



**Application for Residential and Continuing Care Community
Professional and General Liability Insurance
(Claims Made Basis)**

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

PART I

1. Applicant Information

a. Named Insured (as it will appear on the policy): _____

b. Address: _____ Phone #: _____

_____ Fax #: _____

_____ Email: _____

County: _____ Website: _____

Insurance Contact: _____ Risk Management Contact: _____

Total number of locations _____

(attach list of each location with the address, phone number and name of current administrator)

2. Coverage requested:

a. Policy period: _____

b. Limits: _____

Primary GL: _____

Primary Professional: _____

c. Is a retro date requested? Yes No

If so, what date? _____

3. Number of years in business as an insured entity: _____

4. Applicant is:

a. Individual Partnership Corporation Governmental For Profit Not for Profit

b. Owner Lessee Tenant Management Company

c. Accredited by any organization (JCAHO, ADA, CARF, etc.)? Yes No

Name of Accrediting Agency: _____

Date of last accreditation _____

Any restrictions/provisions? Yes No

If yes, please provide explanation. _____

- d. Licensed by the state? Yes No
 License # _____ Expiration Date: _____
- e. Certified for Medicare? Yes No
- f. Certified for Medicaid? Yes No

5. Facility Classification and Bed Census for each facility

	Total # of Beds	Avg. # Occ.
(a) Sub-acute / Rehabilitation Care Provides comprehensive inpatient care for someone who has acute illness (i.e. stroke, heart attack) or recovery from surgery (i.e. hip or knee replacement). Sub-acute care is more nursing intensive than usual nursing home care and less intensive than hospital care.		
(b) 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, tube feedings, injections, and catheterizations. Other procedures ordered by physicians.		
(c) Intermediate Care Services Nursing care during the day shift, 7 days per week, by either RNs. No complex nursing care (IVs, tube feedings, etc.). Assistance with activities of daily living (i.e., walking, transferring, bathing, dressing, eating). Some assistance with medical administration.		
(d) Assisted Living Services Some nursing and/or health-related care to residents who do not require the degree of care and treatment described as skilled or intermediate. Residents may require some minor nursing care or help in activities such as washing, bathing, dressing, transferring, taking of medication, and preparation of special diets.		
(e) Residential Care Services Residents are provided protective environments (meals and planned programs for special and/or spiritual needs). Residents responsible for their own medication.		
(f) Independent Living Services Retirement communities where residents live in apartments. Nursing or personal care is provided on an incidental or emergency basis only. More than 75% of the residents are over the age of 65.		
(g) Other (please describe) _____ _____		

6. Resident/Patient Classifications by age for each facility:

<u>Age Group</u>	<u># of Residents/Patients</u>	<u>% Non-ambulatory</u>	<u>% Bedfast</u>
Under 18	_____	_____	_____
18 – 65	_____	_____	_____
Over 65	_____	_____	_____

7. Level of Care – Note number of Residents for each category

Level of Care	Facility:	Facility:	Facility:
General Geriatric			
Alzheimer's/Dementia			
AIDS			
Spinal/head injuries			
Ventilator Dependent			
Tube feeding			
Decubiti			
Developmentally disabled			
Alcohol/drug rehab			
Psychiatric diagnoses			

8. Are you entered into any written indemnification agreements holding any other party harmless? Yes No

If yes, please provide copy of each indemnification agreement.

9. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory)? Yes No

10. Annual Gross Receipts: Last 12 Months: _____ Next 12 Months (est.): _____

Identify any outpatient services provided by your facility:	<u># of Annual Visits/Revenues</u>
Pharmacy for non-resident/patient	_____
Home Health Care	_____
Physical Rehabilitation/Therapy	_____
Mental Rehabilitation/Therapy	_____
Adult Day Care	_____
Hospice Care	_____

12. Are any athletic or recreational facilities contained on your premises, e.g., swimming pool, gymnasium, exercise room hot tub and playing fields? If yes, please describe in detail with particular attention to the type of equipment present, i.e., high diving boards, trampolines, ropes, treadmills, etc., and level and quantity of supervision. Yes No

13. Is a nursing assessment conducted for new residents? Yes No
If yes, does this assessment include evaluation of:

- (i) Skin breakdown/Decubiti Yes No
- (ii) Mobility limitations. Yes No
- (iii) History of prior injuries Yes No
- (iv) Required assistance Yes No
- (v) Disorientation/cognitive abilities Yes No
- (vi) Current medications Yes No
- (vii) Aggressive behavior Yes No

14. Are all medications kept in a secured (locked) location with limited key access? Yes No

15. Is the dispensing of medications properly controlled with each patient dose recorded? Yes No

16. How long are patient records kept? _____

17. a. Who determines if a resident meets admission criteria or if a resident is no longer appropriate for the community?

b. Who determines if a resident must be transferred to another facility for evaluation or further medical diagnosis or treatment?

18. Is your facility compliant with HIPAA rules? Yes No

19. Staff

- a. Do you conduct an orientation and regularly scheduled inservicing for all staff/employees? Yes No
- b. Is there a formal documented competency process for all staff? Yes No
- c. Are the following background verification checks done on new employees? Yes No
- Work History Yes No
- Education Yes No
- Criminal Record (State and National) Yes No
- Who does the criminal record checks? _____
- Driving record for all employees operating facility vehicles Yes No
- Drug testing Yes No

d. For each position listed below, please respond for each facility

	Employed	Contracted	Full-Time	Part-Time	Years at This Facility	Years Experience
Director of Nursing						
Medical Director						
Administrator						
Licensed Pharmacist						

e. Please provide name and qualifications of the Medical Director: _____

f. For each classification listed below, show the number of full and part-time employees and/or independent contractors for each facility.

	1 st Shift		2 nd Shift		3 rd Shift	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Physicians on Staff						
Physicians on Call						
Registered Nurses						
Licensed Practical Nurses						
Nurses Aides						
Physical Therapists						
Dieticians						
Social Services/ Counselors						
Total Number of Employee / Independent Contractors						

- g. Do you obtain and review physicians' certificates of malpractice insurance? Yes No
- Are the medical staff credentialed? Yes No
- h. Ratio of professional staff to occupied beds by shift: 1st _____ 2nd _____ 3rd _____

20. Claims History

If “yes” to any of the following questions, attach a detailed explanation.

- a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? Yes No
- b. Have you been the subject of any license suspension or revocation or been placed under probation? Yes No
- c. Has any insurance company ever canceled, non-renewed or declined to accept your application for professional or general liability insurance? Yes No
- d. Are written procedures in effect for incident reporting? Yes No
If yes, please provide a copy of the policy.
- e. Are you aware of any circumstances which may result in a malpractice claim or suit being made against you under the coverage requested in the application? Yes No
- f. Provide liability loss experience or loss run from each carrier for the last five (5) years.
- g. List prior general and/or professional liability insurance carriers for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?		Retro Date
						Yes	No	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	
						<input type="radio"/>	<input type="radio"/>	

PART II

I. Premises Information

a. Buildings / Wing

Building Description	#1	#2	#3	#4
Type of Construction				
No. of Stories				
Square Footage				
Total Beds				
Date Built				
Complete or Partial Sprinkler Systems				
Use of Building				

- 2. Is any real or personal property or equipment sold or leased to others? Yes No
If yes, please describe and advise estimated gross sales and/or receipts.

Mandatory Attachments

1. Most recent state inspection report and/or Medicare Survey report with any statement deficiencies and plans of correction
2. Current State License
3. Current accreditation letter or report, if applicable, with recommendations and facility response
4. Hard copy of loss runs for past five years
5. Resume of owner, administrator, medical director and director of nursing
6. All brochures /advertising materials
7. Proof of property insurance
8. Photos of all facilities to be covered, showing interior and exterior of buildings
9. List of additional insureds with address and description of their operations and relationship to you
10. Current financial statement

By my signature below:

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.

2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.

3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify Campmed in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.

4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and Campmed Casualty & Indemnity Company, Inc. of Maryland and my broker, agent or peer review.

CAMPMED FRAUD STATEMENT

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 and denial of insurance benefits.

Please see the attached specific Fraud Warnings required by some states.

APPLICANT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

PLEASE MAIL / FAX / EMAIL COMPLETED APPLICATION TO:

Campania
111 Berry Street SE, Vienna, VA 22180
Fax (703) 242-3815
msackie@thecampaniagroup.com

Thank you for choosing Campania for your insurance needs.

FRAUD WARNINGS

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 or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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 or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana And West Virginia Applicants: Any person who knowing 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 Maryland Applicants: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

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 York 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 or 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 five thousand dollars and the stated value of the claim for each such violation.

Notice to North Carolina Applicants: Any person who knowingly presents false information in an application for insurance is guilty of a felony and may be subject to fines and imprisonment.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he 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 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 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.

Notice to Tennessee and 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.