



CAT

CATASTROPHE COVER FOR LONG TERM CARE FACILITIES

CareSurance™ CAT Application Form

This is an application for excess professional and general liability cover. CareSurance™ is a comprehensive liability insurance program designed to meet the needs of Skilled, Assisted and Independent Long Term Care (LTC) facilities across America. The CAT version provides a unique and cost-effective solution for LTC facilities that are looking to protect themselves against catastrophic events.



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APPLICATION FORM

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™ CAT 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 details for each facility you would like cover for and ensure you complete all questions to avoid an adverse rating. If you have more than four facilities in your group then please continue on a separate form.

SECTION I: GROUP INFORMATION

1.1 Please state name of common ownership / management:

1.2 Has the facility / chain traded at a profit for the last 3 years? Yes No
If no, please attach financials

1.3 Has the facility / chain had any regulatory actions or formal complaints in the last 5 years? Yes No
If yes, please provide details on page 6 and attach documentation

1.4 During the last 5 years, has the facility / chain 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

1.5 Please provide details of your current Professional / General Liability insurance:

Current Professional / General Liability Insurer:	Policy Period: MM / DD / YY to MM / DD / YY
Premium: \$	Limits: \$
Claims Made or Occurrence Form?	Deductible / Self Insured Retention: \$
	If Claims Made, Retroactive Date: MM / DD / YY

SECTION 2: FACILITY | INFORMATION

2.1 Please provide the following details of the facility:

Facility name:		
Address:		
City:	State:	ZIP code:
Telephone:	Facility / chain website:	

2.2 Year facility was built:

2.3 Year of last renovation / upgrade:

2.4 Number of years in operation:

2.5 Total number of beds: Skilled: Intermediate:
Assisted: Independent:

2.6 Administrator name:

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

2.7 Do you supply any other services? Yes No

If yes, please provide full details:

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2.8 Please check which of the following fire detection systems apply:

Common areas:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Hallways:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Resident rooms:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>

2.9 Please indicate how the fire detection system is routed:

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

2.10 Do you have written procedures in place for emergency evacuations and are they routinely tested? Yes No

Please provide any further relevant details about this facility:

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SECTION 3: FACILITY 2 INFORMATION

3.1 Please provide the following details of the facility:

Facility name:		
Address:		
City:	State:	ZIP code:
Telephone:	Facility / chain website:	

3.2 Year facility was built:

3.3 Year of last renovation / upgrade:

3.4 Number of years in operation:

3.5 Total number of beds: Skilled: Intermediate:
Assisted: Independent:

3.6 Administrator name:

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

3.7 Do you supply any other services? Yes No

If yes, please provide full details:

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3.8 Please check which of the following fire detection systems apply:

Common areas:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Hallways:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Resident rooms:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>

3.9 Please indicate how the fire detection system is routed:

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

3.10 Do you have written procedures in place for emergency evacuations and are they routinely tested? Yes No

Please provide any further relevant details about this facility:

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SECTION 4: FACILITY 3 INFORMATION

4.1 Please provide the following details of the facility:

Facility name:		
Address:		
City:	State:	ZIP code:
Telephone:	Facility / chain website:	

4.2 Year facility was built:

4.3 Year of last renovation / upgrade:

4.4 Number of years in operation:

4.5 Total number of beds: Skilled: Intermediate:
Assisted: Independent:

4.6 Administrator name:

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

4.7 Do you supply any other services? Yes No

If yes, please provide full details:

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4.8 Please check which of the following fire detection systems apply:

Common areas:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Hallways:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Resident rooms:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>

4.9 Please indicate how the fire detection system is routed:

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

4.10 Do you have written procedures in place for emergency evacuations and are they routinely tested? Yes No

Please provide any further relevant details about this facility:

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SECTION 5: FACILITY 4 INFORMATION

5.1 Please provide the following details of the facility:

Facility name:		
Address:		
City:	State:	ZIP code:
Telephone:	Facility / chain website:	

5.2 Year facility was built:

5.3 Year of last renovation / upgrade:

5.4 Number of years in operation:

5.5 Total number of beds: Skilled: Intermediate:
Assisted: Independent:

5.6 Administrator name:

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

5.7 Do you supply any other services? Yes No

If yes, please provide full details:

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5.8 Please check which of the following fire detection systems apply:

Common areas:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Hallways:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>
Resident rooms:	Heat detectors <input type="checkbox"/>	Smoke detectors <input type="checkbox"/>	Sprinklers <input type="checkbox"/>

5.9 Please indicate how the fire detection system is routed:

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

5.10 Do you have written procedures in place for emergency evacuations and are they routinely tested? Yes No

Please provide any further relevant details about this facility:

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SECTION 6: DECLARATION

- I / we declare that after proper enquiry the statements and particulars given above are true and that I / we have not mis-stated or suppressed any material fact.
- I / we agree that this Application Form, together with any other material information supplied by me / us shall form the basis of any contract of insurance effected thereon.
- I / we undertake to inform Underwriters of any material alteration to these facts occurring before the completion of the contract.

Signed: _____ Full Name: _____

Position held at Insured: _____ Date: MM / DD / YY

ADDITIONAL INFORMATION:

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