



ALF

LONG TERM PROTECTION FOR LONG TERM CARE

Assisted Living Facility

from CareSurance™

CareSurance™ provides a comprehensive liability insurance program designed to meet the needs of Skilled, Assisted and Independent Long Term Care (LTC) facilities across America. The new Assisted Living Facility (ALF) version of the highly successful CareSurance™ product represents a significant step forward in the LTC insurance market by recognizing that one size does not fit all.



CFC Underwriting Limited
4th Floor Lloyd's Building
12 Leadenhall Street
London EC3V 1LP

T: +44 (0) 870 770 1002
F: +44 (0) 870 770 1005

E: enquiries@cfunderwriting.com
W: www.cfunderwriting.com



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APPLICATION FORM FOR PROFESSIONAL & GENERAL LIABILITY INSURANCE

INTRODUCTION

The purpose of this application form is for us to find out who you are and to obtain information relevant to the cover provided by the CareSurance™ ALF policy. Completion of this application form does not oblige either party to enter into a contract of insurance.

Insurance is a contract of utmost good faith. This means that the information you provide in this application form must be complete, accurate and not misleading. It also means that you must tell us about all facts and matters which may be relevant to our consideration of your application for insurance. Any failure by you in this regard may entitle us to treat this insurance as if it never existed. If a contract of insurance is agreed between you and us this application form will form the basis of the contract.

Whoever fills out the form must be a principal, partner or director of the applicant firm and should make all the necessary enquiries of their fellow partners, directors and employees to enable all the questions to be answered.

Please complete a separate application form for each Facility you would like cover for and ensure you complete all questions to avoid adverse rating.

FACILITY INFORMATION

Name of facility:

Street address:

City: State: Zip:

Telephone number: Facility website address:

1. Is facility licensed by the State? [] Yes [] No Expiration date of licence:

2. Ownership of facility:

3. Number of licensed AL beds at this facility: Average number occupied:

4. Number of new residents in past 12 months:

5. Does the facility provide any health care services to non-residents? [] Yes [] No

If yes, please explain:

6. Has the facility traded at a profit in the last 3 years? [] Yes [] No
If no, please attach financials.

7. Year facility was built: Year of last renovation/upgrade: Number of years in operation:

Number of floors: Number of elevators: Number of separate buildings:

If more than one building, are transfers between buildings secure? [] Yes [] No

8. Is this facility part of a chain (with common ownership/management)? Yes No

If yes, how many facilities in the chain?

9. Is this facility part of a CCRC ? Yes No

If yes, number of: SNF licensed beds SNF occupied beds IL units

Are you utilizing the SNF licensed staff to support the ALF residents? Yes No

CLAIMS / COMPLAINTS

10. Has the facility had any regulatory actions or formal complaints in the last 5 years? Yes No
If yes, please provide details on page 4 and attach documentation

11. During the last 5 years, has the facility had any liability claims, or experienced any circumstances or incidents that could give rise to a liability claim? Yes No
If yes, please attach loss runs

RESIDENT PROFILE

12. Please indicate the percentage of residents in the following age groups:

Less than 50 years:% 50-64 years:% 65-80 years:% Over 80 years:%

13. Average percentage of residents diagnosed with Alzheimer's or Dementia:%

Are residents diagnosed with Alzheimer's or Dementia housed in a specific self-contained unit? Yes No

STAFF DETAILS

14. Administrator name:

Number of years experience as administrator: at this facility: in career:

15. Are all employees subject to criminal background checks? Yes No

If yes, please indicate which of the following background checks are performed:

Drug screening: Fingerprints: Sexual Offender Registry:

16. Is the licensure status of all employees verified? Yes No

17. Are medication technicians used at this facility? Yes No

If yes, are they trained in state-approved programs? Yes No

18. How many new employees (not including contract staff) were added to the nursing staff in the last 12 months, broken down into the following categories?

RN: LPN/LVN: CNA/Personal Care Aides:

19. Please show the number of hours per day (total for all staff in category) of service rendered by each of the following:

RNs: LPNs/LVNs: Certified Nursing Assistants:

Non-certified direct care staff (e.g. personal care assistants): Medication technicians (if applicable):

20. Does the facility use contract (a.k.a. agency, registry) staff? Yes No

If yes, is evidence of insurance requested of them? Yes No

What percentage of all hours are provided by contract staff, broken down into the following categories?

RN:% LPN/LVN:% CNA/Personal Care Aides:% Medication technicians:%

BUILDING FIRE PROTECTION

21. Please check which of the following apply:

Common areas:	Heat detectors:	Smoke detectors:	Sprinklers:
Hallways:	Heat detectors:	Smoke detectors:	Sprinklers:
Resident rooms:	Heat detectors:	Smoke detectors:	Sprinklers:

22. Please indicate how the fire detection system is routed:

Direct to fire dept: Central onsite monitoring: Offsite monitoring: No monitoring:

23. Please indicate which of the following describes the facility's smoking policy:

Smoking permitted in designated indoor area(s):

Smoke-free building with smoking allowed in designated outdoor area(s):

No smoking allowed anywhere on the property:

EXIT CONTROLS

24. Please indicate which of the following exit controls are in place:

CCTV: Wanderguard (or equivalent): Observed exit: Alarms:

Electronic door monitoring device:

25. Number of elopements at this facility in the last 12 months:

CURRENT INSURANCE INFORMATION

Current Professional/General Liability Insurer: Policy Period: / /

Premium: \$ Limits: \$ Deductible/Self Insured Retention: \$

Claims Made or Occurrence Form ? If Claims Made, Retroactive Date:

SIGNATURES

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance. Signing of this application does not bind the applicant or the Company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a Policy be issued, and it will be attached to and become part of the Policy. All written statements and materials furnished to the Company in conjunction with this application are hereby incorporated by reference into the application and made a part thereof. Please note that coverage is written with a non-admitted carrier, Agent warrants that all insurance requirements of applicant's home state have been or will be complied with, including making the surplus lines filings and submitting surplus lines taxes and fees where applicable.

..... Applicant name and title (printed) Applicant signature / / Date
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..... Agency name Producer signature Printed name and title
	 / / Date

