



P.O Box 440549
Kennesaw, GA 30160

Local Telephone (678) 290-2100
Fax (678) 290-2200
WATS 800-476-4940

Visit Our Website At
www.thomcoins.com

SENIOR LIVING SUPPLEMENTAL APPLICATION

Note: All questions must be answered or application will be returned

Applicant Statement and Signature: This application, loss information, and ACORD applications are understood to be an inducement to the issuance of a policy of insurance by the Company. The undersigned hereby:

- Authorizes Company to obtain information necessary for evaluation in determining acceptability including, but not limited to, motor vehicle reports, credit reports, and physical inspection.
- Warrants that all answers to questions are true and correct to the best of the applicant's knowledge and belief.

Applicant Signature: _____ Date: _____

Effective Date Requested: _____ Date Quotation Desired _____

This application requires the following attachments for all accounts:

- ⇒ Acords
- ⇒ Five years currently valued loss runs
- ⇒ Signed Supplemental
- ⇒ Current Financial Statement
- ⇒ Current state inspections including responses to any deficiencies
- ⇒ Current License
- ⇒ Incidents which may give rise to claim
- ⇒ Brochures
- ⇒ Resident Agreement (Incl. any arbitration)

The following are *also* required For CCRC's:

- ⇒ Most recent Quality Indicator Profile
- ⇒ Facility Diagram/Plot plan
- ⇒ Provide a copy of the type of contract used- Life care, etc.

SECTION I

NAMED INSURED

Named Insured (Legal Entity) _____

DBA: _____

Name of Loss Control contact: _____

Phone # _____ Email address: _____

For Profit _____ Not for Profit _____ Religious Affiliated? Yes _____ No _____

Individual _____ Partnership _____ Corporation _____ Other (describe) _____

List all legal entities to be considered an insured, and their relation to the entity:

List all subsidiaries of the named insured:

Of Years in Business under current ownership _____ Federal ID #: _____

Website: _____



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[X] Check all that apply to the applicant

<input type="checkbox"/> Hospital Based	<input type="checkbox"/> CCRC	<input type="checkbox"/> Medicaid Certified	<input type="checkbox"/> Medicare Certified
<input type="checkbox"/> Accredited by JCAHO	<input type="checkbox"/> Accredited by CARF/CCAC	<input type="checkbox"/> Other Accreditation:	<input type="checkbox"/>

Current Insurance Information:

Commercial General Liability Insurance

Occurrence Claims Made Retro Date: _____

Commercial Professional Liability

Occurrence Claims Made Retro Date: _____

Any change in name or operation since retro date?

Yes No If yes, explain _____

SECTION II

CENSUS AND EXPOSURES

	License Capacity	Current Occupancy	Avg. Occupancy for past 12 months	# Of Non-Ambulatory Residents**
ILF				
ALF				
SNF				

****Nonambulatory means anyone who cannot self-evacuate, even with verbal guidance, in the event of an emergency. Residents who use canes, wheelchairs or ambulatory support devices are considered ambulatory.**

List other services provided by your facility

- ◆ Home Health Average visits/per month _____
- ◆ Adult Day Care Average number of clients/per month _____
- ◆ Respite Care Average visits/per month _____
- ◆ Hospice Average visits/per month _____



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1. What is the average length of stay? 0-60 days____ 61-180 days____ Over 180 days_____
2. # Medicaid Beds _____ # Medicare Beds_____
3. Do you accept or retain Alzheimer's residents in your facility? Yes_____ No_____
4. Do you have a separate wing or building designated for Alzheimer's residents? Yes_____ No_____
5. What is the maximum level of Alzheimer's that you will retain in your facility (per the Global Deterioration Scale)?

6. How often are Alzheimer's residents assessed to determine the level of care needed? _____
7. Please advise if any of the following services are provided by the insured or through a Third Party Home Health provider:

a) Ventilator Care	Insured_____ Home Health_____
b) Wound Management, except for emergency first aid administered at the time of injury or within 48 hours thereafter.	Insured_____ HomeHealth_____
c) Total Parenteral Nutrition	Insured_____ HomeHealth_____
d) Catheter insertion and sterile irrigation	Insured_____ HomeHealth_____
e) Gastronomy feeding	Insured_____ HomeHealth_____
f) Care of colostomies and ileostomies	Insured_____ HomeHealth_____
g) Nasopharyngeal and/or tracheotomy suctioning	Insured_____ HomeHealth_____
h) Cutting the toe-nails of diabetic residents	Insured_____ HomeHealth_____
i) Performing digital stool removal therapies	Insured_____ HomeHealth_____
j) Performing ear irrigations	Insured_____ HomeHealth_____
k) Caring for and/or treatment of stage 2, 3, or 4 decubitus ulcers	Insured_____ HomeHealth_____
l) Post operative/trauma recovery	Insured_____ HomeHealth_____
m) Intravenous/antibiotic/hydration/pain therapy	Insured_____ HomeHealth_____
8. If residents receive services by an outside Home Health Agency, Hospice, or Private Sitter Agency, is the contract between the resident and the Third Party Provider? Yes____ No____
9. Is there an on-site pharmacy? Yes_____ No_____
10. If yes, is it used by anyone other than residents? Yes_____ No_____
11. How often is an inventory of the medications performed? _____
12. How do you dispose of expired medications? _____
13. How are the medications stored? _____
14. What type of medication packaging is used (bubble pack, samples, etc.)? _____
15. Is there on-premise swimming pool/sauna? Yes_____ No_____



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16. If yes, is it used by families? Yes_____ No_____ If so, are waivers signed by the resident and family for use of the pool?

17. Is the pool/sauna fenced? Yes_____ No_____

17.a. Is the fence locked when not in use? Yes_____ No_____

18 Does the insured serve any alcohol? _____ Annual Receipts? _____

SECTION III

STAFFING

Key Staff	Name	Years of Employment in current position	# Of Years Experience
Medical Director			
Administrator			
Dir. Of Nursing			

1. Does the Medical Director also acts as the attending physician for any residents? Yes_____ No_____

2. # Of Key staff turnover (Medical Director, Administrator or DON) in the past five years _____

	1 st Shift	2 nd Shift	Night Shift	Turnover Ratio
Nurse Practitioner and Physician Assistants				
RN				
LPN/LVN				
C N A/Personal Caregiver				
Other staff/Volunteers				



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- 3. Number of physicians on staff _____ Employed or Independent Contractor? _____
- 4. Is the insured Operated by an outside Management Co.? Yes _____ No _____ If yes, how many years?

- 5. Name of Management Company _____
- 6. Do you require independent contractors, nurses, physicians, and medical directors to carry their own insurance?
Yes _____ No _____ what are the minimum limits of insurance required? _____
- 7. Do you obtain and verify nursing license upon hire? Yes _____ No _____
- 8. Do you obtain and verify nursing assistant certification? Yes _____ No _____

SECTION IV

HIRING PRACTICES/TRAINING

Please indicate all methods used in **Hiring** new employees (including volunteers):

- _____ Criminal background checks (Federal & state, including sex-related crimes)
- _____ Conduct personal interview
- _____ Validate work history
- _____ Validate education
- _____ Drug Testing
- _____ Reference checks
- _____ Driving record

Please indicate all methods used for **Training** employees (including volunteers):

- _____ Orientation & regularly scheduled in-servicing for all staff and employees?
- _____ Formal training/procedures for incident reporting?
- _____ Formal training for identifying, preventing and avoiding resident abuse? (Including resident on resident)

SECTION V

RISK MANAGEMENT AND RESIDENT SAFETY

1. Is there a formal risk management program in place? Yes_____ No_____
2. Is an assessment done on all residents prior to admission? Yes_____ No_____ Does the assessment include Fall risk? Yes_____ No_____ Elopement Risk? Yes_____ No_____
3. How often are assessments performed after the initial assessment? _____
4. Is the family or guardian and physician notified of any change in condition? Yes_____ No_____
5. Is there a specific transfer and discharge criteria? Yes_____ No_____
6. Does your community have a no-smoking policy? Yes_____ No_____
7. Does the insured have security measures in place to prevent unauthorized entrances or elopement from the facility? Yes_____ No_____; Describe what security measures are in place (I.e.: Wanderguard, Camera Systems, Electronic Locks on Doors, Door Alarms, etc.)

8. Are there written procedures regarding medication handling or storage? Yes_____ No_____
9. What is the medication error ratio ____%?
10. Are there written emergency evacuation procedures and are they properly posted? Yes_____ No_____
11. Are there advance arrangements for transportation to a temporary shelter? Yes_____ No_____
12. Confirm that the insured has the following protocol in place (check all that apply):
Formal incident reporting_____ Skin Integrity Program, including regular assessments_____
Missing resident protocol_____ Fall Prevention_____
13. Does the insured utilize binding arbitration in resident agreements? Yes____ No_____
14. Does the insured utilize shared risk agreements? Yes____ No_____
15. Does the insured utilize resident & family surveys? Yes____ No_____
16. Are pets allowed on premise? Yes____ No_____

SECTION VI

LIFE SAFETY / PROPERTY PROTECTION

1. Is the property built for occupancy? Yes _____ No _____ If no, indicate when and what renovations have been done:
_____ Roof _____ Wiring _____ Plumbing
 2. Are there any surrounding exposures that may be considered hazardous? Yes _____ No _____
 3. # of stories? _____
 4. Are all nonambulatory residents on the ground floor? Yes _____ No _____
 5. Are there at least two remote exits on each floor? Yes _____ No _____
 6. Indicate what types of building protections are in place (check all that apply)
Sprinkler System [] Central Alarm Stations [] Smoke Detectors in resident rooms []
Fire extinguishers [] Battery backup []
 7. How often fire drills are conducted? Monthly _____ Quarterly _____ Annually _____
 8. Does the insured perform at least one fire drill during night hours? Yes _____ No _____
 9. Is there a building maintenance program? Yes _____ No _____
 10. What types of cooking sources are used? Gas _____ Electric _____ Deep Fat Fryer _____
 11. Is there a fire suppression system for the cooking area? Yes _____ No _____
 12. Are hoods/ducts cleaned by outside vendor on semi-annual basis? Yes _____ No _____
-

SECTION VII

AUTOMOBILE

1. Do you provide regular transportation for residents? Yes _____ No _____
2. Do you contract with a transport service for residents? Yes _____ No _____ If so, what kind?
Ambulance _____ Buses _____ Vans _____
3. Do you have any owned autos? Yes _____ No _____
4. Do employees or volunteers use their own vehicles on behalf of the insured? Yes _____ No _____
If yes, indicate frequency and details of usage _____
If yes, does the insured verify insurance coverage and require state minimum limits or higher? _____
5. What is the maximum distance for regular transportation of clients? _____
6. What is the minimum and maximum ages of drivers allowed to drive passengers? _____
7. Do you check MVR's? Yes _____ No _____ How often? _____



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Do you have MVR criteria for drivers? Yes _____ No _____

If so, please describe criteria _____

Is there training provided for proper loading and transportation of nonambulatory residents? _____

8. Is there a vehicle maintenance plan? Yes _____ No _____

9. Is there any personal use of any of your owned vehicles? Yes _____ No _____

If so, how often? _____; Do youthful drivers, or spouse, have access to these vehicles? _____

Notes and Comments _____

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

This application is understood to be an inducement to the issuance of a policy of insurance by the Company. The undersigned hereby authorizes the Company to obtain information necessary for evaluation in determining acceptability including but not limited to motor vehicle reports, credit reports and physical inspection.