








KINSALE INSURANCE

REQUESTED COVERAGE – SKILLED NURSING, ASSISTED AND INDEPENDENT LIVING

☐ **Requesting Professional Liability:**

Requested Retro Date: _____

Professional Liability Limits		Professional Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting General Liability:**

Requested Retro Date: _____ or ☐ Occurrence Based Coverage

General Liability Limits		General Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: _____

Employee Benefits Liability Limits		Employee Benefits Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $1,000	☐ $10,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $2,500	☐ $15,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $5,000	☐ $20,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $7,500	☐ $25,000

☐ **Requesting Non-Owned Auto Liability (supplement required):**

Non-Owned Auto Liability Limits

☐ $100,000	☐ $500,000
☐ $200,000	☐ $1,000,000
☐ $250,000	☐ Other: _____

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.

Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

SKILLED NURSING, ASSISTED LIVING, AND INDEPENDENT LIVING

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days
  - HCFA 672 resident census (Have/Need item)
  - Copy of most recent State Inspection including management responses

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Mailing Address: _____
STREET CITY COUNTY STATE ZIP

3. Location Address: Check here if same as mailing: ☐

(1) _____
STREET CITY COUNTY STATE ZIP

(2) _____
STREET CITY COUNTY STATE ZIP

(3) _____
STREET CITY COUNTY STATE ZIP

(4) _____
STREET CITY COUNTY STATE ZIP

Attach Additional Pages as Needed

4. Website Address: **www.**_____ 5. Telephone: _____

6. Inspection contact: _____

7. Date Established _____ Years under current management _____

8. Applicant is a:

☐ Individual
☐ Corporation
☐ LLC
☐ Professional Associations
☐ Partnership
☐ Joint Venture
☐ Other: _____

9. Enterprise is: ☐ For Profit ☐ Not For Profit

10. Is this entity owned by, associated with or controlled by any other entity? Yes ☐ No ☐

If yes, please provide details:

_____

_____

OPERATIONS

11. Facility classification and bed census:

	Total No. of beds	**Avg. No. Occupied**
Skilled Nursing Facility provides 24- hour a day nursing care by licensed professionals. Most patients are entirely dependent upon these staff professionals for assistance with basic Activities of Daily Living (ADL); these include bathing, dressing, feeding and mobility. Additional services may include administering injections, tube feedings and catheterizations.	_____	_____
Intermediate Care Facility provides similar types of care as Skilled Nursing but at a generally lower acuity. Most patients require assistance with ADLs. Facilities typically do not administer injections or tube feedings, but may assist with medication administration.	_____	_____
Assisted Living (non-ambulatory) Facility provides residents with minimal levels of health care by professional staff. Residents are generally non-ambulatory and require some assistance with ADLs; non-ambulatory patients are those that are wheelchair or bed bound and cannot walk without assistance; Alzheimer's patients are also considered non-ambulatory.	_____	_____
Assisted Living (ambulatory) Facility provides residents with minimal levels of health care by professional staff. Residents are generally ambulatory with minor exceptions for patients with walkers or those required to temporarily utilize a wheelchair. Generally these patients require minimal assistance with ADLs. Residents also receive assistance with medications and other incidental health care services.	_____	_____
Group Homes Facility provides structured living accommodations for senior citizens that are ambulatory and not dependent on others for ADLs. Facilities are typically under the direct supervision of a live-in supervisor or director. This classification will only apply to facilities that house seniors in a setting with some form of group activities (communal dining, social gatherings, group activities, etc).	_____	_____
Independent Living/Apartment Care Facility provides living accommodations for retirement-aged citizens who are in good general health, requiring no assistance with ADLs, medications or health care services. There generally will not be a live-in supervisor, but facilities may still offer voluntary social events, transportation and limited food service.	_____	_____

12. Please provide:

	Location 1	Location 2	Location 3
Number of licensed beds?			
Number of occupied beds?			
How many dementia residents (including Alzheimer's)?			
How many residents receiving skilled care?			
How many residents receiving intermediate nursing care?			
How many residents are independently ambulatory?			
How many residents ambulate with assistance?			
How many residents are in a wheelchair all or most of the day?			
How many residents are bedridden?			
Minimum number of staff on duty during the third shift?			
Indicate number of residents in each age range:	___ 0-18 ____66-74 ___19-39 ____75-84 ___40-65 ____85+	___0-18 ____66-74 ___19-39 ____75-84 ___40-65 ____85+	___0-18 ____66-74 ___19-39 ____75-84 ___40-65 ____85+

13. Please state sources and amounts of total revenue:

Source	Last 12 months	Next 12 months
Medicare	$_____	$_____
Medicaid	$_____	$_____
Charitable	$_____	$_____
Private Pay	$_____	$_____
Total Gross Revenue	$_____	$_____

Please indicate number of residents receiving:

a. Rehabilitation – Physical, Occupational or Speech therapy _____

b. Drug or alcohol rehabilitation _____

c. Psychiatric Care _____

d. Treatment for mental retardation _____

e. Other – Please specify _____

ADMISSION POLICIES

14. Is a nursing assessment conducted for all new residents? Yes ☐ No ☐

If yes, does it include:

a. Mobility limitations Yes ☐ No ☐

b. History of prior illness and injuries Yes ☐ No ☐

c. Required assistance Yes ☐ No ☐

d. History of wandering/ elopement Yes ☐ No ☐

e. History of skin problems Yes ☐ No ☐

f. History of falls Yes ☐ No ☐

g. Psychiatric history Yes ☐ No ☐

h. Cognition Limitations Yes ☐ No ☐

15. Who completes pre-admission assessments? _____

a. Years experience at facility _____

b. Years experience in position _____

16. Do you accept residents who are a threat to themselves or others? Yes ☐ No ☐

17. Is a current (within 60 days) physical required for admission? Yes ☐ No ☐

18. How often is the care plan updated? _____

19. Does each resident have their own attending physician? Yes ☐ No ☐

If no, who performs the attending physician role? _____

STAFF

20. Please indicate the number of employed and contracted staff by type:

Profession	Employed		Contracted		1st Shift	2nd Shift	3rd Shift
	Full-Time	Part-Time	Full - Time	Part-Time			
Administrators							
Physicians							
DON/ADON							
Nurses (RN, LPN)							
Nurse Aids							
Resident Assistants							
Social Workers							
Therapists							
Students/Volunteers							
Other (Specify):_____							

21. a. Are all above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If no, please explain. _____

b. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

22. Please provide name and qualifications of medical director _____

_____

23. What is the staff turnover ratio? _____%

24. 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 / Alcohol / Abuse Screening (circle all that are used)
- ☐ 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?

MONITORING AND RISK MANAGEMENT

25. Does your facility have a locked unit for residents prone to wandering? Yes ☐ No ☐

26. What system is in use for residents prone to wandering? _____

27. Are all exit doors at all locations alarmed? Yes ☐ No ☐
If no, please explain _____

28. How many residents have eloped from your facility in the past three years? _____
If any, please provide details _____

29. Are residents allowed to leave the premises unattended? Yes ☐ No ☐
If yes, what procedures are in place to monitor whereabouts? _____

30. Are all medications kept in a secured locked location with limited key access? Yes ☐ No ☐
If no, please explain _____

31. Is the unit dose medication system used by your facility? Yes ☐ No ☐

32. Is a licensed pharmacist on staff or is there an agreement with an outside pharmacy? Yes ☐ No ☐

33. Is this a non-smoking facility? Yes ☐ No ☐

If no, please provide details as to your smoking policy _____

34. Are call buttons or pull cords provided in each resident's room? Yes ☐ No ☐

35. Are handrails installed in hallways and bathrooms? Yes ☐ No ☐

36. Do tubs and showers have non-slip surfaces installed? Yes ☐ No ☐

37. Please describe all bodies of water on the premises (including pools), their use, and safeguards currently in place.

_____

_____

38. State Inspection:

Date of last State Inspection/Survey: _____
Total # of Deficiencies: _____
Number of D, E & F Deficiencies (Nursing Homes only): _____
Number of G, H & J Deficiencies (Nursing Homes only): _____
Corrective Action Plan accepted by State: Yes ☐ No ☐
Date accepted: _____
Number of complaints investigated by State the past 2 years: _____
Number of substantiated complaints: _____

39. Bedsore Information: Reporting Date: _____/_____/_____

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage II		
Stage III		
Stage IV		

PREMISES INFORMATION

40. Building Description

	Buildings/Wings #1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

41. Do any of the Applicant's locations have any (explain any "yes" answers on page 10):

a. Exposure to flammables, explosive, chemicals? Yes ☐ No ☐
b. Catastrophe exposure? Yes ☐ No ☐
c. Exposure to radioactive materials? Yes ☐ No ☐

COVERAGE AND LOSS HISTORY

42. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Retroactive date

43. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Occurrence or Claims – Made?

If the current expiring GL policy is claims - made what is the retroactive date? _____

Provide details for all "yes" answers to questions 44 - 51 on pages 9 - 10 or attach additional pages as needed.

44. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? Yes ☐ No ☐

45. Has the applicant or any of its employees ever been charged with, or convicted of a crime other than minor traffic violation? Yes ☐ No ☐

46. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

47. Has any insurance company ever rescinded, cancelled, non-renewed, or declined any similar insurance for the applicant? Yes ☐ No ☐
If yes, please provide a detailed explanation.

48. Has any claims or suit for ever been made against the applicant **OR** any other person proposed for this insurance? **(Complete Supplemental Claims form for Each.)** Yes ☐ No ☐

49. Have there been any claims or do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation? Yes ☐ No ☐

50. Is the applicant or any person proposed for in this insurance aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? **(Complete Supplemental Claims form for Each.)** Yes ☐ No ☐

51. 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 or suit? **(Complete Supplemental Claims form for Each.)** Yes ☐ No ☐

SUPPLEMENTAL INFORMATION

Use the remainder of this page as needed or to address questions referenced within the application

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 a 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.

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: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent / Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle?
☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?
Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____