SCOTTSDALE
SURPLUS LINES INSURANCE COMPANY

8877 North Gainey Center Drive
Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752

Convalescent Homes/Residential Care/Homes for the Aged General Liability Application

Applicant's Name _____

Mailing Address _____

_____

Location _____

_____

(Please complete a separate application for each location.)

Agent Name _____

Address _____

_____

PROPOSED EFFECTIVE DATE:

From _____ **To** _____

12:01 A.M., Standard Time at the address of the Applicant

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
☐ Limited Liability Company ☐ Other (Specify) _____

LIMITS OF LIABILITY REQUESTED			**PREMIUMS**
General Aggregate		$	Premises/Operations
Products & Completed Operations Aggregate		$	$
Personal & Advertising Injury		$	Products/Completed Operations
Each Occurrence		$	$
Fire Damage (any one fire)		$	Other
Medical Expense (any one person)		$ Excluded	$
Professional Limit	Each Medical Incident	$	Professional
	Aggregate	$	$
Other Coverages, Restrictions, and/or Endorsements			Total
	Deductible	$	$

Definitions:

"Residential/Personal Care Facility (RCF)":
A facility that provides personal care, residential and social care with some routine health care, but not continuous skilled nursing care. Residents of homes for the aged must be ambulatory; group homes are for trainable developmentally disabled. (There is no daily medical attention.) Patients are responsible for their own medication.

"Intermediate Nursing Care or Intermediate Care Facility (ICF)":
A facility where the residents' physiological and psychological functions are stable, but require individually planned treatment and services under the direction of a licensed nurse and supervision of a licensed physician (not on staff). Emphasis is on maintenance of maximum independence and return to the community as soon as possible. Some assistance in medication administration.

"Skilled Nursing Care or Skilled Care Facility (SCF)":
A facility where the residents' conditions, needs, and/or services are of such complexity and sophistication so as to require the frequent or continuous observation and intervention of a registered nurse, and the supervision of a licensed physician (not on staff). Skilled nursing care includes some or all of the following: medication administration, injections, tube feedings, catherizations, or other procedures ordered by physician.

1. **Full Named Insured*:** _____
   *Note: If more than one Named Insured, explain the ownership/operational interest of each.

2. **Operating as:** ☐ Profit ☐ Non-Profit
   Number of licensed beds: _____ How long under present management? _____

3. **Named Insured is:** ☐ Building owner ☐ Tenant ☐ General lessee

4. **Building owner** (if other than Named Insured): _____

5. **Are there any other occupants of the premises?** ☐ Yes ☐ No If yes, identify: _____

6. **Officers and general partners** **Titles**

   _____ _____

   _____ _____

   _____ _____

   _____ _____

7. **How many years has the facility been in business under the current ownership?** _____

8. **How many years experience does the current ownership have in health facilities?** _____

   How many years does the current management have in health facilities? _____

9. **In what professional or industry association(s) is the facility a member in good standing?** _____

10. **Name of administrator:** _____
    (a) How long at this facility? _____
    (b) Experience as administrator or assistant administrator: _____years

11. **Who is in charge when administrator is absent?** (name and title) _____

12. **Number of administrators at the facility during the prior 10 years:** _____

13. **Does the facility have a medical director?** ☐ Yes ☐ No
    Does the medical director have his/her own professional liability insurance? ☐ Yes ☐ No

14. **Is facility certified for:**
    Medicare? ..... ☐ Yes ☐ No
    Medicaid? ..... ☐ Yes ☐ No
    Other? ..... ☐ Yes ☐ No

15. **Number of patients in each category:**
    Private Pay _____
    Title 18 _____
    Title 19 _____
    Other _____

16. **Gross annual receipts of the facility** (including Medicare and Medicaid): $_____

17. **Please attach the most recent copies of state and county inspections**. Are there any deficiencies uncorrected? ☐ Yes ☐ No
    If yes, what? _____

18. **License Information:**
    (a) Please attach all licenses required for this facility's operation.
    (b) Is license conditional, provisional, probationary or temporary? ☐ Yes ☐ No If yes, explain: _____
    (c) Has license ever been revoked? ☐ Yes ☐ No If yes, explain: _____

19. **Type of Home:** ☐ Convalescent or Nursing ☐ Home for Aged ☐ Residential Care Home
☐ Other (describe): _____

20. **Number of beds in each category:**

Residential _____beds
Intermediate _____beds
Skilled _____beds

State approximate division of patients:

_____% Surgical
_____% Senile or aged
_____% Alzheimer's
_____% Mentally ill/Mentally disabled
_____% Drug addicts
_____% Alcoholics
_____% Developmentally disabled
_____% Any other classes
_____% AIDS/HIV*
*Complete question 49.

21. **Number of patients by mobility:** Ambulatory _____ Non-ambulatory _____

Definition: An ambulatory person is one who is physically capable of walking a normal path to safety, including the ascent and descent of stairs.

22. **Physical features of risk:**

(a) Construction of building: _____Area of building: _____
(b) Number of floors: _____ Are any non-ambulatory residents above second floor? ☐ Yes ☐ No
(c) Year built: _____Age and type of heating system: _____
(d) Age and type of wiring: _____ Date, if remodeled: _____
(e) Purpose for which building was originally constructed: _____
(f) Number of fire extinguishers on premises: _____ Number of fire escapes: _____
(g) Any swimming pools? ☐ Yes ☐ No If yes, is it fenced? ☐ Yes ☐ No
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? _____
(h) Equipped with sprinkler system? ☐ Yes ☐ No All rooms and halls equipped with smoke detectors? ☐ Yes ☐ No
(i) Equipped with fire alarm? ☐ Yes ☐ No ☐ Central station ☐ Local alarm
(j) 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? _____
(k) What security measures are used to control unauthorized entrances to the facility? _____
Explain: _____
(l) Are doors equipped with panic hardware? ☐ Yes ☐ No
(m) Distance to the nearest fire station? _____Distance to the nearest fire hydrant? _____
(n) Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
(o) Are bathtubs and showers equipped with non-skid surfaces? ☐ Yes ☐ No
(p) Does facility have tempering valves to control the temperature of the patients' water? ☐ Yes ☐ No
If yes, how often are they checked? _____
(q) Temperature of hot water _____°F
(r) Are there separate hot water systems for utility and bath areas? ☐ Yes ☐ No
(s) Does the home have emergency lighting? ☐ Yes ☐ No
(t) Where are the powered equipment and fuel stored? _____
Are there any underground storage tanks? ☐ Yes ☐ No
(u) What is the overall condition of the property including maintenance and housekeeping?
☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

(v) Cooking: ☐ Gas ☐ Electric ☐ None If none, describe food service: _____

1. Is stove vented outside with hood and grease filter? ☐ Yes ☐ No
2. Are filters clean? ☐ Yes ☐ No
3. Are hood and cooking surfaces protected with automatic extinguishing system? ☐ Yes ☐ No
4. Are all cooking surfaces directly protected? ☐ Yes ☐ No
5. Is automatic fuel shutdown interlocked to system? ☐ Yes ☐ No
6. Is there any deep fat frying? ☐ Yes ☐ No

23. Emergency Procedures:

(a) Written emergency evacuation plan? ☐ Yes ☐ No
(b) Does plan include advance arrangement including transportation and temporary shelter? ☐ Yes ☐ No
(c) Are evacuation procedures posted in all parts of your facility? ☐ Yes ☐ No
(d) Are drills conducted regularly for each shift? ☐ Yes ☐ No
(e) Is the entire staff familiar with the emergency evacuation plan? ☐ Yes ☐ No
(f) Is the plan filed with the local fire department? ☐ Yes ☐ No

24. Classify number of employees by shift:

	1st Shift	2nd Shift	3rd Shift		1st Shift	2nd Shift	3rd Shift
Physicians, interns, residents	____	____	____	Respiratory therapists	____	____	____
Graduate nurses—RN	____	____	____	Social workers	____	____	____
Practical nurses—LPN	____	____	____	Speech therapists	____	____	____
Nurses' aides	____	____	____	Recreational therapists	____	____	____
Student nurses	____	____	____	Occupational therapists	____	____	____
Physical therapists	____	____	____	X-ray technicians	____	____	____
Inhalation therapists	____	____	____	Lab technicians	____	____	____
Dieticians	____	____	____	Maintenance/security	____	____	____
Beauticians/barbers	____	____	____	Special technicians	____	____	____
Dentists	____	____	____	Housekeeping	____	____	____
Administrative	____	____	____	Laundry	____	____	____
Kitchen	____	____	____	Other (describe) _____	____	____	____

Total number of employees: _____ Full-time: _____ Part-time: _____

25. Physicians:

(a) Residents are ☐ expected ☐ required to have their own physician.

(b) Does facility employ 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? ☐ Yes ☐ No

(f) What minimum limits are required? _____

26. Are pre-employment physicals required? ☐ Yes ☐ No

27. Is prior employment history checked? ☐ Yes ☐ No Attach a copy of the facility's hiring guidelines.

28. 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

29. Does applicant have Workers' Compensation coverage in force? ☐ Yes ☐ No

30. Does applicant lease employees? ☐ Yes ☐ No If yes, explain: _____

31. 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

32. Do nurses make outside calls? ☐ Yes ☐ No If yes, number per week: _____

33. Does applicant provide outpatient hospice care? ☐ Yes ☐ No Attach application GLH-APP-32g.

If yes, describe: _____

34. Does applicant provide outpatient home care? ☐ Yes ☐ No If yes, describe: _____

35. Are physicians or RNs private practitioners (independent contractors) or actual employees of insured? _____

36. 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.

37. Are there any volunteers or volunteer programs? ☐ Yes ☐ No Types of tasks performed: _____

Number of volunteers by shift: 1st _____ 2nd _____ 3rd _____

38. Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.): _____

39. Patient ages: From _____ (youngest) to _____ (eldest)

40. Is there a safety committee? ☐ Yes ☐ No How often does it meet? _____

41. 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

42. **Are all wheelchairs equipped with locks for the wheels?** ☐ Yes ☐ No

43. **Is there a regular extermination program by an outside firm?** ☐ Yes ☐ No

(a) If yes, who? _____

(b) How often? _____

(c) Is certificate of insurance on file? ☐ Yes ☐ No

44. **Does the facility control the possession of smoking materials?** ☐ Yes ☐ No If yes, how? _____

Provide a copy of the facility's smoking policy.

45. **Are there established visiting hours?** ☐ Yes ☐ No If yes, what are they? _____

46. **Are the medications kept under locked conditions?** ☐ Yes ☐ No

Do only authorized personnel have keys? ☐ Yes ☐ No

47. **Does the facility have a policy on restraint usage?** ☐ Yes ☐ No If yes, please attach a copy of the policy.

48. **Any other premises or operations exposures not stated in this application?** ☐ Yes ☐ No

If yes, attach a complete description and underwriting/rating information.

49. **Number of AIDS/HIV patients:** _____

(a) Are patients isolated? ☐ Yes ☐ No If yes, how? _____

(b) What training is provided to new/existing staff? _____

(c) Is staff informed of all patients with AIDS/HIV? ☐ Yes ☐ No

(d) Does insured do any blood testing? ☐ Yes ☐ No

(e) Attach a copy of the insured's written infection control plan.

(f) How is infectious waste stored and disposed of? _____

(g) Are employees tested for AIDS/HIV? ☐ Yes ☐ No How often? _____

(h) Describe how the laundry from the AIDS/HIV patients is handled: _____

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

YEAR	COMPANY	POL. #	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

50. **Have any claims during the past five 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: _____

51. **During the past three years has any company ever cancelled, declined or refused to issue similar insurance to the applicant?** (Not applicable in Missouri) ☐ Yes ☐ No

If yes, explain: _____

SCHEDULE OF HAZARDS								
Loc. No.	Classification	Class. Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem./Ops.	Products/ Comp. Ops.	Prem./Ops.	Products/ Comp. Ops.

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.

APPLICABLE IN THE STATE OF NEW YORK:

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 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.

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 _____

AGENT NAME _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only.)

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

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.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE