The Hanover Insurance Group™

SURPLUS LINES
ELDERCARE ADVANTAGE

New Business 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 ACORD Application (including schedule Named Insureds)
Completed & Signed Supplemental Application
Completed & Signed COVID Supplemental Application
Most Recent Annual State Survey with Accepted POC
Five Years of Currently Valued Carrier Loss Runs
Current Facility License
Expiring Declarations Page (if applicable)

Required Documents for Auto:
Completed ACORD Applications
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)
Five Years of Currently Valued Carrier Loss Runs

A RESPONSE IS REQUIRED FOR EACH QUESTION INCLUDING N/A IF NOT APPLICABLE. PLEASE COPY AND COMPLETE A SEPARATE LOCATION ADDENDUM (REFER TO PAGE 14) FOR EACH ADDITIONAL LOCATION.

Effective Date:		Expiring Carrier:	
Expiring Policy Premium		Current Coverage:	Claims-Made ☐Yes ☐No

I. APPLICANT INFORMATION SECTION

A. Named Insured: _____

Corporate Address: _____

FEIN #: _____

Website: _____

Name of Facility #1: _____

Address of Facility #1: _____

City: _____ State: _____ Zip Code: _____ County: _____

Your Interest in facility: ☐ Owner ☐ Lessor ☐ Management Company

Number of years under current ownership: _____

Organizational Structure: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Trust ☐ LLC

☐ For Profit ☐ Not For Profit Any hospital affiliation ☐Yes ☐No

B. Do you own, manage or control any eldercare entity or location not included in this application? ☐Yes ☐No

If Yes, provide details including names of other entities: _____

_____

C. Do you have plans to purchase, lease, manage or acquire any percentage of ownership in another facility in the next 12 months? ☐Yes ☐No

D. Are you a member of any healthcare or eldercare organizations? ☐Yes ☐No

If Yes, please list the organizations: _____

E. Has this facility

Changed its name in the last five years? ☐Yes ☐No

Been purchased? ☐Yes ☐No

Been sold, or is being considered for sale in the next 12 months? ☐Yes ☐No

Filed for bankruptcy in the last 5 years? ☐Yes ☐No

F. Has your license ever been suspended, revoked or placed on probationary status? ☐Yes ☐No

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 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? _____

K. Is there a formal screening process and training program? ☐Yes ☐No

L. Do you train volunteers on how to recognize and report alleged resident abuse? ☐Yes ☐No

M. Do volunteers have one-on-one access to residents? ☐Yes ☐No

N. Is there a formal written policy on what volunteers are allowed to do? ☐Yes ☐No

O. Indicate the background checks performed for new hires:

	State	Nationwide
Prior Employment		
Licenses/Certifications		
Sexual Offender		
Abuse Registry		
Criminal Record		
Drug Testing		
Driving Record (MVR)		

P. Are Certificates of Insurance obtained for all independent contractors and services provided to your facility? ☐Yes ☐No

Q. Do you require limits equal to or greater than your facilities limits? ☐Yes ☐No

R. Do you have contracts on file for your independent contractors and services? ☐Yes ☐No

S. Do you renew your contracts with your independent contractors annually? ☐Yes ☐No

IV. RISK MANAGEMENT – POLICIES AND PROCEDURES

A. Is there a formal risk management program? ☐Yes ☐No

B. Do you have a program to investigate, document and report incidents? ☐Yes ☐No

C. Who reviews the incidents? _____

D. Who reviews requests for medical records? _____

E. Do you have a resident counsel? ☐Yes ☐No

F. Do you have a family counsel? ☐Yes ☐No

G. Do you train staff on how to recognize and report alleged resident abuse? ☐Yes ☐No

H. Have you had an incident of alleged/suspected abuse in the past 12 months? ☐Yes ☐No

If Yes, # of allegations: _____ # substantiated: _____ Were claims filed? ☐Yes ☐No

I. Select the assessments conducted for all new residents:

☐ **Mobility problems**	☐ **Skin problems**	☐ **Falls**	☐ **Psychiatric conditions**
☐ **Wandering/elopement**	☐ **Nutritional status**	☐ **Prior Injuries**	☐ **Impaired cognitive abilities**

J. Are the same assessments performed at re-admission? ☐Yes ☐No

K. Do you require a current (within 60 days) physical examination by a physician before admission? ☐Yes ☐No

L. Does your client service agreement include criteria defining conditions for discharge and/or transfer? ☐Yes ☐No

M. Do you offer an arbitration agreement at admission? ☐Yes ☐No

N. Are admission and discharge policies disclosed, agreed upon, documented and signed by residents and/or legal guardians prior to move in? ☐Yes ☐No

O. Do you have regularly scheduled evaluations of residents' physical and mental eligibility to remain at the facility? ☐Yes ☐No
If Yes, how frequently? _____

P. Are residents to leave the premises unaccompanied? ☐Yes ☐No
If Yes, under what circumstances? _____

V. RISK MANAGEMENT – SKIN CARE

A. Do you have a skin management program to monitor residents or skin tears? ☐Yes ☐No

B. Do you provide care for residents who need assistance with sterile dressing changes? ☐Yes ☐No

C. Do you accept, retain or provide care for residents with Stage III or IV wounds? ☐Yes ☐No

D. Does your client service agreement stipulate policies defining conditions for discharge related to skin tears? ☐Yes ☐No

E. Are measurements of wounds taken on admission and readmission? ☐Yes ☐No

F. Are measurements of wounds taken to show progress? ☐Yes ☐No

G. Do you use services of a wound care specialist? ☐Yes ☐No

H. Do you stage wounds? ☐Yes ☐No
If Yes, 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										

VI. RISK MANAGEMENT – MEDICATION MANAGEMENT

A. Who distributes medications? _____

B. How are medications distributed? ☐ Full unit dose ☐ Modified unit dose ☐ Open bottle ☐ Other: _____

C. How are medications stored? ☐ Locked room ☐ Locked cabinet ☐ Locked cart ☐ Other: _____

D. Do have a system to track, monitor and document medical errors? ☐Yes ☐No

E. What is your current medication error ratio: _____ Date of evaluation: _____

F. Do you have a method to monitor potential drug interactions? ☐Yes ☐No

G. Are internal pharmacy reviews conducted regularly? ☐Yes ☐No
If Yes, are the results recorded and maintained? ☐Yes ☐No
How often and by whom? _____

H. Do residents self-administer medication? ☐Yes ☐No

I. Do employees assist residents with medication administration? ☐Yes ☐No

J. Do employees assist residents with intravenous injections? ☐Yes ☐No
If Yes, describe the types of injectable medications? _____
K. Are inventory controls for resident prescription medications in place? ☐Yes ☐No

VII. RISK MANAGEMENT – FALL MANAGEMENT

A. Are call buttons/pull cords operational in each room? ☐Yes ☐No
Are they monitored 24/7? ☐Yes ☐No
B. Do you have a fall management program? ☐Yes ☐No
C. Are employees informed about which residents are at risk of falling? ☐Yes ☐No
D. Are falls monitored, investigated and tracked to identify patterns or problems? ☐Yes ☐No
E. Are handrails provided in hall and bathrooms? ☐Yes ☐No
F. Are bathrooms, bathtubs and showers equipped with nonslip floor surfaces? ☐Yes ☐No
G. Are resident beds equipped with side rails or transfer poles? ☐Yes ☐No
If Yes, describe type? _____
H. Are resident mechanical lifts used? ☐Yes ☐No
I. Do you provide staff training for mechanical lists, resident lifting aids or devices? ☐Yes ☐No
J. Do you conduct regular preventive maintenance inspections? ☐Yes ☐No

VIII. 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
Number of residents who smoke: _____
C. Are residents allowed to keep their own smoking materials? ☐Yes ☐No
If No, how do you control the possession of smoking materials? _____
_____
D. Do residents wear fire retardant aprons while smoking? ☐Yes ☐No
E. Do you use noncombustible receptacles for discarded smoking materials? ☐Yes ☐No
F. Do you conduct cigarette butt pick-up using a dampened metal container? ☐Yes ☐No

IX. RISK MANAGEMENT – ELOPEMENT PROTOCOL

A. How often are residents accounted for? _____
B. Do you accept residents who wander? ☐Yes ☐No
If Yes, how many? _____
C. Do you have a program for addressing residents who wander? ☐Yes ☐No

D. Do you have a specialized Alzheimer's or Dementia unit? ☐Yes ☐No
If Yes, is it a(n)? ☐ Entire facility ☐ Specialized unit

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

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

G. 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

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

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

J. Do you perform regular drills to respond to a resident elopement? ☐Yes ☐No

K. Do you perform post elopement assessments? ☐Yes ☐No

L. How many elopements have occurred in the past five years? _____
Provide details: _____

_____

M. Do you utilize physical and/or chemical restraints? ☐Yes ☐No
If yes, what percentage of residents with: Physical Restraints? _____%
Chemical Restraints? _____%
Described restraints used? _____

X. FACILITY SAFEGUARDS

A. Do you have a written emergency/disaster and evacuation plan? ☐Yes ☐No

B. Are exit signs, evacuation routes and directions posted in key areas? ☐Yes ☐No

C. Are emergency drills conducted for each shift? ☐Yes ☐No
If Yes, how often? _____

D. If your facility consists of multistory buildings, are residents with reduced mobility located on the lower floors? ☐Yes ☐No

E. When did the Fire Department/Marshall last inspect the facility? ☐Yes ☐No

F. How often are clothes dryer lint screens cleaned? _____

G. How often are dryer ducts to the outside cleaned? _____

H. How often are laundry rooms swept and/or vacuumed? _____

I. Do you have any laundry chutes? ☐Yes ☐No
If Yes, do the residents have access? ☐Yes ☐No

J. Do you allow residents to use motorized wheelchairs and/or scooters? ☐Yes ☐No
If Yes, do you assess the residents' ability operate the wheelchair/scooter safely? ☐Yes ☐No

K. Are tempering valves used to control the temperature of the water available to residents? ☐Yes ☐No
If Yes, at what temperature are they set? _____
How often are settings measured? _____

XI. 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

D. Do you have maintenance and service contract with a fire sprinkler contractor? ☐Yes ☐No

If Yes, how often is the fire sprinkler system tested? _____

E. Are fire sprinklers connected to a monitored water flow alarm? ☐Yes ☐No

If Yes, indicate how it is monitored: ☐ UL Approved central station alarm company

☐ Local fire department staffed 24 hours a day

F. Are manual pull fire alarms distributed throughout the facility? ☐Yes ☐No

If Yes, are pull alarms connected to a local or central station alarm system? ☐Yes ☐No

G. Are smoke detectors: ☐ Connected to a local alarm?

☐ Monitored by a UL Approved central station alarm company?

H. Are smoke detectors battery operated only? ☐Yes ☐No

If there are any battery operated alarms, do you have a battery replacement and oversight program? ☐Yes ☐No

If Yes, please describe the program and frequency of inspections: _____

_____

I. Do you have a currently tagged Class K fire extinguisher in the kitchen? ☐Yes ☐No

J. Do you have multipurpose ABC Type portable fire extinguishers in areas outside the kitchen? ☐Yes ☐No

K. Do you use or allow use of portable space heaters? ☐Yes ☐No

L. Do you use or allow use of portable hot plates? ☐Yes ☐No

M. Do you have a hood and duct exhaust system over all cooking equipment? ☐Yes ☐No

N. Does a certified contractor clean the kitchen hood and duct exhaust system? ☐Yes ☐No

If Yes, how often? _____

O. How often are the kitchen hood and duct filters cleaned? _____

P. Do you cook with deep fat fryers? ☐Yes ☐No

If Yes, does a contractor inspect and service the deep fat fryers? ☐Yes ☐No

How often? _____

Q. Does an automatic fire suppression system cover all cooking surfaces? ☐Yes ☐No

If Yes, does a contractor inspect and service the fire suppression system? ☐Yes ☐No

How often? _____

R. Does your fire suppression system have a shutoff valve? ☐Yes ☐No

S. Do you have an auxiliary electrical system? ☐Yes ☐No

If No, describe type and location of emergency lighting and/or equipment system: _____

T. Does your auxiliary electrical system run the HVAC system? ☐Yes ☐No
If No, describe how heating/cooling is handled in the event of an extended power shortage: _____

U. Do you have a regular pest extermination program by an outside firm? ☐Yes ☐No
If Yes, how often? _____

XII. 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
If Yes, describe the terms of use: _____
D. Is there a lifeguard on duty when the pool is open? ☐Yes ☐No
E. Is the pool or Jacuzzi secured or locked when not in use? ☐Yes ☐No
F. Is there a daily maintenance and testing procedure in place? ☐Yes ☐No
G. Are there any other bodies of water present on the property? ☐Yes ☐No
If Yes, are these bodies of water fenced? ☐Yes ☐No
H. Do you have a fitness area or fitness equipment? ☐Yes ☐No
If Yes, are residents trained on proper use of equipment? ☐Yes ☐No
I. Is your fitness area: ☐ Supervised? ☐ Equipped with emergency pull cords? ☐ Equipped with telephone?
J. Do you require residents to be cleared by a physician before using exercise equipment? ☐Yes ☐No
K. Do you permit pets/animals to be kept or brought into the facility? ☐Yes ☐No
If Yes, do you require proof of vaccinations? ☐Yes ☐No
L. Do you have spas, beauty salons or retail operations? ☐Yes ☐No
If Yes, who are these operations owned and maintained by? ☐ You? ☐ Outside vendor
M. Are operators of spas, beauty salons or retail operations insured separately? ☐Yes ☐No

XIII. TRANSPORTATION SAFETY

A. Do you transport residents? ☐Yes ☐No
If Yes, within what mileage radius: _____
B. Number of employees that transport residents? _____
C. Are MVRs (driving records) ordered prior to authorizing individuals to transport resident, and at least annually thereafter? ☐Yes ☐No
D. Is resident transportation contracted to a third party? ☐Yes ☐No
If Yes, who assists residents into and out of contracted vehicles? _____
E. What safety equipment is standard on your owned vehicles? _____
F. How are employees trained to properly secure wheelchairs? _____
G. Are employees trained to properly secure wheelchairs? ☐Yes ☐No

H. Do employees or volunteers use their own vehicles to transport residents? ☐Yes ☐No

I. Do volunteers operate any of the insured's vehicles? ☐Yes ☐No

J. Is there a vehicle maintenance program in place? ☐Yes ☐No

XIV. CLAIMS/INCIDENTS

Are you aware of any circumstances or an incident that has occurred and was not reported to your insurance carrier that may lead to a claim? ☐Yes ☐No

If Yes, please provide details: _____

_____

_____

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? _____		

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. **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

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

Q. 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.