ProAssurance Senior Care

Professional and General Liability Insurance Application

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Instructions:

1. Answer all questions (or respond N/A for not applicable), using Appendix A or a separate sheet for explanations.
2. Applicant refers to the company, its predecessors, and all proposed insureds, including subsidiaries.
3. Please complete a separate facility supplemental for each additional facility.
4. **Please read the statement at the end of the application carefully.**
5. Sign and date the application.

Required Attachments:	
- Recently valued carrier loss runs	- State license
- Expiring professional and general liability insurance policy	- Current financial statements
Recommended Attachments:	
- Form HCFA 672 Resident Census and Condition of Residents	- Organizational chart
- Résumé of owner, administrator, and director of nursing	- Schedule of locations
- Current state survey and plan of correction	- Written policies for: physical and sexual abuse, infection control, falls, skin care, restraints, medications, elopement
- Resident agreements including any arbitration language	

Section I - Applicant Information

1. Applicant's legal name (and d/b/a if applicable): ____________________
2. Mailing Address: ____________________
3. Legal structure:

☐ LLC	☐ Corporation – for profit	☐ Government
☐ Partnership	☐ Corporation – not for profit	☐ Individual

4. Year the Applicant started ownership and/or operation at the facility ____________________
5. Revenue or operating budget for: next 12 months: $__________; and past 12 months: $__________
6. Payor Mix: Medicare __________ % ; Medicaid __________ % ; Private Pay__________ %
7. Does the Applicant:
   - Solely own the facility? If no, please name other owner(s)__________ ☐ Yes ☐ No
   - Lease the facility? If yes, please name the lessee __________ ☐ Yes ☐ No
   - Operate the facility? If no, please name management company __________ ☐ Yes ☐ No
   - Project changes in ownership or operations over the next 18 months including but not limited to: merger, acquisition, divestiture, renovation, services offered, licenses, or management? ☐ Yes ☐ No

     If yes, please explain __________
8. Is the Applicant or facility:
   - Associated with a multi-facility chain? If yes, name of chain and location count __________ ☐ Yes ☐ No
   - Publicly traded, private equity owned or sponsored? If yes, ticker or fund name __________ ☐ Yes ☐ No
9. Has the Applicant or facility ever filed for bankruptcy. If yes, please explain __________ ☐ Yes ☐ No
10. Does the Applicant offer services to non-residents including but not limited to home healthcare, daycare, outpatient care, PACE, clinical trials, etc.? If yes, explain __________ ☐ Yes ☐ No

Section II – Claims and Coverage History

Missouri Applicants– Do not answer question # 1, below:

1. Has any insurance company ever cancelled, non-renewed, or declined to accept your professional or general liability insurance? If yes, please explain ______ ☐ Yes ☐ No
2. Have you been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? ☐ Yes ☐ No
   If yes, please explain ______
3. Are you aware of any claims or suits brought against you or any circumstances which may result in a claim or suit being made or brought against you, including but not limited to attorney request for medical records or letter of intent? If yes, please explain ______ ☐ Yes ☐ No
4. Please provide your preferred claim contact:
   Name: ______ Email:______ Phone: ______

Please complete and attach Appendix B – Senior Care Application Claims Schedule if applicable

Section III – Risk Management

Wandering/ Elopement Risk:

1. Do you accept residents with a history or risk of wandering / elopement? ☐ Yes ☐ No
   - If yes, how many residents are high elopement risk ______
   - Number of elopements from facility in the past three years: ______
2. How frequently do you account for all residents? ______
3. Is video surveillance used? If yes, please explain ______ ☐ Yes ☐ No
4. Are all outside exit doors equipped with auditory alarms? If no, please explain ______ ☐ Yes ☐ No
5. Do auditory exit alarms signal at the nurses' desk? ☐ Yes ☐ No
6. Can the auditory alarm be reset from the nurses' desk? ☐ Yes ☐ No
7. Does the facility have a wandering/elopement prevention program in place? ☐ Yes ☐ No
8. Do you have a dedicated memory care or Alzheimer's care unit? ☐ Yes ☐ No
9. Are Wander Guard or similar devices used as part of elopement prevention practices? ☐ Yes ☐ No

Please attach your elopement risk assessment policies and guidelines.

Fall Risk:

1. Do you accept residents with a history or risk of falls:
   - If yes, how many residents fall or at high risk of falls: ______
   - Total number of resident falls in past year: ______
   - Total number of residents falls resulting in injury in past year: ______
2. Do you adhere to a standard fall assessment protocol? ☐ Yes ☐ No
3. Are resident falls recorded, trended, and reviewed by the QAA Committee? ☐ Yes ☐ No
4. Do you have a nurse consulting service whose duties include designing and monitoring a fall prevention program? ☐ Yes ☐ No
5. Do you use physical or chemical restraints? If yes, please explain ______ ☐ Yes ☐ No
6. Do you use mechanical lifts? If yes, how many and what type______ ☐ Yes ☐ No

Please attach your fall assessment policies and guidelines

Skin and Wound Risk:

1. Do you accept residents with existing decubitus ulcers (bedsores)? ☐ Yes ☐ No
   - If yes, please check which stages you accept: Stage I ☐ ; Stage II ☐; Stage III ☐; Stage IV ☐
2. Do you transfer or discharge residents with new or worsening decubitus ulcers? ☐ Yes ☐ No
3. Do you have a skin and wound assessment protocol? ☐ Yes ☐ No
4. Do you have a specialty surface protocol? If yes, please explain ________________________ ☐ Yes ☐ No
5. Do you contract wound care to a third party? If yes, please explain ______________________ ☐ Yes ☐ No

Please attach your skin assessment policies and guidelines.

Physical and Sexual Abuse and Misconduct Risk:

1. Has the applicant had any incidents or claims of actual or alleged physical or sexual misconduct or any other form of abuse? If yes, please explain __________________________________ ☐ Yes ☐ No
2. Do you have formal written policies regarding abuse that are updated regularly? ☐ Yes ☐ No
3. Do you perform initial background checks on all new employees and volunteers? ☐ Yes ☐ No
   - If no, please explain ____
   - If yes, are subsequent background checks a condition of continued employment? ☐ Yes ☐ No
   - Do your checks include the following:

     State / county criminal ☐ ; National criminal ☐; Sex offender registry ☐; Employment ☐; Education ☐; Professional license ☐; Professional references ☐; Personal references ☐; Social Security Number ☐; Residency ☐; Drug testing ☐; Drug testing ☐; Driving Records ☐
4. Upon hire, and at least annually thereafter, do you train all new employees and volunteers on identifying, preventing, and properly reporting actual or suspected abuse? ☐ Yes ☐ No
5. Do you train all new employees and volunteers on statutory rights of residents in your state? ☐ Yes ☐ No
6. Do you immediately suspend or terminate individuals suspected of abuse? ☐ Yes ☐ No

Please attach your written abuse policies and guidelines.

Infection risk prevention and control:

1. Do you have a quality committee that tracks incidents and causes of infection? ☐ Yes ☐ No
2. Are staff trained on identifying and reporting communicable diseases including respiratory illness? ☐ Yes ☐ No
3. Are personnel trained on hand hygiene at the time of engagement and at least annually? ☐ Yes ☐ No
4. Do you ensure adequate personal protective equipment is fully available and accessible? ☐ Yes ☐ No
5. Are all staff and residents offered flu immunization annually? ☐ Yes ☐ No
6. Is there currently or has there ever been an outbreak or cluster of any illness at the facility? ☐ Yes ☐ No

Please attach your infection control policies and guidelines.

Medication risk management:

1. Do your residents self-administer their own medications? ☐ Yes ☐ No
2. Do you distribute medications to residents? ☐ Yes ☐ No
3. Do you administer medications to residents? ☐ Yes ☐ No

4. How are medications stored/secured? ____

5. Do you operate an onsite pharmacy? ☐ Yes ☐ No
   - If yes, is the pharmacy open to non-residents? ☐ Yes ☐ No

6. Do you review residents' medication regimens monthly? ☐ Yes ☐ No

Please attach your medication management policies and guidelines.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance Specialty Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

Name: ______________________________ ***Title:*** ______________________________

Signature: ______________________________ ***Date:*** ______________________________

ProAssurance Senior Care
Facility Supplemental

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Instructions: Please

1. Complete a separate facility supplemental for each facility

Section I – Facility Information

1. Facility Number : ______ of _________
2. Facility Name: ____
3. Physical Address:____
4. Facility Type: Skilled nursing ☐ ; Assisted living ☐; Independent ☐; CCRC ☐

Section II – Census

1. Resident Census:

Bed/unit type	Number of Licensed Beds	Average Number of Occupied Beds	Number of Ambulatory Residents	Number of Non-ambulatory Residents	Number of Bedbound Residents
Independent:					
Assisted:					
Memory Care:					
Alzheimer's Care:					
Skilled Nursing:					
Other _________					

2. Number of residents by age: 0-11 _______; 12-18 ________; 19-54 _______; 55-75________; 75 and up _______
3. Are residents rooms equipped with emergency pull cords? ☐ Yes ☐ No
4. Decubitus Ulcer/Bedsore Census**:**

Stage	Number of residents acquiring or worsening to decubitus ulcer stages at your facility:	Number of residents with existing decubitus ulcers by stage upon admission to your facility:
Stage 1:		
Stage 2:		
Stage 3:		
Stage 4:		
Unstagable		

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Section III – Facility Staffing Details

5.

Staff type	Shift	Number of Full Time Employees	Number of Part Time Employees	Number of Contracted or Agency Staff
RN	Day			
RN	Evening			
RN	Night			
LVN/LPN	Day			
LVN/LPN	Evening			
LVN/LPN	Night			
CNA	Day			
CNA	Evening			
CNA	Night			
Other: ______________				

6. Turnover of staff in past 12 months:____%

Section IV – Facility Management

1. Facility Administrator's Name: ____

   Years Licensed: _____ Years at Facility: _________

   ☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

2. Medical Director's Name: ____

   Years as Medical Director:_____________ Tenure at Facility: ____________________________________

   Number of days per week at facility:___________ Any direct patient care to residents? ☐ Yes ☐ No

   ☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

   Medical Director's Malpractice Insurance:

   Carrier Name: ___________________ Limits: __________________ Expiration Dat:____________

   Ever been the subject of investigatory or disciplinary proceedings or reprimanded by an administrative or governmental agency or professional association? ☐ Yes ☐ No

3. Director of Nursing's Name:_________________ Years as DON:_______ Tenure at Facility:___________________

   ☐ Employed ☐ Contracted ☐ Full-time ☐ Part-time

4. Are Employees Leased? ☐ Yes ☐ No

   If yes, give details: ____

5. Are abuse checks and licensing information required of all employed staff agency, and private duty works? ☐ Yes ☐ No

6. Do you have formal job descriptions for all positions? ☐ Yes ☐ No

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7. Are private duty and agency staffs required to complete an orientation program prior to working with facility residents? ☐ Yes ☐ No
8. Are temporary staffing services used? ☐ Yes ☐ No

   If yes, describe credential and supervisory process: ____________________
9. Does the facility employ a physician? ☐ Yes ☐ No

   If yes, explain ____________________
10. Do you require Certificates of Insurance of Patients Physicians? ☐ Yes ☐ No

    If yes, confirm minimum limits requested: ____________________

Section V – Facility Life Safety

1. Year Built: __________ Protection Class: ______________ Square Footage: __________
2. Type of Construction: ☐ Frame ☐ JM ☐ MNC ☐ MFR/FR
3. Number of Floors: __________ Number of Exits: __________
4. Sprinklered? ☐ Yes ☐ No Smoke Detectors? ☐ Yes ☐ No Fire Alarms? ☐ Yes ☐ No

   Please explain where sprinklers and detectors are located and whether the alarm is central or local:

   ____

   ____
5. Major Renovations/Additions: ☐ Yes ☐ No

   If yes, give dates and describe: ____________________
6. Was facility originally constructed for Nursing Home occupancy? ☐ Yes ☐ No

   If no, explain ____________________
7. Is there a swimming pool or body of water on or proximate to premises? ☐ Yes ☐ No
8. Do you allow smoking in residents rooms or common areas?
9. Is there an Ansul system? ☐ Yes ☐ No

   If yes, is it inspected annually? ☐ Yes ☐ No

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance Specialty Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

Name: ____________________ ***Title:*** ____________________

Signature: ____________________ ***Date:*** ____________________

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Signed: ______________________ Date: ______________

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Appendix B
Senior Care Application
Claims Schedule

Please complete this form if the applicant is aware of any claims or suits as indicated in Section III, question 1 of the Application Form (including any circumstances reported to previous insurers which have not developed into claims) during the last ten (10) years.

1. Name of Defendant: ______________________________
2. Name of Staff Member Involved in Claim: ______________________________
3. Name of (potential) Claimant: ______________________________
4. Date of Incident:______________________ Date Claim Made: ______________________
5. Under which policy was the claim made? ______________________________
   Carrier: ______________________________ Policy No: ______________________
6. Status of Claim:
   ☐ Closed: If closed, please indicate total loss paid (Including defense expenses): $______________________
   ☐ Open: If open, please complete questions 7, 8, 9, and 10
7. Total defense costs and expenses to date: ______________________________
8. Damages or other relief sought by the claimant(s): ______________________________
9. Insurer's Loss Reserve: ______________________________
10. Please give the following details:
    i) The specific act upon which the claimant bases the claim
    ii) A brief description of the claim
    iii) Details of the current status and proposed strategy for handling the claim

    ____
    ____
    ____
    ____
    ____
    ____
    ____
    ____
    ____

    Please continue on a separate sheet if necessary.

Signed: ______________________________ Date: ______________________

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Fraud Warning Notices

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Please read the fraud warning notice for your state.

General Fraud Warning – 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.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas Fraud Warning – Any person who knowingly presents a false or fraudulent claim for payment for 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.

Colorado Fraud Warning – 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Fraud 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.

Florida Fraud Warning – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas Fraud Warning – Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Kentucky Fraud Warning – 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.

Maine Fraud Warning - 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.

Maryland Fraud Warning – Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Fraud Warning – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio Fraud Warning – Any person who, with the 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.

Oklahoma Fraud 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.

Oregon Fraud Warning – Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

Pennsylvania 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.

Tennessee Fraud Warning – 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.

Vermont Fraud Warning - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Fraud Warning – 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.

Washington Fraud Warning - 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.

West Virginia Fraud Warning - 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.