HUNTERSURE LLC

PROFESSIONAL AND GENERAL LIABILITY APPLICATION
FOR RESIDENTIAL FACILITIES (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. Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____ LLC _____

For Profit _____ Non-Profit _____

6. Funding is: Medicare _____% Medicaid _____% Private Pay _____%

7. a.) Desired Effective Date: _____

b.) Desired Limits of Liability: $_____ / $_____

c.) Desired Deductible: $_____

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

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

9. Entity is:

	Number of Licensed Beds (all locations)	Number of Occupied Beds (all locations)
Halfway House / Transitional Living	_____	_____
Sober Living	_____	_____
Alcohol and Drug Rehab	_____	_____
Shelter / Homeless and/or Low-Income Housing	_____	_____

Other (please describe): _____

10. a.) Number of Residents by Age Category: 0-17 _____ 18-39 _____ 40-65 _____ 66+ _____

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

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11. Full description of services provided:
_____
_____
_____

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

If Yes, please provide details: _____
_____

13. Is the organization engaged in, owned by, associated with, or controlled by any other business?
Yes: _____ No: _____ If Yes, please provide details: _____

14. 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? _____

15. 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)			

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16. Are all individuals shown in response to questions 15a and b who are subject to state or federal licensing requirements so licensed? Yes: _____ No: _____ If No, attach explanation.

17. 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: _____

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

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

19. Name of Medical Director: _____ Direct Patient Care: Yes: _____ No: _____
Years as Medical Director: _____ Employed _____ Contracted _____
Length of time at Facility: _____ Full time _____ Part-time _____

20. 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: _____

21. 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 _____

22. 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: _____

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

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

25. Do you accept/retain any residents who are violent, combative, have suicidal tendencies, history of suicidal tendencies, self-harming thoughts and/or thoughts of harming others?

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

26. 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: _____

27. 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:_____

28. 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: _____

29. 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): _____

_____

30. 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?	_____	_____

31. 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.

_____

_____

_____

32. 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? _____

33. 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? _____

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

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

35. 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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36. 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: _____

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.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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