HUNTERSURE LLC

PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR ASSISTED LIVING FACILITIES and ADULT GROUP HOMES (Edition 04.01.24)

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple locations, please attach list with number of licensed and occupied beds per location)

4. Telephone Number: _____ Website Address: _____ Date Established: _____

5. a.) Gross Receipts for the Past 12 Months: $_____

b.) Estimated Gross Receipts for the Next 12 Months: $_____

6. Entity is an:

	Number of Licensed Beds	Number of Occupied Beds
Independent Living Facility (elderly)	_____	_____
Assisted Living Facility (elderly)	_____	_____
Alzheimer's/Memory Care Facility	_____	_____
Group Home for Developmentally Disabled Adults	_____	_____
Group Home for Mentally Ill Adults	_____	_____

Other (please describe) _____

7. a.) Number of Residents by Age Category: 18-39: _____ 40-59: _____ 60+: _____

b.) Are any residents under the age of 18 years old accepted? Yes: _____ No: _____

c.) Please provide details as to what impairments non-elderly residents ("non-elderly" meaning ages 60 and less) have:
_____
_____

8. Does the applicant have any ancillary operations not stated above? Yes: _____ No: _____

If Yes, please provide details: _____

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9. a.) Is the facility staffed 24/7 and residents are never left alone? Yes: _____ No: _____

b.) Does the facility implement two 12-hour shifts or three 8-hour shifts? _____

10. a.) List the number and type of EMPLOYEES by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker/ Counselor			
Therapist				Admin/Clerical			
Caregiver/Aide				Other (add details)			

b.) List the number and type of INDEPENDENT CONTRACTORS by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker/ Counselor			
Therapist				Admin/Clerical			
Caregiver/Aide				Other (add details)			

11. Are all individuals shown in response to questions 10a and b who are subject to state or federal licensing requirements so licensed? Yes: _____ No: _____

If No, attach explanation.

12. Are you seeking coverage under this proposed insurance for the independent contractors? Yes: _____ No: _____

If No, is coverage at equal or greater limits maintained by each independent contractor? Yes: _____ No: _____

13. Name of individual(s) responsible for the administration/management of the facility and their related years of experience:

Name: _____ Facility/Location: _____ Years of experience: _____

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14. a.) Do you conduct pre-employment screening and investigation? Yes: _____ No: _____

b.) Do you have a written incident/occurrence reporting policy and procedures? Yes: _____ No: _____

15. Check all the following that apply if obtained, verified, and kept on file as part of the employee hiring and screening process:

Applications/Resumes _____ Criminal Background Checks _____

Drug Testing _____ Education/Training/Competence _____

16. Are employees/independent contractors up to date on any training required by the state or other governing body, and is proof of this required training kept on file at the facility? Yes: _____ No: _____

17. Are there smoke detectors in all bedrooms/hallways? Yes: _____ No: _____

18. Is a resident agreement signed by all residents upon entering the facility? Yes: _____ No: _____
If yes, please attach a copy.

19. Is an assessment conducted for new patients and do all current residents have a pre-admission assessment on file and available for review? Yes: _____ No: _____

20. Do you admit or currently have residents who have a history or have displayed:

			If Yes, number of residents:
Full body skin breakdown/Bedsores	Yes _____	No _____	_____
Mobility limitations	Yes _____	No _____	_____
History of injuries/falls	Yes _____	No _____	_____
Required assistance	Yes _____	No _____	_____
Disorientation	Yes _____	No _____	_____
Current medications	Yes _____	No _____	_____
Wandering Risk	Yes _____	No _____	_____
Cognitive Assessment	Yes _____	No _____	_____
Violent and/or combative behaviors	Yes _____	No _____	_____
Psychiatric History	Yes _____	No _____	_____
Suicidal or Self-harming behaviors	Yes _____	No _____	_____

21. a.) Does the Administer/Manager personally conduct all pre-admission assessments? Yes: _____ No: _____

b.) Are pre-admission assessments conducted in person? Yes: _____ No: _____

22. How often do you formally reassess your residents (with documentation of the findings being placed in their resident file)? _____

23. a.) Does the facility transfer out residents whose needs exceed the services of the facility?

Yes: _____ No: _____

b.) Please provide the written guidelines that would determine when a resident no longer qualifies for the services provided at the facility: _____

24. Have you accepted, or will you accept residents who have been convicted of a crime? Yes: _____ No: _____

If Yes, how many residents of this category? _____

Please provide details of any such resident(s): _____

_____

25. Do all residents have a current care plan and physician evaluation on file dated within the past 12 months?

Yes: _____ No: _____

26. How many people are in a wheelchair most of or all day?_____

27 a.) How many residents are bedridden? _____ b.) Of these, how many are on hospice care? _____

28. Do any residents currently have, or are being evaluated for, Dementia or Alzheimer's? Yes: _____ No: _____

If so, how many and at what level:

		Description	Number of Residents	Number of Residents on Hospice
1	Normal Adult	No functional decline.		
2	Normal Older adult	Personal awareness of some functional decline.		
3	Early Dementia or Alzheimer's Disease	Noticeable deficits in demanding job situations.		
4	Mild Dementia or Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.		
5	Moderate Dementia or Alzheimer's	Requires assistance in choosing proper attire.		
6	Moderately Severe Dementia or Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.		
7	Severe Dementia or Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of abilities to walk, sit up, smile, and hold head up.		

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29. Is all hospice care provided by an outside home health/hospice agency? Yes: _____ No: _____
If so, does the applicant verify that this home health/hospice agency carries their own professional and general liability coverage at a minimum of $1M/$3M limits? Yes: _____ No: _____

30. Are all exit doors at all locations alarmed? Yes: _____ No: _____

If Yes, are alarms kept in working order at all times and never disabled or turned off? Yes: _____ No: _____

31. Have you had any residents elope (leave the premises without the staff being aware of it) in the past 3 years?

Yes: _____ No: _____ If Yes, please provide details:_____

32. a.) Do any residents currently have bedsores? Yes: _____ No: _____

If Yes, please complete the following:

Stage	**Admitted with Condition**	**Condition Developed at the Insured's Facility**
I		
II		
III		
IV		

b.) Who is responsible for providing bedsore services? _____

i.) Are they required to carry their own Professional Liability Insurance? Yes: _____ No: _____

If yes, at what limits? $_____ / $_____

33. a.) Date of last on-site state or local inspection, survey, or review : _____

b.) Was the state inspection, survey, or review the initial pre-licensing inspection? Yes: _____ No: _____

c.) If an inspection, survey, or review of your location(s) has taken place, list all deficiencies, complaints, or violations that were identified.

_____
_____
_____

34. Are all services provided at the location shown in response to Q3 on the application? Yes: _____ No: _____

If No, please provide details (including types of off-site locations broken down by percentage, duration, and frequency of trips, staff to resident ratios when away from facility, any water or sporting events, etc.)

_____
_____
_____

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35. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:

	YES	NO
a.) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?	_____	_____
b.) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c.) Ever been treated for alcoholism or drug addiction?	_____	_____
d.) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

36. Give Professional Liability coverage for last 5 years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

37. Give General Liability coverage for last 5 years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

38. Has any insurer cancelled or refused to renew any similar insurance during the past 5 years?

Yes: _____ No: _____If Yes, please give details: _____

39. In the last 5 years, has any claim ever been made against the insured or any of its employees that would be covered by this policy? Yes: _____ No: _____

If Yes, please attach the completed Huntersure Claims Supplement (one for each claim or incident reported)

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40. Is the applicant aware of any circumstances which may result in any claim against the insured or any of its employees that would be covered by this policy?
Yes: _____ No: _____
If Yes, please give details: _____

41. Have any of the following occurred in the last 5 years:

a) Death of a patient or resident other than from natural causes? Yes _____ No _____

b) Incident resulting in the hospitalization or transfer of a patient or resident? Yes _____ No _____

c) Injury to a patient, resident or visitor that required medical care? Yes _____ No _____

d) Incident involving alleged or actual abuse, molestation, or improper contact? Yes _____ No _____

e) Incident resulting in a formal complaint or notice from a state or federal licensing board? Yes _____ No _____

g) Injury or complications resulting from medication errors? Yes _____ No _____

If yes to any of the above, please provide details: _____
_____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)