

# ALF / IL APPLICATION

FULL NAME OF INSURED (S): \_\_\_\_\_

LOCATION: \_\_\_\_\_  
\_\_\_\_\_

Proposed effective date: From \_\_\_\_\_ to \_\_\_\_\_  
12:01 A.M. Standard Time at the address of the Applicant

Applicant is:  Individual  Corporation  Partnership  Joint Venture  Other (Specify) \_\_\_\_\_

1. Is the above Named Insured the parent company and sole owner of each location listed above, if not provide details:  
\_\_\_\_\_
2. Operating as:  Profit  Non-Profit Number of licensed beds: \_\_\_\_\_
3. Named Insured is:  Building Owner  Tenant  General lessee
4. Are there any other occupants of the premises?  Yes  No If yes, identify: \_\_\_\_\_
5. Officers and general partners \_\_\_\_\_ Titles \_\_\_\_\_  
\_\_\_\_\_
6. How many years has the facility been in business under the current ownership? \_\_\_\_\_
7. How many years experience does the current ownership have in health facilities? \_\_\_\_\_
8. What professional or industry associations(s) is the facility a member in good standing? \_\_\_\_\_
9. Name of administrator: \_\_\_\_\_  
(a) How long at this facility? \_\_\_\_\_  
(b) Experience as administrator or assistant administrator: \_\_\_\_\_ years
10. Who is in charge when administrator is absent? (name and title) \_\_\_\_\_
11. Is the facility certified for: Medicare?  Yes  No  
Medicaid?  Yes  No  
Other?  Yes  No
12. Number of patients in each category? Private Pay \_\_\_\_\_ Medicare \_\_\_\_\_  
Medicaid \_\_\_\_\_ Other \_\_\_\_\_
13. Gross annual receipts of the facility (including Medicare and Medicaid): \$ \_\_\_\_\_
14. Please attach the most recent copies of state and county inspections. Are there any deficiencies uncorrected?  Yes  No
15. License information:  
(a) Please attach all licenses required for this facilities operation.  
(b) Is licensing conditional, provisional, probationary or temporary?  Yes  No. If yes, PLEASE ATTACH EXPLANATION.  
(c) Has license ever been revoked?  Yes  No If yes, please explain \_\_\_\_\_

16. Patient / Resident Age Groups

Age Group	Number of Patients / Residents	% Non-Ambulatory
Under 50	_____	_____
50 – 65	_____	_____
Over 65	_____	_____

17. State approximate division of patients:

_____ % Surgical	_____ % Mentally ill/mentally disabled	_____ % Developmentally disabled
_____ % Senile or aged	_____ % Drug addicts	_____ % Alcoholics
_____ % Alzheimer	_____ % AIDS/HIV*	_____ % Any other classes

\*Complete question 50.

18. Physical features of risk:

Construction of building: \_\_\_\_\_ Area of building: \_\_\_\_\_  
 Number of floors: \_\_\_\_\_ Are any non-ambulatory residents above second floor? \_\_\_\_\_  
 Year built: \_\_\_\_\_ Age and type of heating system: \_\_\_\_\_  
 Age and type of wiring: \_\_\_\_\_ Date if remodeled: \_\_\_\_\_  
 Purpose for which building was originally constructed: \_\_\_\_\_  
 Number of fire extinguishers on premises: \_\_\_\_\_ Tagged/inspected: \_\_\_\_\_ Number of fire escapes: \_\_\_\_\_  
 Any swimming pools? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, is it fenced? \_\_\_\_\_ Yes \_\_\_\_\_  
 Are patients allowed to use the pool? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what security measures are taken? \_\_\_\_\_

Is staff trained in CPR and emergency training for water emergencies? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is the ratio of staff to patients? \_\_\_\_\_

Equipped with sprinkler system? \_\_\_\_\_ Yes \_\_\_\_\_ No Where \_\_\_\_\_

All rooms and halls equipped with smoke detectors? \_\_\_\_\_ Yes \_\_\_\_\_ No

Equipped with fire alarm? \_\_\_\_\_ Yes \_\_\_\_\_ No Central station \_\_\_\_\_ Local alarm \_\_\_\_\_

Are there alarms or monitors on exit doors to prevent patients from leaving the premises without authorization?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No If no, how is ingress/egress monitored? \_\_\_\_\_

What security measures are used to control unauthorized entrances to the facility? \_\_\_\_\_

Are doors equipped with panic hardware? \_\_\_\_\_ Yes \_\_\_\_\_ No

Distance to nearest fire station? \_\_\_\_\_ Distance to nearest fire hydrant? \_\_\_\_\_

Are handrails provided in hallways and bathrooms? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are bathtubs and showers equipped with nonskid surfaces? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does facility have tempering valves to control the temperature of the patients water? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how often are they checked? \_\_\_\_\_

Temperature of hot water \_\_\_\_\_ F

Are there separate hot water systems for utility and bath areas? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does the home have emergency lighting? \_\_\_\_\_ Yes \_\_\_\_\_ No

Where are the powered equipment and fuel stored? \_\_\_\_\_

Are there any underground storage tanks? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is the overall condition of the property including maintenance and housekeeping? \_\_\_ Excellent \_\_\_ Good \_\_\_ Average

Cooking: \_\_\_\_\_ Gas \_\_\_\_\_ Electric \_\_\_\_\_ None \_\_\_\_\_ Fair \_\_\_\_\_ Poor

If none, describe food service: \_\_\_\_\_

Is stove vented outside with hood and grease filter? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are filters clean? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are hood and cooking surfaces protected with automatic extinguishing system? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are all cooking surfaces directly protected? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is automatic fuel shutdown interlocked to system? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is there any deep fat frying? \_\_\_\_\_ Yes \_\_\_\_\_ No

19. Emergency procedures:

1. Written emergency evacuation plan? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Does plan include advance arrangement including transportation and emergency shelter? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Are evacuation procedures posted in all parts of your facility? \_\_\_\_\_ Yes \_\_\_\_\_ No

4. Are drills conducted regularly for each shift? ..... Yes \_\_\_ No \_\_\_  
 5. Is the entire staff familiar with the emergency evacuation plan? ..... Yes \_\_\_ No \_\_\_  
 6. Is the plan filed with the local fire department? ..... Yes \_\_\_ No \_\_\_

20. Classify number of employees by shift:

	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift		1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
Physicians, interns, residents	_____	_____	_____	Recreational therapists	_____	_____	_____
Graduate nurses / RN	_____	_____	_____	Occupational therapists	_____	_____	_____
Practical nurses / LPN	_____	_____	_____	X – ray technicians	_____	_____	_____
Nurses aides	_____	_____	_____	Lab technicians	_____	_____	_____
Student nurses	_____	_____	_____	Maintenance/security	_____	_____	_____
Physical therapists	_____	_____	_____	Special technicians	_____	_____	_____
Inhalation therapists	_____	_____	_____	Dentists	_____	_____	_____
Dieticians	_____	_____	_____	Administrative	_____	_____	_____
Beauticians/barbers	_____	_____	_____	Kitchen	_____	_____	_____
Respiratory therapists	_____	_____	_____	Housekeeping	_____	_____	_____
Social worker	_____	_____	_____	Laundry	_____	_____	_____
Speech therapists	_____	_____	_____	Other	_____	_____	_____
Total number of employees	_____	_____	_____	Full –time: _____	Part-time: _____		

Staff turnover \_\_\_\_\_ % last twelve (12) months

21. Physicians:

- (a) Residents are \_\_\_ expected \_\_\_ required to have their own physician.  
 (b) Does facility or contract any of the following?

**EMPLOYED**

**CONTRACTED**

Psychologists	___ Yes ___ No	If yes, how many? _____	___ Yes ___ No	If yes, how many? _____
Dentists	___ Yes ___ No	If yes, how many? _____	___ Yes ___ No	If yes, how many? _____
Psychiatrists	___ Yes ___ No	If yes, how many? _____	___ Yes ___ No	If yes, how many? _____
Physicians	___ Yes ___ No	If yes, how many? _____	___ Yes ___ No	If yes, how many? _____

- (c) What are the duties of the contracted physicians? \_\_\_\_\_  
 (d) What are the average hours per week for all contracted physicians? \_\_\_\_\_  
 (e) Does insured obtain and maintain evidence of Professional Liability coverage for contracted professionals? \_\_\_\_\_  
 (f) What minimum limits are required? \_\_\_\_\_

22. Are pre-employment physicals required? \_\_\_ Yes \_\_\_ No

23. Is prior employment history checked? \_\_\_ Yes \_\_\_ No Attach a copy of facility guidelines.

24. Is English the primary language of all professional staff? \_\_\_ Yes \_\_\_ No If no, what procedures does the insured have in place to ensure the staff is fluent enough in English to provide adequate care? \_\_\_\_\_

Does the facility provide in-service training in languages other than English? \_\_\_ Yes \_\_\_ No

25. Does applicant have Workers Compensation coverage in force? \_\_\_ Yes \_\_\_ No

26. Does applicant lease employees? \_\_\_ Yes \_\_\_ No If yes, explain. \_\_\_\_\_

27. Does the facility ever use a nurses registry or other temporary services to provide any staff? \_\_\_ Yes \_\_\_ No

- (a) If yes, are they covered by their own Workers Compensation? ..... Yes \_\_\_ No \_\_\_  
 (b) If yes, do they have their own Professional Liability Coverage? ..... Yes \_\_\_ No \_\_\_  
 (c) Are certificates of insurance obtained? ..... Yes \_\_\_ No \_\_\_  
 What are the limits? \_\_\_\_\_  
 (d) Is the registry or service licensed? ..... Yes \_\_\_ No \_\_\_

28. Do nurses make outside calls?  Yes  No If yes, describe: \_\_\_\_\_
29. Does applicant provide outpatient hospice care?  Yes  No If yes, describe: \_\_\_\_\_
30. Are physicians or RNs private practitioners (independent contractors) or actual employees of Insured? \_\_\_\_\_
31. Does the facility maintain its own: Barber/beauty shop.....  Yes  No  
 Pharmacy .....  Yes  No  
 Gift shop .....  Yes  No  
 (a) Do the operators have their own professional liability?  Yes  No  
 (b) If no, complete and return Professional Application.
32. Are there any volunteers or volunteer programs?  Yes  No Types of tasks performed: \_\_\_\_\_  
 \_\_\_\_\_  
 Number of volunteers by shift: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_
33. Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.): \_\_\_\_\_  
 \_\_\_\_\_
34. Is there a resident council?  Yes  No How often does it meet? \_\_\_\_\_
35. Are employees taught to lift using proper techniques?  Yes  No  
 (a) Are Hoyer Lifts being used?  Yes  No  
 (b) Are Gate Belts being used?  Yes  No
36. Are all wheelchairs equipped with locks for the wheels?  Yes  No
37. Is there a regular extermination program by an outside firm?  Yes  No  
 If yes, who? \_\_\_\_\_  
 How often? \_\_\_\_\_  
 Is certificate of insurance on file?  Yes  No
38. Does the facility control the possession of smoking materials?  Yes  No If yes, how: \_\_\_\_\_  
 \_\_\_\_\_
- Please provide a copy of the facility smoking policy.
39. Are there established visiting hours?  Yes  No If yes, what are they: \_\_\_\_\_

**Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.**

Year	Company	Pol #	Premium	Losses Paid	Losses Reserved	Description

40. **Have any claims during the past six years ever been made or suit brought against the applicant because of any alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation?**  
 Yes  No If yes, date: \_\_\_\_\_ Brief description: \_\_\_\_\_

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40 During the past three years has any company ever cancelled, declined, or refused similar insurance to the applicant  
(Not applicable in Missouri) \_\_\_\_ Yes \_\_\_\_ No

If yes, explain: \_\_\_\_\_

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**REQUIRED ATTACHMENTS**

- ACORD Application
- Resumes of Administrator and Charge Nurse (if any)
- Copy of current license to operate
- Fully Completed Supplemental Guide Requirement
- Financial Statement (most recent)
- At least six (6) year Hard Copy Loss Run (valued most recently)
- Admission / Discharge / Eviction Criteria
- Assessment / Evaluating / Services
- Fall Prevention Program
- Elopement Program

**NOTE: WILL NOT BE ABLE TO CONSIDER FOR QUOTATION WITHOUT THIS APPLICATION FULLY COMPLETED AND THE ABOVE ATTACHMENTS**

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:**

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 conceals for the purpose 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 \_\_\_\_\_

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT \_\_\_\_\_

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IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning Character, general reputation, personal characteristics and mode of living. Upon written request, additional information As to the nature and scope of the report, if one is made, will be provided.

Underwritten by **EXCESS SPECIALTY PLACEMENT, INC.**