

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application  
For  
**Institutional Care Facilities**

1. Name of Applicant \_\_\_\_\_  
 Street address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Applicant's Web Site address \_\_\_\_\_  
 Date established \_\_\_\_\_ Phone # for inspection \_\_\_\_\_ Agent phone # \_\_\_\_\_

2.  Individual  Corporation  Partnership  Professional Association  Non-profit Corporation  
 Other (Explain) \_\_\_\_\_

3. List all names which you or the corporation have operated under during the past 4 years, if different from above  
 \_\_\_\_\_  
 \_\_\_\_\_

3a. Is applicant engaged in, owned by, associated with or involved in any other enterprise?  Yes  No  
 If yes, provide details \_\_\_\_\_

4. Is facility run by an outside management company?  Yes  No  
 If yes, describe contractual relationship \_\_\_\_\_

4a. Do you provide consultant services for or manage any other facilities?  Yes  No  
 If yes, describe \_\_\_\_\_

5. List all losses and amounts paid or reserved that have been incurred by these entities. Add pages, if needed.

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

6. Attach Copies of:
- a. Currently valued (within last 3 months), hard copy, Company loss runs for the last 5 years.
  - b. Current State License
  - c. Most recent state inspection report with state approved plan of corrections, if deficiencies are noted.
  - d. Insured's guidelines/procedures for care of Alzheimer's or senile dementia patients.  
 Include details of training and certification required of staff to handle such patients.
  - e. Emergency Evacuation Plan

7a. Licensed bed capacity \_\_\_\_\_  
 Has license ever been revoked or suspended? Give details: \_\_\_\_\_

8. Will temporary clients be accepted?  Yes  No  
 If yes, what additional staffing provisions will be made if the condition of the client is above what facility is licensed for? \_\_\_\_\_

9. Other operations (if any)

Counseling (outpatient) \_\_\_\_\_

Day care (other than for residents) \_\_\_\_\_

Home healthcare service/agency \_\_\_\_\_

Psychiatric Clinic \_\_\_\_\_

Other (describe) \_\_\_\_\_

Number of visits \_\_\_\_\_

Number of persons \_\_\_\_\_

Amount of receipts \_\_\_\_\_

Type of conditions treated \_\_\_\_\_

10. Type of facility \_\_\_\_\_

Nursing home for senile or aged \_\_\_\_\_

Alcohol or drug treatment \_\_\_\_\_

Psychiatric facility \_\_\_\_\_

Group home for mentally challenged \_\_\_\_\_

Shelter for runaways, abused spouses, foster homes \_\_\_\_\_

Sub-acute care \_\_\_\_\_

Other (provide full details below) \_\_\_\_\_

Number of beds \_\_\_\_\_

11. Patient breakdown by age group

0 – 10 years \_\_\_\_\_ 36 to 50 years \_\_\_\_\_

11 to 17 years \_\_\_\_\_ 51 to 65 years \_\_\_\_\_

18 to 35 years \_\_\_\_\_ Over 65 years \_\_\_\_\_

12. What precautions are taken to keep track of patients?

Sign out procedure?  Yes  No Alarms on doors?  Yes  No

Other (please describe) \_\_\_\_\_

13. Do any patients work full or part time or attend school or workshops?  Yes  No

If yes, describe activities? \_\_\_\_\_

14. Indicate total number of employed personnel: \_\_\_\_\_

Total number and types of independent contractors: \_\_\_\_\_

	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Residing on Premises
(A) MD's	_____	_____	_____	_____
(B) RN's	_____	_____	_____	_____
(C) LPN's	_____	_____	_____	_____
(D) Nurses Aides	_____	_____	_____	_____
(E) Psychologists	_____	_____	_____	_____
(F) Therapists	_____	_____	_____	_____
(G) Counselors	_____	_____	_____	_____
(H) Other (specify)	_____	_____	_____	_____

15. Are any of the above required to maintain their own professional coverage?  Yes  No

Limits required? \_\_\_\_\_ How is coverage verified? \_\_\_\_\_

15a. Are background checks made with all prior employers and educational institutions?  Yes  No

Does background check include Police record?  Yes  No

(If either answer is "No", refer risk to Company.)

15b. Do you want employees covered as additional insureds? (There is a premium charge).  Yes  No

(NOTE: The policy already protects *you* for the acts of your employees.)

16. List medication administered and in what form given: (e.g. methadone, given in pill form) \_\_\_\_\_

17. Describe therapy other than drugs used in the course of treatment: (e.g. group therapy, individual counseling, shock treatment, etc.) \_\_\_\_\_

18. What floors are the nonambulatory patients on? \_\_\_\_\_ How many on each floor? \_\_\_\_\_

Are physical or chemical restraints used?  Yes  No If yes, describe

18a. How many patients do you have of the following types? Do not count same patient in more than one class.

	Ambulatory	Nonambulatory
1. Seriously mentally impaired (e.g. Alzheimer's, senile)	_____	_____
2. Skilled Care	_____	_____
3. Intermediate Care	_____	_____
4. Somewhat mentally impaired (e.g. mentally challenged)	_____	_____
5. Aged but mentally and physically fully functional	_____	_____
6. Drug or alcohol detoxification patients	_____	_____
7. Drug or alcohol rehabilitation patients	_____	_____
8. Has a communicable disease (e.g. AIDS)	_____	_____
9. Other - specify _____	_____	_____
<b>Totals (Totals must not exceed total number of patients.)</b>	_____	_____

19. What other services (such as beauty care, podiatry, dentistry) are provided by staff or independent contractor? \_\_\_\_\_

20. BUILDING INFORMATION:
- (A) Construction of building? \_\_\_\_\_
  - (B) Number of stories? \_\_\_\_\_
  - (C) Year built? \_\_\_\_\_
  - (D) Built as a nursing home?  Yes  No
  - (E) Is building sprinklered?  Yes  No  Fully or  Partially sprinklered?  
If partially, what percentage? \_\_\_\_\_%
  - (F) Has an emergency evacuation plan been prepared?  Yes  No
  - (G) Are all rooms and halls equipped with smoke detectors?  Yes  No
  - (H) What is the total square footage of the building? \_\_\_\_\_
  - (I) Any swimming pools?  Yes  No Describe protection and use: \_\_\_\_\_
  - (J) Is building equipped with fire alarm?  Yes  No  Central Station  Local Station
  - (K) Is smoking permitted?  Yes  No
  - (L) Are there designated smoking areas?  Yes  No
  - (M) Distance to the nearest fire station? \_\_\_\_\_ Nearest hydrant? \_\_\_\_\_
  - (N) Temperature of hot water? \_\_\_\_\_
  - (O) Are handrails in bathrooms and hallways?  Yes  No
  - (P) Are bathtubs and showers equipped with non-skid surfaces?  Yes  No

21. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? If yes, please provide details.  Yes  No

22. Has applicant, or any other person for whom coverage is being requested, had any liability application denied, If yes, provide details.  Yes  No

23. Limits of insurance requested:
- |  |          |                                |
|--|----------|--------------------------------|
| General Aggregate Limit (Other than Products – Completed Operations) | \$ _____ |                                |
| Products – Completed Operations Aggregate Limit                      | \$ _____ |                                |
| Personal and Advertising Injury Limit                                | \$ _____ | any one person or organization |
| Each Occurrence Limit  | \$ _____ |                                |
| Damage to premises rented to you                                     | \$ _____ | any one premises               |
| Medical Expense Limit (up to \$5,000 limit available)                | \$ _____ | any one person                 |
| Each Professional Incident Limit (if applicable)                     | \$ _____ |                                |
24. Effective Dates Desired: From \_\_\_\_\_ To \_\_\_\_\_

**IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 25 THROUGH 29.  
If not desired, please sign application at bottom of page.**

25. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime?  Yes  No  
If yes, provide details. \_\_\_\_\_
- 
26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct?  Yes  No  
If yes, provide details. \_\_\_\_\_
- 
27. Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there?  Yes  No  
If yes, provide details. \_\_\_\_\_
- 
28. Does your facility do background checks on all employees and volunteers?  Yes  No  
Describe types of checks done (prior employer, police, etc.) \_\_\_\_\_
- 
29. Sexual Molestation sub limit wanted:  
 \$25,000/50,000       \$50,000/100,000       \$100,000/300,000

**FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes 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.**

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Producing Agent: \_\_\_\_\_