HAMILTON

Clear Form

LONG-TERM CARE RESIDENTIAL APPLICATION

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space than is given, continue in the comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

Required documents, in addition to this application:

- Loss runs, dated within 60 days of submission, covering the past five years
- Declarations page from current insurance carrier, showing retroactive date if claims-made coverage
- Most recent state survey reports, licensure reports and accreditation survey reports as applicable
- Current license
- Resume of owner or administrator

APPLICANT INFORMATION

Legal Name of Applicant:	
Mailing Address: (Street, City, State, Zip Code):	
Location Address: (If different from above)	

(If there are multiple locations, please attach a list separately)

Date Established:		**Website:**					
Legal Structure:	For Profit ☐	Non-Profit ☐	Government ☐	Other (explain)			
Sole proprietorship ☐	Corporation ☐	Partnership ☐	Joint Venture ☐				

Main Contact (name, position):		**Telephone Number:**	
Manager/Owner:			
Brief description of experience or attach résumé:			

COVERAGE REQUESTED (Attach current Dec Page or Policy, if applicable)

Policy Period:				
Professional Liability Limits:	Per Claim:	$	Aggregate:	$
General Liability Limits:	Per Claim:	$	Aggregate:	$
Deductible: $	**Retroactive Date:** (declarations page required)			
Other Coverage requests:				

GENERAL INFORMATION

1. Years of operation:		**Owned by Present Owner:**		
2. Is the applicant managed by a management company?			○ Yes	○ No
If yes, please answer the following:				
a) Name of management company?				

HAMILTON

b) How many years in place with this management company?		
c) Who is the professional liability insurance carrier for the management company?		
d) Do you require proof of coverage?	○ Yes	○ No
e) Describe management services provided:		

3. Please provide the total annual revenue for the years indicated below:			
Revenue Source	**Projected**	**Current**	**1 Year Prior**
Medicare:	$	$	$
Medicaid:	$	$	$
Private Pay:	$	$	$
Charitable:	$	$	$
Total Gross Revenue:	**$**	**$**	**$**

4. Subsidiaries and Affiliates, if none, check here ☐

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims Made	Coverage Desired? Y/N
		%				
		%				

5. Licensing (include copies of licenses)		
Has the applicant's license ever been suspended, revoked, or placed under probation?	○ Yes	○ No
If yes, please explain:		

6. Has the applicant ever filed for bankruptcy?	○ Yes	○ No
If yes, please explain:		

7. Inspection/Surveys	
When was the last inspection/survey of the applicant by an outside entity?	
Indicate total number of deficiencies:	
Was a corrective action plan accepted by the state?	○ Yes ○ No
How many patient/family complaints were investigated in the past three (3) years?	
How many complaints were substantiated?	

8. Please provide location information:

Buildings	#1		#2		#3		#4	
Type of construction:								
No. of stories:								
Square footage:								
Date built:								
Smoke detectors	○ Y	○ N	○ Y	○ N	○ Y	○ N	○ Y	○ N
Local/central station fire alarm	○ Y	○ N	○ Y	○ N	○ Y	○ N	○ Y	○ N
Sprinkler system:	○ Y	○ N ○ P	○ Y	○ N ○ P	○ Y	○ N ○ P	○ Y	○ N ○ P

P = partial

HAMILTON

9. Is there a pool at any location?	◯ Yes	◯ No
If yes, is there a fenced, self-locking gate?	◯ Yes	◯ No
If yes, are there slides and/or diving boards?	◯ Yes	◯ No

OPERATIONS

10. Please provide the following:

	Number of Licensed Beds:	Average Occupancy:
Skilled Care		
Intermediate Care		
Assisted Living – Memory Care		
Assisted Living		
Elderly Independent Living		
Other (please specify)		

11. Resident Census:	
Number of Alzheimer's/Dementia Residents	
Number of Ambulatory Residents	
Number of Bedridden Residents	

12. Residents in each age range:			
0-55		75-84	
55-65		85+	
65-74		**Total Resident Count:**	
Please provide an explanation for any residents under the age of 55:			

13. Decubitus Ulcers/Pressure Sores		
Stage	Acquired Ulcers	Inherited Ulcers
I		
II		
III		
IV		

14. Are resident assessments done prior to admission for the following conditions?		
Alzheimer's/Dementia	◯ Yes	◯ No
Bedsores/History of Skin Breakdown	◯ Yes	◯ No
Risk of Falls	◯ Yes	◯ No
Wandering or Elopement Risk	◯ Yes	◯ No
Violent Behaviors or Aggressive Tendencies	◯ Yes	◯ No
15. Who performs resident assessments?		
16. How often are these assessments done after admission?		

17. How many residents have eloped from your facility in the last 3 years?	
If any, please provide details:	

18. Are there sign-out procedures?	◯ Yes	◯ No
19. Are there alarms on doors to prevent clients from wandering from the residence?	◯ Yes	◯ No

HAMILTON

20. Please describe any other precautions that are made to keep track of residents:

21. Do you provide care for any residents with the following conditions?		
Traumatic Brain Injury	○ Yes	○ No
Chemical Dependency	○ Yes	○ No
Tube Feeding	○ Yes	○ No
Ventilator/Tracheostomy Services	○ Yes	○ No
Psychiatric/Sociopathic/Schizophrenic	○ Yes	○ No
If "Yes" to any of the questions above, please explain below:		

22. Are adult daycare services provided to non-residents?	○ Yes	○ No
Total number of licensed slots		
Average daily participants		
Any overnight stays? If "Yes" please explain below	○ Yes	○ No

23. Are pull cords/call buttons provided in each resident's room? If "yes":	○ Yes	○ No
Is there Direct 911 Notification?	○ Yes	○ No
Is there Third Party Monitoring?	○ Yes	○ No
If yes, provide the name of the Third Party:		
Is there a Front Desk Notification?	○ Yes	○ No
If yes, explain the response protocol:		
Is there a Hall Light/Alarm?	○ Yes	○ No
Does the resident agreement include call button protocols?	○ Yes	○ No

STAFF

24. Indicate number of staff			
	1st Shift	**2nd Shift**	**3rd Shift**
Administrators			
DON			
Licensed practical nurses (LPN)			
Nurse aides/CNAs			
Therapists			
Students/Volunteers			
Therapists			
Other (specify)			

25. Are all of the above Individuals licensed in accordance with applicable state and federal regulations?	○ Yes	○ No
If "No", please explain:		
26. Do you require contracted staff to carry their own professional liability insurance?	○ Yes	○ No

HAMILTON

If yes, minimum limits of insurance required:			
Per Claim/Occurrence:		Aggregate:	

27. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:			
☐	Check of educational background or residency program, when applicable		
☐	Check of previous employers	☐ In writing	☐ By telephone
☐	Criminal background check	☐ State	☐ Federal
☐	Drug screening		
☐	Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities		
☐	Require information on any professional liability or work-related claim that has previously been made against any individual?		

INSURANCE AND LOSS HISTORY

28. Professional Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
If the current policy is claims-made, what is the current retroactive date?					

29. General Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
If the current policy is claims-made, what is the current retroactive date?					

For any "Yes" answers to the following questions, please provide detailed information in the Supplemental Information section of this application or provide separate attachments.

30. Has any insurance company ever rescinded, cancelled or non-renewed any similar insurance for the applicant?	◯ Yes	◯ No
31. Has the applicant or any of its employees ever been charged with or convicted of a crime?	◯ Yes	◯ No
32. Has any claim been made or suit been filed against the applicant or any other person proposed for this insurance? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No
33. Do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No
34. Is the applicant or any person proposed for this insurance aware of any known losses, claims or suits that have not yet been reported?	◯ Yes	◯ No

HAMILTON

If "Yes", please complete supplemental claim/incident form for each.		
35. Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a claim? **If "Yes", please complete supplemental claim/incident form for each.**	◯ Yes	◯ No

SUPPLEMENTAL INFORMATION

Please use this section to provide additional details for Questions 30-35, or for any other questions requiring additional space for answers.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA,WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA 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 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 the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

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 APPLICANTS: Any person who knowingly and with intent to defraud an 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 $5,000 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/she 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 a 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 the person to criminal and civil penalties.

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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

HAMILTON

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant Signature _____ **Title:** _____

(Must be signed by an owner, principal, partner or officer) **Date:** _____