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| Healthcare/Hospital Facilities Liability Application |
| Long-Term Care Facility Supplement |
| * Ace American Insurance Company * Illinois Union Insurance Company * Westchester Surplus Lines Insurance Company |

# Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly. Use  \_for Yes or No answers and other selections.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice: This supplement is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions*. All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Coverage Requested, Loss Adjustment, Loss Experience, Exposures (prospective and historical Professional Liability, General Liability, Helipad Liability, Aircraft Liability, Automobile Liability, Watercraft Liability, Employee Benefits Liability, and Employer’s Liability), Staff Privileges, Medication Administration, Blood Bank Services, Day Care Services, Emergency Management and Health Care Facility Evacuation Plans, Risk Management, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – Applicant & Retroactive Dates

1. Legal name of the legal entity or entities providing Long Term Care treatment and care to be insured exactly as it shall be shown on the policy. Include location information and requested retroactive date(s).

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |
| Professional Liability Retroactive Date: | General Liability Retroactive Date: |
|  |  |

1. Parent entity:

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |

# Section B. – General Information

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| --- | --- | --- | --- | --- |
| 1. Have any long-term care facilities been acquired, divested or sold in the past 10 years? If Yes, explain: | | | | Yes  No |
| 1. Has any applicant experienced any allegations or substantiated incidents of physical or sexual abuse (resident upon resident, staff upon resident, visitor upon resident) in the past 3 years?  If Yes, explain: | | | | Yes  No |
| 1. For multi-story buildings, are all non-ambulatory residents on lower floors, i.e. 1st or 2nd floor?   Not Applicable   No multi-story buildings  If No, provide: | | | | Yes  No |
| Location | Construction Type (1) | Fire Protection (2) | # Stories | Year Built |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Construction Type Key: F = Frame, JM = Joisted Masonry, NC = Non-Combustible, MNC = Masonry Non-Combustible, MFR = Modified Fire Resistive, FR = Fire Resistive
2. Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm

# Section C. – Licensing And Certification

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| --- | --- | --- |
| 1. Has the applicant had its state license for any facilities revoked, suspended or limited within the past 3 years?  If Yes, explain: | | Yes  No |
| 1. Has the applicant had its Medicaid or Medicare certification for any facilities limited, suspended or revoked, for any reason, within the past 3 years?  If Yes, explain: | | Yes  No |
| 1. Has the applicant been placed under Immediate Jeopardy within the past 3 years? If Yes, explain: | | Yes  No |
| 1. Date of last State inspection/survey: | |  |
| Total Number of Deficiencies: |  | |
| Number of D, E & F Deficiencies: |  | |
| Number of G, H & I Deficiencies: |  | |
| Number of J, K, & L Deficiencies: |  | |
| 1. Corrective action plan accepted by the State?  Not Applicable, no deficiencies If Yes, date accepted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Yes  No |
| Number of complaints investigated by the State in the past 3 years: | | |
| Number of substantiated complaints in the past 3 years: | | |

# Section D. – Administration

## 1. Administrator:

Name of Administrator

License Number:

State:

Length of Time at Applicant’s Facility

Number of Years as a Nursing Home Administrator

## 2. Nurse Staffing:

Name of Director of Nursing

Professional Credentials: 🞏 R.N. 🞏 L.P.N. 🞏 Other

Length of Time at Applicant’s Facility:

Length of Time as Director of Nursing

### Attach the resume and job description for the Director of Nursing.

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| --- | --- |
| 1. Does the applicant utilize agency staff?  If Yes, What percentage is agency staff? | Yes  No |
| 1. Does the applicant require its Medical Director to maintain separate Professional Liability insurance for his or her non-administrative duties? | Yes  No |

# Section E. – Risk Management

1. Who is the individual responsible for risk management

Name of Risk Manager

Title

Telephone Number:

E-mail Address

Length of Time at Applicant;’s Facility

1. Describe any other responsibilities the risk manager may have:
2. Does the applicant’s risk management program include the following?

|  |  |
| --- | --- |
| Incident Reporting Process | Yes  No |
| Claims Management: | Yes  No |
| Resident Complaints and Grievances Process & Procedure: | Yes  No |
| Contract Review & Evaluation | Yes  No |
| Describe any coordination of the risk management program with the healthcare system parent entity: | |
| 1. Are incidents trended and presented to the executive committee and board of directors? | Yes  No |

# Section F. – Clinical Practices

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| --- | --- |
| 1. Number of elopements in the past 12 months that resulted in injury to a resident: |  |
| 1. Are falls monitored and tracked to identify patterns or problems? | Yes  No |
| 1. Are policies in place for the immediate suspension/termination of staff suspected or involved in resident abuse? | Yes  No |
| 1. Number of alleged abuse incidents investigated and/or reported in the past 12 months: |  |
| 1. Are all residents evaluated for skin breakdown and the risk for skin breakdown at the time of admission? | Yes  No |
| 1. What is the current resident population with facility acquired Stage III and IV pressure ulcers? |  |
| 1. When was the last time the written emergency management plan was reviewed? |  |
| 1. Does the emergency management plan address natural disasters such as fire, earthquake, hurricane, tornado, and flood? | Yes  No |

# Section G. – Supplemental Materials as Attachments

The most current versions of the following documents must be submitted:

|  |  |
| --- | --- |
| Resumes & Job Descriptions of the Administrator & Director of Nursing | Included |
| State Inspection Reports Along With Any Complaint Investigations -  Include All Statements of Deficiencies & Plans of Correction | Included  Not Included  Not Applicable |
| State License | Included  Not Applicable |

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions**

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| --- |
| Signature of Applicant |
| Title |
| Date |