NOTICE

The liability coverage sections of the policy for which this application is made provide claims made coverage, which applies only to claims first made against the insureds during the policy period or any applicable extended reporting period. The limits of liability to pay insured loss may be reduced and may be exhausted by payment of defense costs and defense costs may be applied against any applicable retention. Please read the entire application carefully before signing.

INSTRUCTIONS

Please answer all questions fully and print clearly.
If additional space is needed to fully answer a question please attach a separate document.
The application must be signed and dated by an authorized representative of the applicant. Authorized representative may include any executive officer, member of human resources, risk management or in-house general counsel.
For multi-location risks, please complete below at a corporate level and complete Berkley Healthcare Multi Location Supplemental for exposure information by location.

I. General Information		
1.	Legal Name of Applicant:	
2.	Address: Street _____ _____ City _____ State _____ Zip _____	
3.	Type of Entity: ☐ Corporation ☐ Partnership ☐ Limited Liability Company ☐ Other _____	
4.	Federal Provider ID:	
5.	Tax Status: ☐ For Profit ☐ Not for Profit/Religious Affiliated ☐ Not for Profit/Non-Religious Affiliated ☐ Other _____	
6.	Years Under Current Ownership: Years Under Current Management:	
7.	Applicant's Website:	
8.	Within the next 12 months does the Applicant plan to:	
	Obtain another operation or entity?	☐ Yes ☐ No
	Divest any locations?	☐ Yes ☐ No
	Expand the number of locations?	☐ Yes ☐ No
	Begin operations in another state?	☐ Yes ☐ No
	Expand or cease any services?	☐ Yes ☐ No
	If yes, please provide details:	

II. Insurance Information

9. Coverage Requested

Primary Coverage	Limits	Retroactive Date	SIR or Deductible	Target or Expiring Premium
Professional Liability ☐ Claims-Made ☐ Occurrence	Per Occurrence: Per Location: Policy Aggregate:	___/___/_____	$	$
General Liability ☐ Claims-Made ☐ Occurrence	Per Occurrence: Per Location: Policy Aggregate:	___/___/_____	$	$
Employee Benefits Liability ☐ Claims-Made ☐ Occurrence	Per Occurrence: Per Location: Policy Aggregate:	___/___/_____	$	$
Excess Liability	Policy Aggregate:	___/___/_____		

10. Expiring Carrier: _____

Limits (If different than requested above): _____

SIR or Deductible (If different than requested above) _____

11.	Is the Applicant participating in a state Patient Compensation Fund? (IN, KS, LA, PA, etc.)	☐ Yes ☐ No
12.	**Missouri Applicants:** Do Not Answer Question 12 Has the applicant ever been declined or had its coverage cancelled or non-renewed? If yes, please provide details:	☐ Yes ☐ No

III. Applicant Credentials

13.	When was the date of the Applicant's last state inspection or survey?	___ /___ /_____
14.	Was a Corrective Action Plan submitted to and accepted by the state?	☐ Yes ☐ No
15.	If yes to any of below, please provide details on separate attachment. In the past 5 years:	
	Has the Applicant's License been suspended, revoked or been placed on probation?	☐ Yes ☐ No
	Has the Applicant's Medicare or Medicaid Certification been revoked or suspended?	☐ Yes ☐ No
	Has the Applicant been fined by a state or federal agency?	☐ Yes ☐ No

IV. Risk Classification

16. **Description of Operations:** For more than 1 location, please document all locations in the multi-location Excel application.

Level of Care	Total # Licensed Beds/Units	Average # of Occupied Beds/Units
Sub-Acute/High Acuity Care: Dedicated beds for medically fragile residents requiring intensive care. This includes intravenous tube feeding, tracheotomy care, ventilator care, traumatic brain injury and complex wound care		
Skilled Nursing: Dedicated beds for administration of medication, catheter care, physical and occupational therapy, routine changing of dressing, tube feeding and assistance for activities of daily living		
Memory Care/Alzheimer's Care: Dedicated beds for residents with memory loss or impairment and/or Alzheimer's Care and Services		
Assisted Living: Dedicated beds for residents that need assistance with medication, activities of daily living, meals, etc.		
Independent Living: Dedicated units for individuals that are self-sufficient and occupy their own units. These residents do not receive health care services and administer their own medications without assistance.		
	Total # Licensed Attendees	**Average # of Daily Attendees**
Adult Day Care: Social services provided for adults including but not limited to crafts, games, shopping, wellness programs. Services may include medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, physical therapy, occupational therapy and speech therapy.		

17.

Additional Services	Total # of Visits	Total Revenue
Home Health Care: Services such as in-home hospice, rehabilitation therapy, respiratory services or skilled nursing care.		

18. What is the percentage of residents based upon the below age ranges?

<18: _____	18-54: _____	55-64: _____	65-75: _____	76-94: _____	>94: _____

If the facility has residents under 55, please provide details:

19.	Are there any swimming pools onsite?	☐ Yes ☐ No
	Is it open to the public?	☐ Yes ☐ No
	Is the pool locked when not in use?	☐ Yes ☐ No
	If outdoors, is there a fence around the pool?	☐ Yes ☐ No
	Is there a lifeguard on duty full-time?	☐ Yes ☐ No
	Is there a telephone in the pool area?	☐ Yes ☐ No
20.	Is there an exercise/weight room?	☐ Yes ☐ No
	Is it open to the public?	☐ Yes ☐ No
	Is there an attendant on duty?	☐ Yes ☐ No
	Is there a required user orientation for demonstration and safety of equipment?	☐ Yes ☐ No
21.	Is there a restaurant that is open to the public?	☐ Yes ☐ No
	Does the facility have a liquor license?	☐ Yes ☐ No
	If yes,	☐ Yes ☐ No
	Is alcohol served?	☐ Yes ☐ No
	Is there a per drink charge?	☐ Yes ☐ No
22.	Does the applicant have a day care center for children?	☐ Yes ☐ No
	If yes, please provide the following:	
	Total number of licensed centers:	#_____
	Average occupancy:	#_____
	Is facility open to public?	☐ Yes ☐ No
	Is it licensed?	☐ Yes ☐ No
23.	Are pets allowed to live in the facility?	☐ Yes ☐ No
	If yes, are vaccinations required and documentation maintained by the applicant?	☐ Yes ☐ No

V. Staffing and Hiring Information

24.	Administrator		
	Name of Administrator:	State:	Full time? ☐ Yes ☐ No
	Years as Administrator:	Years at this facility:	
25.	Director of Nursing		
	Name of DON:	Professional Credentials: ☐ RN ☐ LPN	
	Years as DON:	Years at this facility:	
26.	Medical Director		
	Name of Medical Director:	State:	# Hours Per Week:
	Years as Director:	Years at this facility:	

27.	Is the Medical Director also acting as the attending physician to any residents? ☐ Yes ☐ No If yes, does the Medical Director carry their own coverage? ☐ Yes ☐ No	
28.	Is a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No	
29.	Have any leaderships' individual licenses been suspended or other disciplinary actions taken? ☐ Yes ☐ No If yes, please provide details:	

30. Please provide # of staff by shift and Turnover %:

Category	1st Shift	2nd Shift	3rd Shift	Staff Turnover %
RN				%
LPN/LVN				%
CNA/Personal Caregiver				%
Agency/Pool				%

What was the applicant's prior year's turnover rate? %

31.	Does the Applicant require employed nurses to carry malpractice coverage? ☐ Yes ☐ No If yes, does the Applicant obtain and review the employed nurses' certificates of malpractice insurance? ☐ Yes ☐ No	

32. Are background checks performed on all staff for the following items?

Licensure type and status ☐ Yes ☐ No	How frequently do you review?	Work History and Education ☐ Yes ☐ No	How frequently do you review?
National Criminal Records ☐ Yes ☐ No	How frequently do you review?	Driving records/MVRs ☐ Yes ☐ No	How frequently do you review?
State Criminal Records ☐ Yes ☐ No	How frequently do you review?	Abuse Registry ☐ Yes ☐ No	How frequently do you review?

33.	Is there a formal, documented assessment process to measure the competency skills of staff members? ☐ Yes ☐ No	
34.	Does the Applicant conduct regularly scheduled in-service education and training for all employees? ☐ Yes ☐ No	
35.	How long are education records stored for employees?	

VI. Resident Services

36. Does the Applicant provide the following services?

Service	Provided	# of Residents	Service	Provided	# of Residents
Enteral Tube Feeding	☐ Yes ☐ No		Developmentally Disabled	☐ Yes ☐ No	
Ventilation Therapy	☐ Yes ☐ No		Bariatric Care	☐ Yes ☐ No	

37.	Are certificates of insurance obtained for all outside clinical services and vendors? ☐ Yes ☐ No	

38.	Does the Applicant accept residents with a primary healthcare need related to mental health services? If yes, please provide on a separate document a summary of services, age distribution and types of diagnoses accepted at each location	☐ Yes ☐ No

VII. Risk Management						
Procedures and Prevention						
39.	Are nursing assessment protocols in place and completed according to state and federal regulations to identify residents at risk for:					
	Elopement	☐ Yes	☐ No	Falls	☐ Yes	☐ No
	Nutritional Deficiency	☐ Yes	☐ No	Skin Integrity	☐ Yes	☐ No
	Cognitive Impairment	☐ Yes	☐ No	Self-Harm Screening	☐ Yes	☐ No
40.	Are risk assessments performed prior to admission of residents?				☐ Yes	☐ No
41.	How often are residents monitored during the first 72 hours following admission?				☐ Hourly ☐ Daily ☐ As Needed	
42.	Are admission, discharge and transfer criteria established at time of admission?				☐ Yes	☐ No
43.	Do facilities have policy/procedure in place for confidentiality of resident health information, including but not limited to, third party communications, access to resident information and records storage?				☐ Yes	☐ No
44.	Is there a risk management program implemented throughout all facilities?				☐ Yes	☐ No
45.	Is there a formal safety program related to the following?					
	Life Safety	☐ Yes	☐ No	Hazardous Materials	☐ Yes	☐ No
	Service Providers	☐ Yes	☐ No	Environment	☐ Yes	☐ No
	Emergency Evacuation	☐ Yes	☐ No	Public Health Emergency	☐ Yes	☐ No
	Food Handling and Safety	☐ Yes	☐ No	Resident Lift Safety	☐ Yes	☐ No
46.	What security measures are used to control unauthorized entrance to and exit from the facility? Please provide details:					
47.	Number of Elopements in the past 3 years?				#_____	
48.	Are Wander Guards or similar devices used as part of elopement prevention practices?				☐ Yes	☐ No
49.	Is there an automatic medication dispensing system in place? If yes, are overrides monitored and addressed?				☐ Yes ☐ Yes	☐ No ☐ No
50.	Does the facility have a procedure for monitoring side effects after medication changes and adjustments? If so, does the facility have a protocol for reporting to the residents' primary care physician?				☐ Yes ☐ Yes	☐ No ☐ No

51.	Does the Applicant have a formal grievance procedure in place to address resident and/or family complaints?	☐ Yes	☐ No
52.	Does the facility have an "incident reporting" policy? If yes, are all related incidents reviewed by DON and Administrator?	☐ Yes ☐ Yes	☐ No ☐ No
Infection Control			
53.	Do all facilities follow CDC Recommendations for infection control?	☐ Yes	☐ No
54.	Do all facilities have written infection control policy and procedures based on CDC Standards?	☐ Yes	☐ No
55.	Do all facilities have adequate PPE supplies?	☐ Yes	☐ No
56.	Is annual education provided on infection control based on previous year's issues and/or concerns?	☐ Yes	☐ No
Sexual Abuse			
57.	Do all facilities have a formal, documented Abuse Policy? If yes, does it include the following: Documented, annual training with staff/volunteers including how to identify symptoms or signs of abuse with a recommended course of action? Policy with restrictions on use of electronic devices and social media? Does the organization express in writing that volunteers are prohibited from being alone with residents? Protocols on reporting incidents and suspicious or inappropriate behavior? Guidelines on what behaviors may be inappropriate (verbal comments, touching, etc.)? Written procedures for responding to and reviewing allegations? Written procedures for reporting allegations to authorities within regulated time frames? Action Planning to prevent any future similar incidents?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No
58.	Are staff members required to complete annual abuse prevention training?	☐ Yes	☐ No
59.	Are staff members required to review the written abuse policy annually and is completion documented?	☐ Yes	☐ No

VIII. Claim History and Prior Known Incidents			
60.	Has any claim, suit or regulatory proceeding been made against the Applicant, or any facility proposed for coverage at any time during the last 3 years?	☐ Yes	☐ No
61.	Does the Applicant have any knowledge of any wrongful act, fact, circumstance, situation, transaction or event which could reasonably be expected to give rise to a future claim or loss? This includes but is not limited to: Death of resident or client other than natural causes Incident resulting in hospitalization or transfer of resident or client Injury to resident or client that required medical care Incident that generated a formal complaint or notice from any licensing agency	☐ Yes	☐ No

	Elopement of a resident or client Improper medication or improper dosage resulting in medical complications Request for medical records If yes, please provide full details on a separate attachment to this application.	
62.	Have you had any abuse incidents, claims or suits, or do you have any knowledge or information which might reasonably be expected to give rise to a claim of sexual abuse or molestation? If yes, please provide details on a separate document	☐ Yes ☐ No
63.	Does the Applicant's current insurer(s) provide an incident sensitive claim trigger?	☐ Yes ☐ No

IX. Submission Attachments

1. Loss History – submit a currently valued loss run(s) for the past five years
2. Detailed narrative for any claim greater than $250,000 and remedial actions taken as a result of the claim
3. Financials – submit a copy of the most recent audited financial statement
4. Resume for Administrator and Director of Nursing if at facility for less than 3 years
5. List of Named and Additional Insureds including Retroactive Dates
6. Sample copy of admission risk assessment
7. Details to "yes" responses as required in above questions

Fraud Warnings

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE INSURER TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE INSURER SHALL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT ACKNOWLEDGES THAT ITS BROKER/PRODUCER IS NOT APPOINTED BY THE INSURER AND IS ACTING AS THE APPLICANT'S REPRESENTATIVE, AUTHORIZED TO PRESENT THIS APPLICATION ON THE APPLICANT'S BEHALF TO THE INSURER. IN THIS CAPACITY THE BROKER/PRODUCER HAS NO UNDERWRITING OR BINDING AUTHORITY WITH THE INSURER AND CANNOT BIND COVERAGE OR MODIFY THIS APPLICATION OR ANY INSURANCE POLICY. ANY BINDER OR POLICY MODIFICATION SHALL BE VALID ONLY IF ISSUED BY THE INSURER. APPLICANT FURTHER ACKNOWLEDGES THAT ANY FEES THAT IT PAYS TO THE BROKER/PRODUCER FOR THIS SERVICE IS AGREED TO IN WRITING BETWEEN APPLICANT AND THE BROKER/PRODUCER.

Notice to Arkansas, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the 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 Regulatory agencies.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 and Rhode Island 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, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

Notice to Alabama and Maryland Applicants: 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 (in Alabama; additionally restitution).

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 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 Oregon Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 New York 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 also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE

The undersigned authorized representative of the applicant declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements set forth in this application for insurance and in any materials submitted with this application are true and complete and may be relied upon by the insurer.

If the information in the application changes prior to the inception date of the policy, the applicant shall notify the insurer of such changes, and the insurer may modify or withdraw and outstanding quotation. The insurer is authorized to make inquiry in connection with this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the insurer under any policy of any actual or potential claim or loss.

This application must be signed by an authorized representative of the applicant. Authorized representative may include any executive officer, member of human resources, risk management or in-house general counsel. By signing this application, the undersigned authorized representative agrees to conduct electronic commerce and to accept an

electronic insurance policy and other documents issued by the insurer. The undersigned authorized representative acknowledges that he or she may request a written (paper) policy.

Signature of Authorized Representative

Signature	Title
Printed Name	Date

UTAH APPLCANTS ONLY (NO SIGNATURE REQUIRED)