Other _____

3 Sprinklers: None _____ Entire Facility _____ Common Areas _____

4 Smoke Detectors: None _____ Entire Facility _____ Common Areas _____

5 Was the building originally designed and constructed for Nursing Home occupancy? _____ Yes _____ No
6 Does the facility maintain a centrailized alarm system? _____ Yes _____ No
7 Are there alarms on all exit doors? _____ Yes _____ No

E. Daycare

1 Do you offer onsite daycare for children? _____ Yes _____ No
2 If "Yes" to the previous question, is it open to the public? _____ Yes _____ No

F. Medication Administration

1 Indicate who is responsible for administering residents medications _____ Licensed Staff _____ Medication Aide

G. State Inspections (Nursing Homes Only)

1 Total number of deficiencies on most recent survey: _____
2 Total number of deficiencies with severity level of G or higher on most recent survey: _____
3 Total number of life safety code deficiencies on most recent survey: _____

H. Staffing

1

	Employed or Contracted	Years at this facility	Years of experience	Full-Time	Part-Time
Director of Nursing					
Medical Director					
Administrator					

2 Does Medical Director provide direct patient care? _____ Yes _____ No

3 What medical malpractice limits is Medical Director required to carry? _____

4 How many hours per week is the Medical Director physically at the facility? _____

5 Other Staffing:

	Employed	Contracted
MD/Physicians		
Registered Nurses		
Licensed Practical Nurses		
Certified Nursing Assistants		
Nurse Aides		
Medication Aides		
Psychologists		
Counselors		
Physical Therapists		

	Employed	Contracted
Students/Volunteers		
Pharmacists		
Dieticians		
Administrative Personnel		
Independent Contractors		
Maintenance/Security Personnel		
Beauticians/Barbers		
Other		
TOTAL # of EMPLOYEES		

6 Please list departments for any contracted employees that were indicated in the "Other" row: _____

7 Actual number of employees working at a time on each shift (average):

	1st shift	2nd Shift	3rd Shift	Weekends	Holidays
RNs					
LPNs					
CNAs					
Medication Aides					

8 Are Certificates of Insurance obtained for all independent contractors? _____ Yes _____ No

9 What percentage of the licensed nursing staff has been working for the applicant for more than one year? _____ %

I. Risk Management Policies and Procedures:

1 Is there an established risk management program? _____ Yes _____ No

2 Are nursing assessment protocols in place to identify residents at risk for:

Falls: _____ Yes _____ No

Elopement: _____ Yes _____ No

Nutritional deficiency: _____ Yes _____ No

3 Is a comprehensive nursing assessment conducted for new residents? _____ Yes _____ No

4 Does the facility have a formalized resident complaint resolution program? _____ Yes _____ No

5 Who is responsible for overseeing any documents resulting from a resident complaint? _____

6 Are Wander Guards or similar devices used? _____ Yes _____ No

7 Are all visitors required to sign-in at the receptionists area? _____ Yes _____ No

8 Does the facility have locked doors prior to entering the reception area? _____ Yes _____ No

9 Is there a written evacuation plan? _____ Yes _____ No

10 Are evacuation plans posted in all areas of the facility? _____ Yes _____ No

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

12 How often are fire/evacuation drills conducted? _____

13 Does the Applicant offer continuing education for their staff? _____ Yes _____ No

14 Does the Applicant provide an Employee Handbook to every employee? _____ Yes _____ No

15 Does the Applicant utilize a vendor to analyze MDS submissions? _____ Yes _____ No

J. Current and Past Professional Liability Coverage History

List prior Primary Professional & General Liability insurance carried for each of the past five (5) years:

Insurance Carrier	Effective Date	SIR	Premium	Limits of Liability	Retro Date	Included (Y or	Excess Carrier (N/A if none)	Excess Limits	Excess Premium

K. Coverage Terms Requested

(Please note that coverage for this request is not automatically available; the terms and conditions of the policy, if issued, will determine actual coverage.)

Requested Limits of Liability: _____ Per Claim _____ Annual Aggregate

Requested Self-Insured Retention: _____ Per Claim

L. MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER THIS QUESTION:

Has any insurance company ever cancelled, non-renewed or declined to accept your Professional Liability and/or General Liability insurance? _____ Yes _____ No

If Yes, please provide details: _____

M. Claims

1 Please provide five (5) years of insurance company or third party adminstrator produced loss runs that have been valued within the last three (3) months. The loss run should describe all claims/incidents during the past five (5) years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. Please include both primary and excess coverage loss runs as applicable.

If you are not aware of any claims in the last five (5) years, please state, "None". _____

2 Please provide detailed descriptions of all claims with either paid or reserved amounts of $50,000 or more. Attach the descriptions to this application.

3 During the past five (5) years are you aware of any fact, circumstance, situation, transaction, event, act, error, or omission which you have reason to believe may result in a claim that has not been reported on the loss runs attached to this application?

_____ Yes _____ No

If the Applicant answered "Yes" to question number 3 above, please complete the attached Claims Supplement.

N. Warranty Statement

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSONS AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL NOTIFY THE INSURER WHO MAY MODIFY OR WITHDRAW ANY QUOTATION.

THE INFORMATION CONTAINED AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER AND, ALONG WITH THE APPLICATION, IS CONSIDERED TO BE PHYSICALLY ATTACHED TO THE POLICY AND WILL BECOME PART OF THE POLICY ISSUED.

Print Applicant Name: _____

Applicant Signature: _____

Title: _____

Date: _____

Risk Management Contact

Name: _____

Phone: _____

Email:. _____

Please attach the following documents to the application:

- Information on disciplinary actions or license revocations
- IF any of Applicant's skilled nursing facilities are located in PA - MCare Loss Runs
- Copy of Current certificate of Licensure
- Copy of Brochure(s) , marketing or advertising materials
- Copy of most current declarations page from professional liability policy

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for 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 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 Regulatory Agencies.

NOTICE TO D.C. 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 insurance company 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 HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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 confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 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 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 YORK INSURANCE 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 be also subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 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 RHODE ISLAND APPLICANTS: Under Rhode Island law, there is a criminal penalty for failure to disclose a conviction of arson.

NOTICE TO TENNESSEE 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 VIRGINIA 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 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 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 ALL OTHER STATE APPLICANTS: Any person who knowingly includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

1 Name of applicant: _____

2 Name of other parties or defendants named in suit: _____

_____

3 Date of alleged occurrence: _____

4 Date claim was reported: _____

5 Name of claimant: _____

6 Name of insurance company or third party administrator handling claim: _____

_____

7 Present status of claim or final disposition: _____ **OPEN** _____ **CLOSED**

_____

_____

8 Defense costs paid to date inclusive of any deductible or self-insured retention: _____

9 Indemnity costs paid to date inclusive of any deductible or self-insured retention: _____

10 Defense reserves inclusive of any deductible or self-insured retention: _____

11 Indemnity reserves inclusive of any deductible or self-insured retention: _____

12 Description of case and events including allegations and assessment of liability: _____

_____

_____

_____

_____

_____

13 Claimant's last settlement demand: _____

_____
Signature

_____
Date