HEALTHCAREPros
A DIVISION OF U.S. Risk, LLC

MG Insurance SERVICES

APPLICATION FOR LONG TERM CARE FACILITIES
PROFESSIONAL AND GENERAL LIABILITY

Each question must be fully answered. If not applicable, please state "N/A".
(Please complete a separate application for each location.)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

❑ New Application
❑ Renewal of Policy #_____ Desired Effective Date: _____

PLEASE INCLUDE THE FOLLOWING ATTACHMENTS WITH THIS APPLICATION FOR INSURANCE:

1. ACORD General Application
2. Hard copy, currently valued professional and general liability loss runs for the past five (5) years.
3. Most current HCFA/State survey and/or any other regulatory inspection **including** complaint survey(s), if applicable.
4. Current financials statements that include both the balance sheet and income statement.
5. Facility Quality Indicator Profile for a recent 6-month period of time.
6. Facility Characteristics Profile for a recent 6-month period of time.

PART I – GENERAL INFORMATION

1.a. **Named Insured:** _____
(Include full legal entity and all trade names. Attach separate sheet if necessary).

b. **Mailing Address:** _____
(City, State, Zip)

c. **Named Insured is:** ❑ Building Owner ❑ Tenant ❑ General Lessee ❑ Management Company ❑ Other _____

Building owner (IF OTHER THAN THE NAMED INSURED): _____

d. **Named Insured organizational structure (check all that apply):** ❑ Individual ❑ Corporation ❑ Partnership ❑ Joint Venture ❑ LLC ❑ Governmental ❑ Private Company ❑ Public Company ❑ For Profit ❑ Not-for-profit

e. **Is the Named Insured engaged in, owned by or associated with or involved in any other enterprise?** ❑ Yes ❑ No
If yes, please describe: _____

f. **If management company, provide name and corporate address:** _____
_____

2.a. **Name of Facility:** _____
(Include full legal entity and all trade names. Attach separate sheet if necessary).

b. **Physical Address of Facility:** _____
(City, State, Zip) **Email address**_____

c. **Facility Phone #:** _____ **Facility Fax #:**_____ **Facility Web Site:** www:_____

d. **Facility organizational structure (check all that apply):** ❑ Individual ❑ Corporation ❑ Partnership ❑ Joint Venture ❑ LLC ❑ Governmental ❑ Other _____ ❑ For Profit ❑ Not-for-profit

e. **Under what type of license is the facility operating (check all that apply):** ❑ Nursing Facility ❑ Assisted Living Facility ❑ Residential Care Facility ❑ Other _____

f. **Facility Total Gross Revenue: $_____**

g. **Total number of employees**: _____

3. **Number of YEARS the facility has been:** Operating: _____ Owned by current owners: _____
Operated by the current management _____
How many years experience does the **current ownership** have as respects the operation of long term care facilities?
_____
How many years experience does the **current management** have as respects the management of long term care facilities? _____

4. **Within the past 2 years, has the facility:**

Filed bankruptcy?	❑ Yes ❑ No
Medicare Certification suspended?	❑ Yes ❑ No
Medicaid Certification suspended?	❑ Yes ❑ No
License suspended, revoked or been placed on probation?	❑ Yes ❑ No
Fined by a State or Federal Agency?	❑ Yes ❑ No

Incident that resulted in an allegation of sexual abuse or bodily injury? ❑ Yes ❑ No

5. **Facility surveys and inspections:**
a. Date of Last Department of Health Survey: _____
b. Date of Last Department of Health Life Safety Survey: _____
c. Date of Last Fire Marshall Inspection: _____
d. Date of any complaints or sentinel event investigation(s) within the past 18 months: _____
e. During the past three (3) years, has the facility been cited with an **Immediate Jeopardy**? ❑ Yes ❑ No

6. **Additional Insured's and/or additional interests:**
Please list all additional insured's and/or additional interests (Attach a separate sheet if necessary):

Name	**Address**	**Relationship/Interest**
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART II – CURRENT ADMINISTRATION

1. Please complete the chart below:

Position	**Name**	**How many years in this position?**	**How many years of experience in this position?**	**How many hours are worked per week?**	**Employee or Independent Contractor?**
Administrator					
Director of Nurses (DON)					
Medical Director					
Risk Manager					

2. As respects the Administrator:
   a. Who is in charge when the administrator is absent (provide name and title)? _____
   b. How many administrators has the facility employed in the past 10 years? _____

PART III – DESCRIPTION OF OPERATIONS

1. **Facility Classification and Occupancy**	**Licensed beds/Units**	**Current Occupancy**
Sub-Acute/Rehab – RN coverage 8 consecutive hours every day, RN or LPN coverage other shifts. Ventilator care, wound management, post operative/trauma recovery, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, blood plasma transfusion, central line care, tracheostomy, dialysis		
Skilled Nursing – Inpatient nursing services to residents requiring 24-hour medical and nursing care. Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients		
Intermediate Care – Residents may require some minor nursing care or help in activities of daily living (ADL's) such as taking of medications, bathing, dressing and walking.		
Assisted Living – Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. May assist residents to take their own medications.		
Independent Living – Residents are in general good health and occupy an apartment, condominium or dwelling units that may include cooking facilities. Residents do not receive any health care services or assistance with medications or ADL's, but have access to nursing care within the same facility complex as needed.		
Other - _____ _____		

2. **Facility Characteristics:**
   a. How many ***current*** residents have a ***primary*** psychiatric diagnosis? _____
   b. How many ***current*** residents exhibit wandering tendencies? _____
   c. How many ***current*** residents are bedfast? _____
   d. Check all the services that are available, provide the number of beds available **and** provide the number of patients for each:

Available Services	**# of available beds**	**# of current residents receiving this service**
AIDS/HIV Care	_____	_____
Alzheimer's/dementia Care	_____	_____
Developmentally/mentally disabled Care	_____	_____
Drug and/or Alcohol Abuse Rehabilitation Care	_____	_____
IV Infusion Therapy Care	_____	_____
Psychiatric Care	_____	_____
Mentally Ill Care	_____	_____
Tracheostomy Care *	_____	_____
Ventilation therapy Care *	_____	_____
Other _____	_____	_____

*If services are provided, please complete the supplemental application.

3. **Resident Characteristics:**
   a. Do any residents have a history of violent behavior? ❑ Yes ❑ No

b. **Resident ages**: # of residents under the age of 18: ___, # of residents aged 19 to 55: ___,
# of residents aged 55 and older: _____

c. For **current residents** aged 55 and younger, **advise the age of each resident** and confirm there are no conditions that would make them a danger to themselves or to others: _____

_____

4. **Other Professional Liability Exposures** (check those that apply and indicate the ***annual*** number of visits or clients for the following):
   a. Adult Day Care ❑ # of Licensed beds: _____ ❑ # of client days per year: _____
   b. Home Health Care ❑ # of visits per year: _____
   c. Child Day Care ❑ **NOTE: We are unable to provide coverage for this service.**
   d. Other ❑ _____
   e. None of the above ❑

5. **Provide percentage of payment/reimbursement for each category:**
   a. Medicaid: _____ b. Medicare: _____ c. Private Pay: _____ d. Other _____

PART IV – RISK MANAGEMENT

1. Does the facility have a ***formalized*** risk management program? ❑ Yes ❑ No

2. Who coordinates the facility's risk management activities? _____

3. Does the risk management program include the following (check "yes" or "no" as applicable):
   a. Incident reporting/critical indicator screening? ❑ Yes ❑ No
   b. Tracking and trending of incidents at the corporate level? ❑ Yes ❑ No at the facility level? ❑ Yes ❑ No
   c. Claims management? ❑ Yes ❑ No
   d. Patient complaint/grievance procedures? ❑ Yes ❑ No
   e. Contract review and evaluation at facility? ❑ Yes ❑ No

4. Is there a written evacuation plan? ❑ Yes ❑ No
   a. Are evacuation plans posted in all parts of the facility? ❑ Yes ❑ No
   b. Does the plan include advance arrangements for transportation and shelter? ❑ Yes ❑ No

PART V – ADMISSION POLICIES

1. Is a comprehensive nursing assessment completed for new residents? ❑ Yes ❑ No For re-admissions? ❑ Yes ❑ No
   a. How frequently is the nursing assessment repeated (check those that apply)? ❑ Quarterly ❑ Monthly ❑ Other (list)
   _____

2. Who completes admission assessments? _____

3. Does the nursing assessment include the evaluation of (check those that apply):

Mobility Limitations?	❑ Yes ❑ No	Disorientation, history of wandering or elopement?	❑ Yes ❑ No
History of prior injuries?	❑ Yes ❑ No	History of skin problems?	❑ Yes ❑ No
Required Assistance?	❑ Yes ❑ No	Psychiatric history?	❑ Yes ❑ No
History of Falls?	❑ Yes ❑ No	Cognition limitations?	❑ Yes ❑ No

4. Is an inventory taken of residents' personal belongings on admittance with a copy maintained in the file? ❑ Yes ❑ No

5. Does the facility obtain advance written consent from the resident or guardian that allowed the facility to provide emergency medical care when it is needed? ❑ Yes ❑ No

PART VI – MONITORING AND CONTROLS

1. **General Operation Procedures:**
   a. Does your facility utilize any of the following (check all that apply):

- ❑ Shared Risk Agreement/Waiver
- ❑ Disclosure Forms
- ❑ Release of Liability Agreements
- ❑ Arbitration Agreements

b. Are **ALL** residents accounted for at least once every 24 hours? ❑ Yes ❑ No
c. Is there 24-hour "Awake Staff" of premises? ❑ Yes ❑ No
d. Do residents have their own attending physician? ❑ Yes ❑ No
If no, who performs the role of the attending physician? _____

e. How many residents utilize the Medical Director as their attending physician? _____

f. Are written orders from an attending physician required for (check those that apply):

Admission?	❑ Yes ❑ No	Any other therapy/treatment?	❑ Yes ❑ No
All drugs and medications?	❑ Yes ❑ No	Restraints?	❑ Yes ❑ No
Special dietary requirements?	❑ Yes ❑ No	Facility or hospital transfers?	❑ Yes ❑ No

g. Who determines if the resident must be transferred to another facility for further medical diagnosis or treatment?
_____

_____

2. **Fall Prevention** (answer "Yes" or "No" for the following)**:**
   a. Do you have a fall prevention program? ❑ Yes ❑ No
      i. If yes, does it include an assessment tool for identifying patients at risk for falls? ❑ Yes ❑ No
   b. Is there a communication system in place so staff knows which residents are at risk for falls **and** the appropriate interventions to use (i.e. Falling Star Program)? ❑ Yes ❑ No
   c. Are falls monitored and tracked to identify patterns or concerns? ❑ Yes ❑ No
      i. If yes, are corrective actions taken? ❑ Yes ❑ No
   d. Are handrails provided in halls and bathrooms? ❑ Yes ❑ No
   e. Is the bathtub and shower flooring nonskid? ❑ Yes ❑ No
   f. Are call-lights kept within resident reach when in the bedroom? ❑ Yes ❑ No Bathroom? ❑ Yes ❑ No
      i. If yes, who responds? _____
   g. Are personal and/or sensor alarms used? ❑ Yes ❑ No
   h. Are low beds and floor mats used when appropriate? ❑ Yes ❑ No
   i. Are mechanical lifts and gait belts used during resident transfers? ❑ Yes ❑ No

3. **Physical and Chemical Restraints** (answer "Yes" or "No" for the following):
   a. Is there a program in place to reduce the use of restraints? ❑ Yes ❑ No
   b. Are restraints applied while the resident is in bed? ❑ Yes ❑ No
   c. Is the use of restraints continuously evaluated and monitored? ❑ Yes ❑ No
   d. Is a physician evaluation **and** written notice from the physician (except in the case of emergency) required for the use of chemical or physical restraints? ❑ Yes ❑ No
   e. Is a patient or patient's legal representative/guardian written approval required prior to the use of physical or chemical restraints? ❑ Yes ❑ No
   f. What type of physical restraints are used (check those that apply)?
      ❑ Lap buddies ❑ Waist belts ❑ Chest or vest restraints ❑ Geri Chairs ❑ Side Rails
      ❑ Lap trays ❑ Other: _____
   g. Chemical restraints are currently in place for (enter number) _____ of residents
   h. Physical restraints are currently in place for (enter number) _____ of residents

4. **Skin Care** (answer "Yes" or "No" for the following):
   a. Are there written policies and procedures in place for the prevention and treatment of skin breakdown? ❑ Yes ❑ No
   b. How often are residents assessed for skin breakdown? ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Other_____
   _____

c. Who reviews the skin assessment reports? _____

_____

d. Is there a wound care nurse on staff? ❑ Yes ❑ No

e. Are dietary needs re-calculated for residents when a pressure sore is discovered? ❑ Yes ❑ No

f. Identify wounds:

Stage	**Inherited**	**Acquired**	**As of Date**
I			
II			
III			
IV			

g. Does the facility photograph all ulcers and include the photos in the resident's medical record? ❑ Yes ❑ No

5. **Medication Administration** (answer "Yes" or "No" for the following):

a. Who is responsible for administering medications to the residents in the facility? ❑ Licensed Nurse ❑ Medication Aide ❑ Other_____

What system do you have in place to ensure medications are administered according to manufacturer's recommendations and industry standards? _____

_____

b. Where are medications stored? _____

c. Are medications kept under locked conditions? ❑ Yes ❑ No Do only authorized personnel have keys? ❑ Yes ❑ No

d. Is there a system in place to track medication errors? ❑ Yes ❑ No

e. What is the medication error ratio for the last month? _____ as of _____

6. **Smoking policies and procedures** (answer "Yes" or "No" for the following):

a. Are any residents allowed to smoke unattended? ❑ Yes ❑ No

i. If yes, under what circumstances? _____

b. Are any residents allowed to possess their own matches or lighters? ❑ Yes ❑ No

i. If yes, under what circumstances? _____

c. Where are the designated smoking areas? _____ ❑ Inside ❑ Outside

d. Is smoking allowed in the residents' rooms? ❑ Yes ❑ No

e. Are smoking areas ***directly supervised*** by a member of the staff? ❑ Yes ❑ No

i. If no, what type of supervision is provided? _____

f. Are fire alarms in place and fully functional in ***all*** smoking areas? ❑ Yes ❑ No

i. If no, what areas are missing fire alarms? _____

7. **Elopement** (answer "Yes" or "No" for the following):

a. Are alarms on exit doors to prevent residents from wandering or leaving the premises without proper authorization? ❑ Yes ❑ No

i. If no, how is this controlled? _____

ii. Are residents allowed to sit or wander unsupervised in unsecured areas such as on the facility grounds? ❑ Yes ❑ No

b. Do you have a Wander Guard or similar alert system to prevent elopements? ❑ Yes ❑ No

i. Identify brand if other than Wander Guard: _____

ii. What is the protocol or criteria for placing an alarm bracelet on a resident, ***and*** do you notify the family? _____

_____

c. Does your facility have a locked unit(s)? ❑ Yes ❑ No

i. If yes, what system secures the unit? _____

ii. Number of beds in the unit: _____

iii. What type of unit(s) is/are locked? _____

d. During the past three (3) years has your facility had any residents elope from the facility? ❑ Yes ❑ No

i. If yes, how many? _____

ii. If yes, how many of the elopements ***resulted in injury*** to the resident? _____

iii. If yes, how many of the elopements ***resulted in death*** to the resident? _____

PLEASE PROVIDE A COPY OF THE INCIDENT REPORT(S) FOR EACH OF THE MISSING RESIDENT / ELOPEMENT INCIDENT(S)

PART VII – STAFFING

1. Are all employees required to attend an orientation program prior to beginning their employment? ❑ Yes ❑ No
   a. If no, who does not attend an orientation and why? _____
2. Does the facility have written job descriptions? ❑ Yes ❑ No
3. Is staff trained to perform CPR? ❑ Yes ❑ No
4. Is staff trained to perform basic first aid? ❑ Yes ❑ No
5. Is the facility a drug and alcohol free workplace? ❑ Yes ❑ No
6. Is 24-hour supervision of **ALL** employees provided? ❑ Yes ❑ No
7. Describe **Pre-Hire** practices (check those that apply):
   a. ❑ Criminal background check
   b. ❑ Verification of past work
   c. ❑ Board of Nursing/CNA registry checks
8. Are employees competencies assessed? ❑ Yes ❑ No
9. Are volunteers utilized? ❑ Yes ❑ No If yes, describe the selection process and training provided: _____
10. Does the facility utilize temporary nurses/nursing registry to provide any staff? ❑ Yes ❑ No
    a. If yes, what is the percentage of temporary nurses/nursing registry? _____
    b. If yes, are the temporary nurses/nursing registry covered by their own Worker's Compensation Insurance? ❑ Yes ❑ No
    c. If yes, does the temporary nurses/nursing registry have separate Professional Liability Insurance? ❑ Yes ❑ No
       i. If yes, does the facility obtain Certificates of Insurance? ❑ Yes ❑ No
       ii. What are the limits of insurance? _____
11. Provide the total number of standard daily staff working on each shift below:

Staff member	**Day Shift (1st shift)**	**Evening Shift (2nd shift)**	**Night Shift (3rd shift)**	**Does the staff member carry their own malpractice insurance?**
Contracted Physician(s)				❑ Yes ❑ No
DON/ADON				❑ Yes ❑ No
RN (Graduate nurses)				❑ Yes ❑ No
LPN (Practical nurses)				❑ Yes ❑ No
CNA's				❑ Yes ❑ No
Resident Assistants				❑ Yes ❑ No
Medication Aide				❑ Yes ❑ No
Activity				
Kitchen (dietary)				
Housekeeping				
Laundry				
Maintenance				
Other - _____				

PART VIII – CONTRACTUAL ARRANGEMENTS

1. Identify all contracted professional services performed for the Facility, advise if certificates of insurance are obtained and provide the minimum required medical professional liability insurance limits, if applicable:

Type of Service	**Certificate of Insurance obtained?**	**Required Medical Professional Liability Insurance Limits**

Barber/Beautician	❑ Yes ❑ No	$_____
Chiropractors	❑ Yes ❑ No	$_____
Dental	❑ Yes ❑ No	$_____
X-Ray/Laboratory/Radiology	❑ Yes ❑ No	$_____
Pharmaceutical	❑ Yes ❑ No	$_____
Physician	❑ Yes ❑ No	$_____
Podiatrist	❑ Yes ❑ No	$_____
Psychiatric	❑ Yes ❑ No	$_____
Social Worker	❑ Yes ❑ No	$_____
Therapy (PT, OT, Speech)	❑ Yes ❑ No	$_____
Other _____	❑ Yes ❑ No	$_____

PART IX – OTHER EXPOSURES

1. Do you rent or allow public use of your facility? ❑ Yes ❑ No
   If yes, describe: _____
2. Recreational facilities (check all that apply):
   ❑ None ❑ Exercise/Weight Room ❑ Sauna/Hot Tub Area ❑ Other _____
3. Does the facility have a swimming pool? ❑ Yes ❑ No
   If yes, please provide the following:
   a. Is the pool: ❑ Indoors ❑ Outdoors
   b. Description including depth and supervision provided: _____
   _____
   c. Does a fence surround the pool? ❑ Yes ❑ No If yes, what is the fence height? _____
   d. Does the pool area have a self locking entrance? ❑ Yes ❑ No
   e. Are residents permitted to use the pool **without** staff present? ❑ Yes ❑ No
   f. Is there posted times to use the pool? ❑ Yes ❑ No If yes, when may the pool be used? _____
   _____
   g. Do any of the units open directly to the pool? ❑ Yes ❑ No
4. Fully describe all bodies of water on the premises, their use and safeguards currently in place: _____
   _____
5. Is alcohol served on the premises? ❑ Yes ❑ No
   a. If yes, fully describe under what circumstances, how often and for what purpose: _____
   _____
   b. Amount of receipts generated from sales of alcohol: $_____
6. Are pets allowed on the premises? ❑ Yes ❑ No If yes, under what circumstances? _____
   _____
   a. Are owners required to provide proof of all necessary vaccinations? _____
7. Fully describe all ***off premises*** activities sponsored or conducted by the facility in the past three months (you may attach your activity calendar): _____
   _____

PART X – TRANSPORTATION

1. Does the facility own or lease vans or other vehicles? ❑ Yes ❑ No
   a. If yes, what safety equipment is standard on the facility owned vehicles? _____
   _____
   b. Are employed drivers trained in vehicle safety? ❑ Yes ❑ No
   c. Fully describe the use of facility owned vehicles: _____
   Is transportation to facility sponsored activities provided? ❑ Yes ❑ No
   d. If the facility ***does not*** own any vehicles for the use of transporting residents, is the service contracted to a third party?
   ❑ Yes ❑ No If yes, who assists the residents into the contracted vehicles? _____

2. Do employees transport residents in their own automobiles? ❑ Yes ❑ No

3. Are there written transportation arrangements for residents at the time of medical emergencies? ❑ Yes ❑ No
If yes, outline the procedure to be followed: _____

4. Are residents allowed to use public transportation unassisted and unattended? ❑ Yes ❑ No

PART XI – PHYSICAL PREMISES

1. Was the building originally designed and constructed for elder care occupancy? ❑ Yes ❑ No
If no, what was the original building occupancy? _____
_____

2. What is the building construction? _____

3. Has your facility ever been inspected or tested for mold, spores, fungus, mildew, yeast and/or other toxins? ❑ Yes ❑ No
If any of the foregoing were discovered, were proper steps taken to remove, contain, clean up or treat those toxins?
❑ Yes ❑ No
If no, please explain in detail: _____
Have steps been taken for prevention of future occurrences? ❑ Yes ❑ No Please explain in detail: _____
_____
_____

4. a. Year the facility was built? _____ b. Year of any additions: _____ c. Number of floors: _____

5. a. Age and type of wiring: _____ b. Age and type of heating system: _____

6. a. Number of fire escapes/exits: _____ b. Number of fire extinguishers: _____

7. How often are evacuation drills conducted? _____ Are evacuation drills conducted on each shift? ❑ Yes ❑ No

8. How often are fire drills conducted? _____ Are fire drills conducted on each shift? ❑ Yes ❑ No

9. Does the facility contemplate any new construction during the next 12 months? ❑ Yes ❑ No
If yes, please provide details: _____

11. Check the areas where the following are located:

	Smoke Detectors	**Sprinklers**
None		
Entire facility		
Common areas		
Patient or Resident rooms		
Hallways		
Other _____		

12. Are smoke detectors hard wired to a central station? ❑ Yes ❑ No
Where is the automatic contact (check those that apply): ❑ Fire Department ❑ Nurses Station ❑ Office
❑ Other: _____

PART XII – CURRENT INSURANCE

1. Is current professional and general liability insurance in place? ❑ Yes ❑ No

Carrier	Policy Term	Limit of Liability	Deductible	Expiring Premium	Is this a claims made policy form?	Retroactive Date, if claims made
					❑ Yes ❑ No	

3. Please provide details regarding additional coverage:

Coverage	Included in current policy?	Sub-limit provided
Sexual Abuse and Molestation	❑ Yes ❑ No	❑ Yes ❑ No If yes, what is sub-limit? _____
Defense in Addition to the Limit of Liability	❑ Yes ❑ No	❑ Yes ❑ No If yes, what is sub-limit? _____
Punitive Damages	❑ Yes ❑ No	❑ Yes ❑ No If yes, what is sub-limit? _____

4. Is the current carrier offering renewal terms? ❑ Yes ❑ No
   a. If yes, explain the reason for submitting the account to us _____

5. Please list the ***prior 5 years*** of professional liability (PL) and general liability (GL) insurance carriers, effective dates and policy numbers:

PL Effective Date	PL Carrier	PL Policy Number	GL Effective Date	GL Carrier	GL Policy Number

PART XIII – CLAIMS HISTORY

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED HARD COPY PROFESSIONAL AND GENERAL LIABILITY LOSS RUNS FOR THE PAST FIVE (5) YEARS. IF NO PRIOR COVERAGE, ADVISE OF ANY AND ALL CLAIMS.

2. Is the named insured ***or*** facility, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑ Yes ❑ No

   If yes, please provide full details: _____

3. Have there been any prior complaint(s) or incident(s) reported arising out of the alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No

If yes, please provide full details: _____

_____

THE NAMED INSURED **AND** FACILITY DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

*Notice applicable in most states:
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____/_____ _____

Applicant's Signature/Title Date