SENIOR LIVING PROFESSIONAL LIABILITY NEW BUSINESS APPLICATION

MMIC Insurance, Inc.

curi.com

Application Instructions

- Please print or type all responses clearly and answer all questions as instructed.
- If you need more space than is given, continue in the Comments section at the end of the application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed and all required documents are provided.

Required Documents

In addition to this application, the following information is required:

1. Prior carrier loss runs covering the past ten (10) years (dated within sixty (60) days of the application submission date).
2. Declarations page from current insurance carrier, including retroactive date if claims-made coverage.
3. Latest annual financial statements.
4. Corporate organizational chart.
5. Quality Improvement or Risk Management Plan.
6. Most recent state survey reports, licensure reports, and accreditation survey reports as applicable.
7. Current CMS forms: 671 Facility Staffing, 672 Resident Census, CMS 2567, and Quality Indicator Report for the past two (2) six-month periods.
8. Copy of facility license for each location.

Please explain all "yes" answers in the Comments section at the end of the application. Include section and question number for each response.

A. BROKER INFORMATION

Broker Office:	Producer:
Mailing Address:	
Email Address:	Phone:

B. APPLICANT INFORMATION

The term "Applicant" used throughout this application shall mean all entities proposed for coverage.

Name of Applicant:			
Mailing Address:			
Physical Address:			
Tax ID:	County:	Website:	
Main Contact Name:		Phone:	Email:
Administrator Name:		Phone:	Email:
Risk Manager Name:		Phone:	Email:
Director of Nursing Name:		Phone:	Email:

Legal Structure (check all that apply):

☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Government

☐ Not For Profit ☐ For Profit ☐ Other (specify): _____

Describe services provided: _____

_____

_____

Accreditations/Certifications (check all that apply):

☐ JCAHO Accredited ☐ CCAC Accredited ☐ CCRC Accredited

☐ Medicare/Medicaid Certified ☐ Other (specify): _____

Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? ☐ Yes ☐ No

If yes, please specify fund name: _____

A. COVERAGE REQUESTED

1. Policy Period: _____

2. Limits of Liability (limits are expressed as per claim/aggregate):

Professional Liability Limit	☐ $1,000,000/$3,000,000*	Other: _____
General Liability Limit	☐ $1,000,000/$3,000,000*	Other: _____
Employee Benefits Liability Limit	☐ $1,000,000/$3,000,000*	Other: _____

If Employee Benefits Liability coverage is desired, please specify total number of employees: _____

**For limits above $1,000,000/$3,000,000, please complete sections F and G of this application.*

3. Deductibles: ☐ None ☐ Other: _____

4. Coverage Type: ☐ Claims-Made ☐ Occurrence

If claims-made, is retroactive coverage being applied for? ☐ Yes ☐ No Retroactive Date: _____

B. CURRENT COVERAGE

1. Professional Liability Carrier Information

Limit of Coverage: _____

Deductible/Retention: _____

Policy Period: _____

Policy Premium: _____

Coverage Type: _____

If claims-made, retroactive date is: _____

2. General Liability Carrier Information

Limit of Coverage: _____

Deductible/Retention: _____

Policy Period: _____

Policy Premium: _____

Coverage Type: _____

If claims-made, retroactive date is: _____

3. Has any insurer canceled or declined to issue any coverages applied for under this application? ☐ Yes ☐ No

If yes, please include an explanation in the Comments section at the end of the application.

*Missouri applicants do not need to answer this question.

C. GENERAL INFORMATION

1. Indicate the number of years the Applicant has been:

Operating: _____ Owned by present owners: _____

2. Is the Applicant managed by a management company? ☐ Yes ☐ No

If yes, please answer the following.

a. What is the name of the management company: _____

b. How many years in place with this management company? _____

c. Who is the professional liability insurance carrier for the management company? _____

d. Do you require proof of coverage? ☐ Yes ☐ No

e. Describe management services being provided:

_____

3. Within the next twelve (12) months, does the Applicant plan to:

a. Obtain another operation/entity? ☐ Yes ☐ No

b. Add or reduce the number of employees? ☐ Yes ☐ No

c. Add or reduce the number of locations? ☐ Yes ☐ No

d. Add or reduce current services? ☐ Yes ☐ No

e. Operate in additional states? ☐ Yes ☐ No

If yes to any questions above, please explain in the Comments section at the end of the application.

4. Within the past five (5) years, has the Applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

If yes, please explain in the Comments section at the end of the application.

5. Provide total annual revenue for the years indicated:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Total Annual Revenue	$	$	$	$	$

6. Financial Interest If none, check here: ☐

List the following details for each medical professional that has a financial interest in the Applicant's business.

If additional space is needed, please use the Comments section at the end of the application.

Name	Profession	Policy Number	Interest (owner, director, etc.)	Patient Care	
				For Facility	Outside Practice
				%	%
				%	%
				%	%
				%	%
				%	%

7. Subsidiaries and Affiliates

List all subsidiaries and affiliates of the Applicant. If none, check here: ☐

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retro Date (if Claims-Made)	Coverage Desired
		%				☐ Yes ☐ No
		%				☐ Yes ☐ No
		%				☐ Yes ☐ No
		%				☐ Yes ☐ No
		%				☐ Yes ☐ No

8. Licensing

List all licenses held by the Applicant including type and expiration date.

License	Expiration Date

9. Has the Applicant's license been suspended, revoked, or placed under probation? ☐ Yes ☐ No

If yes, please provide a detailed explanation (including the date license was reinstated) in the Comments section at the end of the application.

10. Has the Applicant ever filed for bankruptcy? ☐ Yes ☐ No

If yes, please give name of corporation and details of the arrangement in the Comments section at the end of the application.

11. Medicare/Medicaid

a. Is the Applicant approved for Medicare or Medicaid? ☐ Yes ☐ No

b. Has the Applicant been denied a Medicare or Medicaid certification? ☐ Yes ☐ No

c. Has the Applicant had its Medicare or Medicaid certification limited, suspended, or revoked? ☐ Yes ☐ No

If yes, please explain in the Comments section at the end of the application.

d. Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? ☐ Yes ☐ No

If yes, please explain in the Comments section at the end of the application.

12. Inspection/Surveys

a. When was the last inspection/survey of the Applicant by an outside entity? _____

b. Who performed the inspection? _____

c. Indicate total number of deficiencies:

D, E, F, G deficiencies: _____ F, H, I, J, K, L deficiencies: _____

d. Was a Corrective Action Plan accepted by the state? ☐ Yes ☐ No

e. How many patient/family complaints were investigated in the past three (3) years? _____

f. How many complaints were substantiated? _____

13. Has the Applicant signed any contractual agreements to provide services to others? ☐ Yes ☐ No

If yes, describe the types of services: _____

14. Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? ☐ Yes ☐ No

If yes, describe the types of services: _____

Specify the minimum limits of liability required: $_____

Proof of coverage verified? ☐ Yes ☐ No

Does the contract contain an indemnification (hold harmless) clause? ☐ Yes ☐ No

D. PROFESSIONAL SERVICES

Indicate applicable professional services below. Complete any corresponding questions with information for the most recent twelve (12) months. Please add further explanation or any additional classifications not listed in the Comments section at the end of the application.

☐ **Sub-Acute Care**	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy, and dialysis. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ **Skilled Care**	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ **Intermediate Care**	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living—bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation. **Total Licensed Beds:** _____ **Average Occupancy:** _____

☐ **Assisted Living**	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self-administration and/or assistance with medication. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ **Independent Living**	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication. **Number of Units:** _____ **Total Number of Residents at Full Occupancy:** _____
☐ **Rehabilitation**	Applicable to facilities offering short-term or long-term rehabilitation services to residents. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ **Dementia or Alzheimer's Care**	Applicable to facilities offering services to residents with dementia or Alzheimer's. **Total Licensed Beds:** _____ **Average Occupancy:** _____
☐ **Group Home**	Applicable to facilities offering group homes for residents. **Number of Homes:** _____ **Total Number of Residents at Full Occupancy:** _____
☐ **Home Health Care**	Applicable to facilities offering home health care services. ☐ **Personal Care/Companion Care** Number of Visits: _____ ☐ **Skilled Care** Number of Visits: _____ ☐ **Intravenous Therapy** Number of Visits: _____ ☐ **Rehabilitation Therapy** Number of Visits: _____ ☐ **Respiratory Therapy** Number of Visits: _____
☐ **Miscellaneous Services**	☐ **Durable Medical Equipment** Annual Revenue: _____ Residents Only? ☐ Yes ☐ No ☐ **Pharmacy** Annual Revenue: _____ Residents Only? ☐ Yes ☐ No ☐ **Adult Daycare** Total Licensed: _____ Average Participants: _____ ☐ **Child Daycare** Total Licensed: _____ Average Participants: _____

Please list and describe any additional professional services in the Comments section at the end of the application.

E. INFECTION CONTROL

List all premises owned, rented, leased, occupied, or used by the Applicant.

1. Have any facilities been cited for any of the following tags: ☐ Yes ☐ No

- F880 Infection Prevention and Control Program
- F881 Antibiotic Stewardship
- F882 Infection Preventionist Role and Qualifications
- F883 Influenza and Pneumococcal Vaccinations
- F945 Infection Control Training

If yes, please attach the Plan of Correction that was sent to CMS at the end of the application.

2. Has the facility completed the CMS Long Term Care (LTC) Infection Control Worksheet? ☐ Yes ☐ No

a. Are the answers on the CMS Long Term Care (LTC) Infection Control Worksheet still accurate, and correct? ☐ Yes ☐ No

Please attach the most recent completed CMS Infection Control worksheet.

If the response to any question differs, please describe in the Comments section at the end of the application.

b. Are all answers on the CMS Infection Control Worksheet applicable to all facilities applying for insurance? ☐ Yes ☐ No

If the response for any individual facility differs from the answers on the CMS Long Term Care (LTC) Infection Control Worksheet, please describe in the Comments section at the end of the application.

Please complete the following questions if CMS infection control worksheet has not been completed within the past three (3) years:

3.	Do all facilities follow the CDC recommendations for infection control?	☐ Yes	☐ No
4.	Do all facilities have a qualified Infection Preventionist overseeing the facility infection control program?	☐ Yes	☐ No
5.	Do all facilities have dedicated trained staff on site to monitor the facility infection control program including conducting surveillance and tracking of infectious organisms?	☐ Yes	☐ No
6.	Do all facilities have evidence-based written policies and procedures readily available on the following topics? a. standard, transmission-based, and enhanced barrier precautions, b. hand hygiene, c. cleaning/disinfection policies for resident rooms, common areas, and reuseable medical devices, d. emergency preparedness, e. outbreak response, including a list of conditions or potential exposures to infectious agents that should be monitored and/or reported to public health agencies, and f. Blood Borne Pathogen Exposure plan.	☐ Yes	☐ No
7.	Do all facilities have procedures to audit, monitor, and document the following items? a. staff training and competency, b. compliance with infection control policies, including the appropriate use of PPE at least every twelve (12) months, c. injection, and sharps safety, d. the facility hand hygiene policy, inclusive of monitoring compliance with hand hygiene throughout the facility, e. the quality of cleaning and disinfection procedures at least every twelve (12) months, f. infections occurring among residents and implementation of necessary precautions, g. clusters of illness among staff and implementation of necessary precautions, h. potentially infectious residents at the time of intake (i.e. history of recent travel/antibiotic use, or colonization with multi-drug resistant organisms), and i. residents who have temporary medical devices in place (i.e. indwelling catheters, central lines).	☐ Yes	☐ No
8.	Does the facility have a written surveillance plan, based on the facility risk assessment, outlining activities for monitoring/tracking infections occurring in new admissions and existing residents of the facility?	☐ Yes	☐ No
9.	Does the facility have a system in place for early detection and management of potentially infectious symptomatic residents at the time of admission, including implementation of precautions as appropriate? Examples: Influenza, Norovirus, Legionnaires, MRSA, C difficile or other antibiotic-resistant organisms.	☐ Yes	☐ No
10.	Does the facility have a system in place (e.g., notification of Infection Preventionist (IP) by clinical laboratory) for early detection and management of potentially infectious symptomatic residents, including implementation of precautions as appropriate?	☐ Yes	☐ No
11.	Do all facilities have a process to review infection control related data and issues inclusive of reporting to a Quality Assurance (QA)/Infection Control Committee to monitor and review the facilities infection control program?	☐ Yes	☐ No
12.	Do all facilities have supplies accessible in appropriate locations to implement infection control plan, including but not limited to PPE, EPA-registered products for cleaning/disinfecting, that are effective against C. difficile, and norovirus, appropriate sharps containers, soap, water, and alcohol-base hand rub (ABHR)?	☐ Yes	☐ No

13. Do all facilities have an antibiotic stewardship program that includes the following: ☐ Yes ☐ No

a. a responsible individual to monitor antibiotic use,
b. a system for tracking antibiotic use,
c. monitoring for documentation to support reason for the antibiotic when prescribed,
d. follows treatment recommendations for common infections based on national guidelines to assist in the decision for antimicrobial use,
e. monitoring for appropriate antimicrobial use (e.g. right antibiotic, completion of treatment, improvement of infection),
f. education to facility staff on improving antimicrobial use, and
g. leadership support.

F. EXCESS LIABILITY – UNDERLYING COVERAGE (if applicable)

Complete the chart below with all liability policies requested as underlying insurance.

Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability	Annual Premium
Auto Liability					
Employers Liability					
Helipad Liability					
Other:					
Other:					
Other:					

G. EXCESS LIABILITY – AUTO LIABILITY COVERAGE (if applicable)

Complete the chart and corresponding auto liability questions below.

Type		# Owned	# Non-Owned	# Leased	Property Hauled	0-50 Miles	50-200 Miles	Over 200 Miles
Private Passenger								
Buses								
Trucks	Light							
	Medium							
	Heavy							
	Ex Heavy							
Trucks/ Tractors	Heavy							
	Ex Heavy							

1. Are passengers carried for a fee? ☐ Yes ☐ No

2. Are vehicles leased or rented to others? ☐ Yes ☐ No

3. Do employees drive their own vehicles on behalf of the Applicant? ☐ Yes ☐ No

If no, proceed to the next section.

If yes, please answer the following questions.

a. How many employees are driving personal vehicles on behalf of Applicant? _____
b. Purpose: _____
c. How often is auto liability coverage verified for each employee? _____
d. What minimum limits of liability are required? _____
e. How often are Motor Vehicle Reports obtained? _____

H. PREMISES AND OPERATIONS

Complete the chart and corresponding premises and operation questions below.

1. List all premises owned, rented, leased, occupied, or used by the Applicant.
Please attach a separate schedule with application if more space is needed.

Address	Use	Year Built	Constr. Type Number*	Fire Class	Number of Stories	Sprinkler System	Total Area
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

*Construction Type Number: **1** = Frame **2** = Joisted Masonry **3** = Non-Combustible, **4** = Masonry Non-Combustible **5** = Fire Resistive/Modified Fire Resistive

2. Does each location meet applicable NFPA building codes? ☐ Yes ☐ No

3. Does the Applicant have a written emergency evacuation plan? ☐ Yes ☐ No
If yes, please attach a copy of the plan.

4. If an inpatient care facility location is more than fifteen (15) years old, when was the last qualified inspection of electric, heating and plumbing? _____

5. List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:
_____

6. Are there any construction projects planned for the next year? ☐ Yes ☐ No
If yes, please provide a description of the project in the Comments section at the end of the application. Include estimated cost, duration of the project and if you have purchased a builders' risk policy.

7. Do any locations have vacant land? ☐ Yes ☐ No
If yes, how many total acres: _____

8. Do any locations have paid parking area(s)? ☐ Yes ☐ No
If yes, what is the total revenue? _____

9. Does the applicant operate a fitness center? ☐ Yes ☐ No Is it open to the public? ☐ Yes ☐ No
If yes, what are the hours of operation: _____
Is there an attendant on duty during hours of operation? ☐ Yes ☐ No
Annual Revenue: $_____

10. Does the applicant use a pool? ☐ Yes ☐ No
If yes, please answer the following questions:

a. Is the pool owned by the Applicant? ☐ Yes ☐ No
b. Is it open to the public? ☐ Yes ☐ No
c. Is a certified lifeguard present? ☐ Yes ☐ No
d. Is the area secured when the pool is not in use? ☐ Yes ☐ No
e. What is the depth of the pool? _____feet
f. Is there an emergency call system close in proximity? ☐ Yes ☐ No
g. Where is the pool located?
h. ☐ Inside ☐ Outside ☐ Other: _____
i. Are employees allowed to access the pool? ☐ Yes ☐ No
j. How is access controlled? _____

11. Are there other bodies of water present? ☐ Yes ☐ No

If yes, please describe: _____

12. Are there saunas and/or hot tubs? ☐ Yes ☐ No

If yes, how many: _____

Is there an attendant on duty? ☐ Yes ☐ No

13. Is the facility used for activities and services, other than by residents? ☐ Yes ☐ No

If yes, please provide additional explanation in the Comments section at the end of the application.

14. Complete this section if there are Independent Living Facilities. If none, check here: ☐

a. Do individual units have cooking appliances (e.g. stove and/or oven)? ☐ Yes ☐ No

b. Is there a daily mechanism to keep track of residents? ☐ Yes ☐ No

If yes, explain procedure: _____

c. Are there licensed nursing personnel on staff? ☐ Yes ☐ No

What hours are they available? _____

What services do they provide? _____

d. Are there written guidelines in place that stipulate the types of residents able to live within the facility? ☐ Yes ☐ No

If yes, how often are residents re-assessed for adherence to the guideline? _____

I. ADMINISTRATION AND STAFF

1. Medical Director

a. Is the medical director:

☐ Employed ☐ Contracted ☐ Other (specify): _____

b. Medical Director Name: _____

c. Length of time with the Applicant: _____

d. What is the medical director's specialty? _____

e. How many hours per month (on average) is the medical director on-site at the facility? _____

f. Does the medical director have direct patient contact? ☐ Yes ☐ No

If yes, indicate the insurance carrier and limits of liability:

Insurance Carrier: _____ Limits of Liability: _____

g. Is the medical director involved in credentialing facility medical staff? ☐ Yes ☐ No

h. Is the medical director an active participant in the facility's quality improvement program? ☐ Yes ☐ No

i. Is the medical director responsible for hiring and firing? ☐ Yes ☐ No

j. Is the medical director involved with peer review of physicians? ☐ Yes ☐ No

2. Director of Nursing

a. Length of time with the Applicant: _____

b. Length of time as director of nursing: _____

c. Professional credentials: ☐ RN ☐ LPN ☐ Other (specify): _____

3. Is there a licensed administrator on staff? ☐ Yes ☐ No

If no, who assumes the administrative duties? _____

a. Length of time with the Applicant: _____

b. Length of time as administrator: _____

4. Staff – Specify the number of personnel in each applicable category:

Provider Type	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physicians						
Dentists						
Chiropractors						
Podiatrists						
Oral Surgeons						
Nurse Practitioners						
Phys Assist/Surgical First						
EMTs/Paramedics						
Occupation Therapists						
Therapists						
RNs/LPNs/LVNs						
Social Workers						
Psychologists						
Lab Technicians						
Optometrists						
Pharmacists						
Estheticians						

Please list and describe any additional personnel in the Comments section at the end of the application.

5. Specify staffing by shift:

Category	1st shift	2nd shift	3rd shift	Annual Turnover %
Registered Nurse (RN)				
LPN/LVN				
CNA/Personal Caregiver				
Staffing Agency				

6. Is there a licensed nurse for each shift? ☐ Yes ☐ No

7. Is there a physician on site or on call on a 24-hour basis? ☐ Yes ☐ No

8. Are nursing agencies/registries utilized? ☐ Yes ☐ No

If yes, how many agencies/registries are used? _____

9. Is a complete shift staffed exclusively by temporary staff? ☐ Yes ☐ No

10. Insurance Requirements

Does the Applicant require the following health care professionals to carry professional liability insurance?

If no, please describe in the Comments section at the end of the application.

a. Physicians ☐ Yes ☐ No Limits: $_____

b. Allied Healthcare Professionals ☐ Yes ☐ No Limits: $_____

11. Hiring/Screening Procedures

a. Are hiring/screening procedures in place for all workers providing patient care services? ☐ Yes ☐ No

b. Do the procedures apply to: ☐ Employees ☐ Contractors ☐ Volunteers

c. Please indicate if the following procedures are included in the hiring and screening process:

i. Verification of educational background, including licensure and/or certification? ☐ Yes ☐ No

ii. Check for any license suspensions, revocations, or any disciplinary actions? ☐ Yes ☐ No

iii. Check criminal history? ☐ Yes ☐ No

iv. Check sexual offender registry? ☐ Yes ☐ No

v. Require information regarding medical professional claims history? ☐ Yes ☐ No

d. Does the Applicant have a formal/documented orientation program in place? ☐ Yes ☐ No

e. Are workers transporting patients? ☐ Yes ☐ No

If yes, are driving records (MVRs) verified? ☐ Yes ☐ No How often: _____

12. Risk Management

Is the overall responsibility for Quality Improvement/Risk Management designated to one individual? ☐ Yes ☐ No

Name: _____ Title: _____

Email: _____ Phone: _____

Length of time in position: _____

If no, please describe how these functions are monitored:

_____

J. RESIDENT INFORMATION

1. Indicate the percentage of residents by age range:

< 30: _____ 30-64: _____ 65-74: _____ 75-84: _____ 85-94: _____ > 94: _____

If any residents are younger than 64, please explain in the Comments section at the end of the application.

2. Please indicate the following number of residents on an annual basis for each category of service/type of resident:

Service/Type of Resident	Provided	Number of Residents
Residents requiring IV infusion therapy	☐ Yes ☐ No	
Residents requiring ventilation therapy	☐ Yes ☐ No	
Residents requiring dialysis services	☐ Yes ☐ No	
Patients recovering from bariatric surgery	☐ Yes ☐ No	
Developmentally disabled residents	☐ Yes ☐ No	
Alzheimer's/dementia residents	☐ Yes ☐ No	
Residents requiring psychiatric care and/or supervision	☐ Yes ☐ No	
Residents requiring chemical dependency treatment	☐ Yes ☐ No	
Short-stay rehabilitation residents	☐ Yes ☐ No	

3. Does the Applicant have a dedicated/special unit for any of the categories listed below? ☐ Yes ☐ No

If yes, please explain in the Comments section at the end of the application.

4. Are nursing assessment protocols in place to identify residents at risk for the following:

a. Elopement ☐ Yes ☐ No

b. Falls ☐ Yes ☐ No

c. Cognitive Impairment ☐ Yes ☐ No

d. Nutritional deficiency ☐ Yes ☐ No

e. Pressure Ulcers ☐ Yes ☐ No

f. CAUTI ☐ Yes ☐ No

5. During intake assessment, do you screen for registered sex offenders? ☐ Yes ☐ No

If yes, do you accept them as residents? ☐ Yes ☐ No

6. How many elopements have occurred in the past three (3) years? _____

7.	Do you have precautions in place to deter and prevent resident elopement? If yes, please explain what devices are used in your facility in the Comments section at the end of the application.	☐ Yes ☐ No
8.	Have you had any medicine diversion incidents in the past five (5) years? If yes, please explain in the Comments section at the end of the application.	☐ Yes ☐ No
9.	Is there a facility "no smoking" policy and is it enforced?	☐ Yes ☐ No
10.	If you allow smoking, are smoking residents supervised in designated areas?	☐ Yes ☐ No
11.	Do you employ or contract barbers, beauticians, and/or clergy? If yes, and they are contracted, do you obtain Certificates of Insurance?	☐ Yes ☐ No ☐ Yes ☐ No

K. LOSS INFORMATION

1.	Have any claims or suits ever been made against you, your owners, employees or contractors arising out of your operations? a. If yes, indicate the number of previous and/or pending claims or suits: _____ b. Number of resolved lawsuits and whether they were dismissed, settled or tried to a verdict: _____	☐ Yes ☐ No
2.	Are you aware of any potential claims including alleged injury, incidents or circumstances that might reasonably lead to a claim or suit even if the claim or suit would be without merit? This includes any request for records related to an adverse outcome. If yes, have they all been reported to your current or prior liability carrier?	☐ Yes ☐ No ☐ Yes ☐ No

L. COMMENTS

Please explain all "yes" answers in the Comments section. Please include section and question number.

APPLICATION: All application information is considered important. Signing this application does not bind insurance. We must review and formally approve or reject the application.

FRAUD WARNING/STATEMENT: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information on an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines, and denial of insurance benefits.

KANSAS FRAUD STATEMENT: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CLAIMS-MADE AND REPORTED DISCLOSURE: If any portion of the policy is issued on a claims-made and reported basis, such portions will apply only to claims first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the prior acts date shown on the policy. Claims must be reported to us during the policy period or under an extended reporting period endorsement.

PRIVACY STATEMENT: We will keep your application confidential. We may, however, communicate the results of the application to his or her authorized representative, prospective or current employer. To review the newest privacy notice on collection and use of information visit the company website at curi.com.

APPLICANT ACKNOWLEDGEMENT: The applicant certifies this information is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this application.

PRIOR ACTS ACKNOWLEDGEMENT: All claims or potential claims have been reported to my current or prior carrier. I understand that the company will not provide coverage for any claim, suit or potential claim known on the effective date.

Applicant Signature	Title	Date