



CFC Underwriting

CareSurance™ Application Form

THE INSURANCE WE PROVIDE

We, at CFC, have tailored this CareSurance™ insurance policy for the specific needs of Nursing Homes.

We fully appreciate the value of your time and thank you for providing the important information which will allow us to accurately assess the risks which you face.

The purpose of our insurance is to indemnify you against your liability which arises from your breach of duty.

You must refer to our insurance policy which fully explains the rules governing the way we provide the cover, those things which are not covered and your obligations to us.

THIS PROPOSAL FORM

The purpose of this proposal form is for us to find out who you are and what material information specific to your circumstances for this cover. Completion of this proposal form does not oblige either party to enter into a contract of insurance.

Insurance is a contract of utmost good faith. This means that the information you provide in this proposal form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your proposal for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed.

If a contract of insurance is agreed between you and us this proposal form will form the basis of the contract.

Whoever fills out the form must be a principal, partner or director of the proposer and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered.

CareSurance™ Long Term Solutions For Long Term Care

APPLICATION FOR PROFESSIONAL AND COMMERCIAL GENERAL LIABILITY INSURANCE

I. GENERAL INFORMATION (CORPORATE)

A. Name: _____

Address: _____

Telephone: _____ Facsimile: _____

E-Mail: _____ Web Address: _____

B. List all subsidiaries for which coverage is required, date acquired, description of operations and percentage of ownership. (Attach separate page if necessary)

<u>Name</u>	<u>Percentage of Ownership</u>	<u>Date Acquired</u>	<u>Operations</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Applicant is (check all that apply):

_____ Individual	_____ For-Profit	_____ Charitable
_____ Partnership	_____ Not For Profit	_____ Other (Describe:)
_____ Corporation	_____ Government	_____

D. Are all facilities:

Medicare Certified: Yes No

Accredited by JCAHO: Yes No

Licensed/Approved State Board of Health: Yes No

If "no" please explain: _____

SECTION II THROUGH AND INCLUDING SECTION VIII MUST BE COMPLETED FOR EACH FACILITY.

II. FACILITY INFORMATION

Name: _____

Address: _____

County: _____

A. Number of Years:

- In operation: _____

- Owned by present owner: _____

- Managed by present management: _____

B. List all association memberships held:

C. **Attach copies of all licenses held.**

D. Provide facility classifications and bed census:

Skilled Care Services

Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following:

- Medical Administration
- Other procedures ordered by physician
- Injections
- Tube feeding
- Catheterizations

Intermediate Care Services

Nursing care during the day shift, 7 days, per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc). Assistance with activities of daily living (e.g., walking, bathing, dressing, eating). Some assistance with administering medications.

Residential Care Services / Assisted Living / Personal Care

Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs). Residents are eligible for incidental health care services, including assistance with medications.

Independent Living

Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.

	<u>Total # Licensed Beds</u>	<u>Average # Occupied</u>	
1)	_____	_____	Skilled Care Services
2)	_____	_____	Intermediate Care Services
3)	_____	_____	Residential Care Services
4)	Number of Residents: _____		Independent Living
5)	_____		Other – Define

E. Number of visits per year for all outpatient services provided or state "None". _____

<u>Services</u>	<u>Visits</u>
Adult Day Care	_____
Home Health Care, Personal Care, Chore or Companion Services	_____
Infusion Therapy	_____
Occupational Rehabilitation	_____
Physical Therapy	_____
Rehabilitation Therapy	_____
Respiratory Therapy	_____
Other _____	_____

F. Resident/Patient Profiles:

<u>Age Group</u>	<u>Number</u>	<u>% Non Ambulatory</u>
Under 50:	_____	_____
50 – 65:	_____	_____
Over 65	_____	_____

G. State number of employees in each classification. If none, state "None". Show number of employees in full time equivalents (FTE's) based on 40 hrs. per week. For example, 4 RN's each working 10 hrs. per week equals 1 FTE.

	1ST SHIFT	2ND SHIFT	3RD SHIFT
Administrative Personnel			
Beauticians/Barbers			
Dieticians			
Licensed Practical Nurses			
Maintenance/Security Personnel			
Nurse's Aides			
Physical Therapists			
Physicians			
Recreation Therapists			
Registered Nurses			
Social Workers			
Speech Pathologists			
Others – Describe:			

H. Administrator's name and summary of experience.

I. Is there a full time employed medical director? Yes No

III. HIRING/STAFFING PROCEDURES

A. Check all procedures you use when hiring professional and para-professional staff:

- Check of educational background or residency program, when applicable
- Check of previous employers: in writing by telephone
- Check on hospital privileges for physicians, oral surgeons and dentists.
How often do you update your list of specific privileges? _____
- 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 the individual.

B. Do you have written job descriptions? Yes No

C. Are all employees required to attend an orientation program prior to beginning their employment? Yes No

Describe or attach the agenda for your orientation program.

D. Do you have a new employee preceptor, mentor or "buddy" program? Yes No
For which classes of Employees? How does it work? How long do you monitor new caregivers?

E. Provide full details of methods used to ensure you are fully and properly staffed at all times.

F. Do you have regularly scheduled inservices? Yes No
Describe and attach the type of inservices that have been conducted in the past six months.
By whom have they been conducted?

G. How do you ensure attendance at your inservices? Are they mandatory?

H. Do you perform criminal background investigations on all potential employees? Yes No

I. Annual staff turnover ratio for:

RN's ____% LPN's ____% CNA's ____%

J. Please provide ratios of staff to residents for RN's, LPN's and CNA's

IV. RISK MANAGEMENT

A. Are all new residents required to have evidence of acceptable health (physical examination)?
How is this assured?

B. Describe security measures to control unauthorized entrance: _____

C. Evacuation Procedures:

- Is there a written emergency evacuation plan? Yes No
- Does it include advance arrangements for transport and temporary shelter? Yes No
- Are evacuation directions posted in all areas? Yes No
- Is a review and "walk through" of disaster plans a part of staff orientation? Yes No
- How often are fire/evacuation drills conducted each year? _____

D. As respects skilled and intermediate care:

Do all residents have their own attending physician? Yes No
If "no", who performs that role? _____

- Are written orders required from attending physician for:

- All Drugs/Medicines Yes No
- Dietary Special Requirements Yes No
- Specific Therapy/Treatment Yes No

E. How often are resident's charts updated by the attending physician? _____ # of days

F. Do you conduct a nursing assessment for new residents? Yes No

Does it include:

- History of prior injury? Yes No
- Disorientation? Yes No
- Mobility limitations? Yes No
- Required assistance? Yes No

G. Is advance written consent obtained from resident or guardian allowing you to provide non-emergency medical care? Yes No

H. Is smoking permitted in resident rooms? Yes No

Describe other rules applying to smoking: _____

I. Is there a physician on site or on call on a 24 hour basis? Yes No

J. Who determines if a patient must be transferred elsewhere for medical diagnosis or treatment?

K. Medication Error Control

1) Do you employ _____ or contract _____ with a registered pharmacist to supervise pharmacy services?

2) How often does the pharmacist review every resident record?

3) Describe the method used to prevent medication errors.

4) Does your consultant Pharmacist review your incident log? Yes No

5) Are any of your residents receiving 9 or more medications Yes No

If yes, how many: _____

L. Fall Prevention

1) How often and when are residents assessed for their risk of falls?

2) How are patients identified as “at risk” for falls?

3) Describe your fall prevention program. Attach a copy of your policy and procedures.

4) Describe other methods you have to prevent falls.

5) What percentage of your residents are physically restrained?

6) What techniques are utilized to reduce the use of restraints?

7) How many residents in the past year have had falls from bed or while ambulating, which required transport of the resident to a hospital or other facility for treatment or evaluation? What percentage of residents over a 12-month census does this represent? _____%

8) What other fall prevention strategies have you adopted?

M. Elopement/Wandering Prevention

1) How and when is your Elopement Prevention program implemented?

2) How are your entrances/exits secured?

3) Is there a system in each facility to identify residents “at risk” for wandering?
 Yes No

4) Describe other methods you have to prevent patient elopements.

5) How many elopements occurred in your facilities in the past 12 months that required implementation of your elopement procedures?

N. Pressure Ulcer and Skin Care

1) Describe your program to prevent pressure ulcers. Attach a copy of your policy and procedures pertaining to this.

2) How often are resident skin assessments made? Provide the tool used to assess and document residents’ skin condition.

3) How many residents in the past year developed pressure sores after admission? What percentage of residents over a 12-month census does this represent? _____%

4) Do you have a wound care team or designated individual responsible for this program?
 Yes No
If yes, describe the additional training or credentials of the team/individual.

5) Describe the staging system that you use when assessing a wound.

6) On average, how many residents are receiving weekly special skin care?

7) Describe additional quality improvement efforts to reduce pressure ulcers.

O. Safety Committee Risk Management and Incident Reports

1) What criteria do you use for reporting incidents or occurrences?

2) Explain how you track and trend incident information.

3) How are substantial complaints addressed?

4) Describe the components of your Safety/Risk Management program as it pertains to professional liability issues. Attach a copy of your policy and procedures.

P. Physical/Sexual Abuse

1) Attach a copy of your policy and procedures related to physical and sexual abuse.

2) How many reported physical abuse incidents (upon residents) occurred in your facility in the past 12 months? _____

a. How many involved allegations of resident-to-resident physical abuse? _____

- b. How many involved allegations of employee-to-resident physical abuse? _____
- c. How many of the reported physical abuse allegations were substantiated? _____

Provide complete details of substantiated physical abuse allegations.

3) How many reported sexual abuse incidents (upon residents) occurred in your facility in the past 12 months? _____

- a. How many involved allegations of resident-to-resident sexual abuse? _____
- b. How many involved allegations of employee-to-resident sexual abuse? _____
- c. How many of the reported sexual abuse allegations were substantiated? _____

Provide complete details of substantiated sexual abuse allegations.

Q. Weight Loss Monitoring and Prevention Program

- 1) How often are your residents monitored for weight loss? Please attach a copy of your policy and procedures pertaining to this. _____
- 2) Does your facility employ a Registered Dietician to evaluate each resident's needs?
 Yes No
- 3) How many residents in the past year experienced a significant weight loss? (5% or > in the past 30 days; or 10% or > in the past 180 days.)

R. Additional Information

- 1) What is your facility's quality improvement team doing to improve quality (i.e.: pressure ulcers, fall prevention, B&B retraining, sentinel events [fecal impaction, dehydration, and pressure ulcers in low risk residents])?

2) How many complaints were investigated by the State in the past year? _____

a. How many were substantiated? _____

Provide complete details of substantiated complaints investigated by the State.

b. Has your facility ever had an immediate jeopardy determination? Yes No
If yes, please provide complete details.

3) Have you ever been de-licensed, de-certified, issued a restricted license, had reimbursement denied, or had new admissions restricted or denied? Yes No

If yes, provide full details and documentation.

V. CONTRACTUAL AGREEMENTS

A. Please list all contracted professional services provided for you and the minimum professional liability insurance limits you require of each provider: (Attach additional pages if necessary)

<u>Services Contracted</u>	<u>Limits Required</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

B. Are there other service contracts in effect? Yes No
Please describe: _____

VI. LOSS INFORMATION

A. Describe in detail each professional liability and general liability claim or suit made against you in the past 5 years. (Identify location if you have more than one facility).

1. Attach a currently dated loss summary from current and prior insurers (past 5 years).
2. If you do not have a loss summary, attach a separate sheet for each claim showing:
 - Date of event and date reported to you / to insurance carrier
 - Description of Cause of event
 - Current Status (Open or Closed matter)
 - Amounts Paid and/or Current Reserves. Specify indemnity payments and expenses.

VII. CURRENT INSURANCE INFORMATION

Current Professional Liability Insurer: _____

Policy Period: _____

Limits: \$ _____

Deductible or Self Insured Retention: \$ _____

Claims Made Form? _____ Occurrence Form? _____

If Claims Made, Retroactive Date: _____ Premium: \$ _____

Employee Benefits Liability Retroactive Date: _____

VIII. GENERAL LIABILITY/BUILDING INFORMATION (Complete for Each Facility.)

A. Construction/Protection

1. Name of facility _____

2. Address of facility _____

3. Year built _____

4. Construction type _____

5. Number of stories _____

6. Originally designed as long term care facility? Yes No

If no, what was original purpose? _____

7. Sprinkler System

- Is building completely sprinklered? Yes No

17. Are you planning any new construction for the next twelve months? Yes No

If yes, use the comment section to describe the purpose, estimated costs and estimated completion date for such construction.

18. Recreation Facilities: Please check here if “None”: or,

Please indicate number corresponding to item below.

Swimming Pool _____ Exercise/Weight Room _____

Sauna/Hot Tub _____ Other: _____

Tennis or Racquetball Court _____ Other: _____

B. Please provide details of all General Liability claims or suits against you for the past 5 years which were not listed in Section VI as follows:

<u>Policy Year</u>	<u>Date of Loss</u>	<u>Cause of Loss</u>	<u>Status:</u> <u>Open / Closed</u>	<u>Reserves</u>	<u>Amounts Paid</u>
to					
to					
to					
to					
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to					
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to					
to					

IX. ATTACHMENTS

Attach the following:

1. Most recent audited financial statement
2. Most recent State Surveys including re-visits and compliance letters
3. Loss Runs for the last five years with a Loss Summary Sheet outlining the claims
4. Narrative by the Insured of all open claims and all claims closed over \$25,000 in the last five years.
5. Fall Prevention Policy
6. Elopement/Wandering Policy
7. Pressure Ulcer/Skin Care Policy
8. Abuse (Physical/Sexual) Policy
9. Safety/Risk Management Policy
10. Orientation Program

- 11. Inservice Program
- 12. Admission Material and Agreements
- 13. Copy of all Licenses

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART THEREOF.

COMMENT SECTION

Applicant Name: _____

Applicant Signature	Printed Name and Title	Date
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Agent Signature	Agent Printed Name	Date
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Agency: _____

NAME

ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE	FAX	EMAIL
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