The Hanover Insurance Group™

SURPLUS LINES
ELDERCARE ADVANTAGE

Renewal Supplemental Application

Underwritten by The Hanover Atlantic Insurance Company, Ltd.

NOTICE: THIS APPLICATION MAY BE FOR BOTH OCCURRENCE COVERAGES AND CLAIMS-MADE COVERAGES. CLAIMS-MADE COVERAGE IS LIMITED TO LIABILITY TO CLAIMS FIRST MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

The insurer is not licensed by the insurance department and is subject to its limited regulation. In the event the insolvency of an eligible surplus lines insurer losses will not be paid by any state funds.

Required Documents for PL/GL:
Completed & Signed Supplemental Application
Completed & Signed COVID Renewal Supplemental Application
Most Recent State Survey with Accepted POC
Current Facility License

Required Documents for Auto:
Driver List including Name, State, Date of Birth & Driver's License Number
(drivers under age 25 and over age 75 are not eligible for auto coverage)

A RESPONSE IS REQUIRED FOR EACH QUESTION INCLUDING N/A IF NOT APPLICABLE. PLEASE COPY AND COMPLETE A SEPARATE LOCATION ADDENDUM (REFER TO PAGE 7) FOR EACH ADDITIONAL LOCATION.

I. APPLICANT INFORMATION SECTION

A. Named Insured: _____
Name and address of facility #1: _____
Medicare/Medicaid #: _____

B. Is a management company involved in operations? ☐Yes ☐No
Do they share ownership? ☐Yes ☐No
If Yes, please provide name and confirm ownership interested:____

C. Are all required licenses to operate as an Eldercare facility current and in good standing? ☐Yes ☐No

D. Have you opened or closed any locations within the past 12 months? ☐Yes ☐No
If Yes, please explain:_____

E. Have there been any other material changes in your business or new services added' during the past 12 months? ☐Yes ☐No
If Yes, please describe:_____

II. EXPOSURES

A. Licensure

Type of License	Total Licensed Beds/Units	Average Occupancy
Sub-Acute		
Skilled Nursing		
Intermediate Care		
Assisted Living		
Alzheimer's/Memory Care		
Independent Living Any residents under 55 years of age? ☐Yes ☐No Is this a HUD Financial Location? ☐Yes ☐No Is this section 8/housing voucher Subsidized? ☐Yes ☐No If Yes, then how many units? _____		

B, Resident Profile

# of Residents	Under 50	51-64	65-79	Over 80
Ambulatory				
Non-Ambulatory				
Bedbound				
Short term residents				

Average Length of Stay	0-60 days	60-180 days	Over 180 days
# of Residents:			

C. Number of residents receiving services related to:
Alcohol/Drug Abuse: ____ Dementia: ____ Alzheimer's: _____ Brain Injury: _____
Psychiatric Care: _____ Developmental Disabled: _____ Other: ____
*Explain: _____

D. Do you accept any residents with a primary psychiatric diagnosis? ☐Yes ☐No
If Yes, please provide details: _____

E. Do you accept or retain residents who are or could be a threat to other residents? ☐Yes ☐No
If Yes, please explain: _____

F. **Additional Services Offered**:
Respite Care: Total Number of Licensed Spots: _____ Average Occupancy: _____
Maximum # of days: _____
Adult Day Care: Number of Participants in Each: Medical _____ Social: _____
Home Health Care: Annual Revenues: onsite Medical: $_____ onsite Non-Medical: $_____
offsite Medical: $_____ offsite Non-Medical: $_____
Community Center: Square Footage: _____
Durable Medical Equipment: Annual Revenues: $_____ Provided to residents only? ☐Yes ☐No

Meals on Wheels: Annual Revenues: onsite Medical: $_____ Annual Number of Meals: ____

PACE: Annual Revenues: $_____

Pharmacy: Annual Revenues: $ _____ Is this a closed pharmacy? ☐Yes ☐No

Restaurant: Annual Revenues: $_____ Open to the public? ☐Yes ☐No

Liquor: Annual Revenues: $_____ Available to the public? ☐Yes ☐No

Special Events: Number of events annually:_____ Number of attendees per event: _____

Offsite or Valet Parking: # of Spaces: _____

Do you offer Childcare services? ☐Yes ☐No

Do you have an intergenerational program? ☐Yes ☐No

III. STAFFING

A. Key Staffing/Management

Title, Name & Contact Info	Years with Facility	Years of Experience in Healthcare	Hours Per Week
Administrator: _____ Contact Phone: _____ Contact E-mail:_____			
Director of Nursing: _____			
Risk Manager: _____ Contact Phone: _____ Contact E-mail:_____			
Medical Director: _____ Attending Physician to Residents? ☐Yes ☐No If Yes, how many:_____			

B. Physicians/Physician Assistants/Nurse Practitioners (to be covered under this policy):

Physicians: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No

Physician Assistants: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No

Nurse Practitioners: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No

Do they carry insurance? ☐Yes ☐No

If Yes, what limits are required: _____

C. Indicate the number of care staff per shift:

Coverage by Shift			
Specialty	1st Shift	2nd Shift	3rd Shift
RNs			
LPNs			
CNAs			
Aides			
Other:			

IV. RISK MANAGEMENT – SKIN CARE

Please provide the last three months of wound documentation below:

Month	Stage I		Stage II		Stage III		Stage IV		Unstaged	
# of wounds	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired
1										
2										
3										

V. CLAIMS/INCIDENTS

A. Since your last applications, has the named insured or any subsidiary been sanctioned or any convictions? ☐Yes ☐No

B. Have you had any elopements during the past 12 months? ☐Yes ☐No

If Yes, please provide details including any injuries and disposition of the resident:

_____

_____

C. Have any new claims or suits for alleged malpractice been brought against you since the date of your last application, or are you aware of any recent circumstances that might lead to such a claim or suit that you have not yet reported to us? ☐Yes ☐No

Claimant/Resident: _____

Circumstances: _____

By my signature below:

1. I confirm 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 and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for, whether or not disclosed. Any claim based upon, arising out of or in connection with any misrepresentation, omission, concealment, untruthful, inaccurate, or incomplete statement of a material fact in this application or otherwise shall be excluded from coverage. Signing of this application does not bind The Hanover Atlantic Insurance Company, Ltd. or any of its insurance affiliates or subsidiaries to offer, nor the authorized signer to accept insurance.
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 The Hanover Atlantic Insurance Company, Ltd. in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotations 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 The Hanover Atlantic Insurance Company, Ltd. and my broker, agent or peer review.

GENERAL FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly provides false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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.

FLORIDA AND OKLAHOMA: 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 in FL).

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY, OHIO AND PENNSYLVANIA: 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.

MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: 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. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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 subjects such person to civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF APPLICANT's AUTHORIZED REPRESENTATIVE

SIGNATURE IN FULL: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

Produced By: Producer:_____ Agency:_____

Taxpayer ID:_____ License Number:_____ Email:_____

Address (Street, City, State, Zip):_____

PLEASE COPY AND COMPLETE ONE ADDENDUM FOR EACH ADDITIONAL LOCATION/FACILITY

Facility Name: _____ Address: _____

I. EXPOSURES

A. Licensure

Type of License	Total Licensed Beds/Units	Average Occupancy
Sub-Acute		
Skilled Nursing		
Intermediate Care		
Assisted Living		
Alzheimer's/Memory Care		
Independent Living Any residents under 55 years of age? ☐Yes ☐No Is this a HUD Financial Location? ☐Yes ☐No Is this section 8/housing voucher Subsidized? ☐Yes ☐No If Yes, then how many units? _____		

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# of Residents	Under 50	51-64	65-79	Over 80
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Non-Ambulatory				
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Short Term Residents				

Average Length of Stay	0-60 days	60-180 days	Over 180 days
# of Residents:			

C. Number of residents receiving services related to:
Alcohol/Drug Abuse: ____ Dementia: ____ Alzheimer's: _____ Brain Injury: _____
Psychiatric Care: _____ Developmental Disabled: _____ Other: ____
*Explain: _____

D. Do you accept any residents with a primary psychiatric diagnosis? ☐Yes ☐No
If Yes, please provide details: _____

E. Do you accept or retain residents who are or could be a threat to other residents? ☐Yes ☐No
If Yes, please explain: _____

F. **Complete all that apply:**
Respite Care: Total Number of Licensed Spots: _____ Average Occupancy: _____
Maximum # of days: _____
Adult Day Care: Number of Participants in Each: Medical _____ Social: _____

Home Health Care: Annual Revenues: onsite Medical: $_____ onsite Non-Medical: $_____
offsite Medical: $_____ offsite Non-Medical: $_____
Community Center: Square Footage: _____
Durable Medical Equipment: Annual Revenues: $_____ Provided to residents only? ☐Yes ☐No
Meals on Wheels: Annual Revenues: onsite Medical: $_____ Annual Number of Meals: _____
PACE: Annual Revenues: $ _____
Pharmacy: Annual Revenues: $ _____ Is this a closed pharmacy? ☐Yes ☐No
Restaurant: Annual Revenues: $_____ Open to the public? ☐Yes ☐No
Liquor: Annual Revenues: $_____ Available to the public? ☐Yes ☐No
Special Events: Number of events annually:_____ Number of attendees per event: _____
Offsite or Valet Parking: # of Spaces: _____
Do you offer Childcare services? ☐Yes ☐No
Do you have an intergenerational program? ☐Yes ☐No

II. STAFFING

A. Key Staffing/Management

Title, Name & Contact Info	Years with Facility	Years of Experience in Healthcare	Hours Per Week
Administrator: _____ Contact Phone: _____ Contact E-mail:_____			
Director of Nursing: _____			
Risk Manager: _____ Contact Phone: _____ Contact E-mail:_____			
Medical Director: _____ Attending Physician to Residents? ☐Yes ☐No If Yes, how many:_____			

B. Physicians/Physician Assistants/Nurse Practitioners (to be covered under this policy):

Physicians: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No
Physician Assistants: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No
Nurse Practitioners: # Employed: _____ # Contracted: _____ License Verified: ☐Yes ☐No
Do they carry insurance? ☐Yes ☐No
If Yes, what limits are required: _____

C. Indicate number of care staff per shift and annual turnover percentage below:

Title	Day Shift	Evening Shift	Night Shift	Annual Turnover Percentages
RN				
LPN/VPN				
CNAs				
Licensed Registry				
CNA Registry				

D. What percentage of your licensed staff for the past 12 months was from a registry/staffing company? _____%

E, What percentage of your CNA staff for the past 12 months was from a registry/staffing company? _____%

F. Do have a contract with all staff registry companies that you use? ☐Yes ☐No

G. Do require staffing agencies to carry workers' compensation and professional liability insurance? ☐Yes ☐No

H. Does your contract clarify who is responsible for verifying licenses and certifications for all? ☐Yes ☐No

I. Is there 24-hour "awake staff" on premises? ☐Yes ☐No

J. Do you have volunteers? ☐Yes ☐No

If Yes, how many? _____

III. RISK MANAGEMENT – SKIN CARE

Do you stage wounds?

If Yes, provide the last three months of wound documentation below:

Month	Stage I		Stage II		Stage III		Stage IV		Unstaged	
# of wounds	**Admitted**	**Acquired**	**Admitted**	**Acquired**	**Admitted**	**Acquired**	**Admitted**	**Acquired**	**Admitted**	**Acquired**
1										
2										
3										

IV. RISK MANAGEMENT – SMOKING PROTOCOL

A. Do you allow resident smoking anywhere on the premises? ☐Yes ☐No

If Yes, where: _____ Is it supervised? ☐Yes ☐No

B. Are residents assessed upon admission and regularly thereafter for the ability to smoke safely? ☐Yes ☐No

C. Are residents allowed to keep their own smoking materials? ☐Yes ☐No

If No, how do you control the possession of smoking materials? _____

_____

V. RISK MANAGEMENT – ELOPEMENT PROTOCOL

A. Do you have a specialized Alzheimer's or Dementia unit? ☐Yes ☐No

If Yes, is it a(n)? ☐ Entire facility ☐ Specialized unit

B. Are the units locked/secured? ☐Yes ☐No

C. Do the units have delayed regress? ☐Yes ☐No

D. Do you have a WanderGuard or a similar door system? ☐Yes ☐No

If Yes, is the system installed on all resident doors leaving facility? ☐Yes ☐No

E. Do you have staff trained in managing residents with Alzheimer's or Dementia? ☐Yes ☐No

F. Do you have activities for residents with Alzheimer's or Dementia to keep them engaged? ☐Yes ☐No

G. Have there been any elopements in the past year? _____

If yes, please provide details: _____

_____

VI. RISK MANAGEMENT – SKIN CARE

Do you stage wounds?

If Yes, provide the last three months of wound documentation below:

Month	Stage I		Stage II		Stage III		Stage IV		Unstaged	
# of wounds	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired	Admitted	Acquired
1										
2										
3										

VII. LIFE SAFETY EXPOSURES – FACILITY OPERATIONS

A. Year facility was constructed: _____ Construction type: _____

Number of stories: _____ Square footage: _____

Any modular structure? ☐Yes ☐No

B. Was building originally designed and constructed for senior living occupancy? ☐Yes ☐No

C. Is the facility 100% sprinklered? ☐Yes ☐No

Including attics and closets? ☐Yes ☐No

VIII. LIFE SAFETY EXPOSURES – FACILITY RECREATION

A. Do you have a swimming pool, hot tub or Jacuzzi? ☐Yes ☐No

If Yes, indicate the total number and the square footage and water depth? _____

B. Does any pool have a diving board or slide? ☐Yes ☐No

C. Do you allow anyone other than residents to use the pool, hot tub or Jacuzzi? ☐Yes ☐No

D. Do you have a fitness area or fitness equipment? ☐Yes ☐No

If Yes, are residents trained on proper use of equipment? ☐Yes ☐No

E. Is your fitness area: ☐ Supervised? ☐ Equipped with emergency pull cords?

☐ Equipped with telephone?

F. Do you require residents to be cleared by a physician before using exercise equipment? ☐Yes ☐No

Note: This Addendum is subject to the same representations and statements as the corresponding Eldercare Supplemental Application to which this is attached.