



**PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR RESIDENTIAL FACILITIES**

1. Name of Applicant: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_

3. Location Address: \_\_\_\_\_  
 (If multiple name and locations, please attach list)

4. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

5. a) Date Established: \_\_\_\_\_

b) Entity Type: Corp. \_\_\_\_\_ Partnership \_\_\_\_\_ Prof. Assoc. \_\_\_\_\_ Individual \_\_\_\_\_

c) 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) Gross Receipts Estimated for the Next 12 Months: \$ \_\_\_\_\_

9. Entity is an:	Number of Licensed Beds (all locations)	Number of Occupied Beds (all locations)
Independent Living Facility (elderly)	_____	_____
Assisted Living Facility (elderly) (PLEASE COMPLETE SUPPLEMENT)	_____	_____
Alzheimer's Facility	_____	_____
Halfway House/Shelter	_____	_____
Alcohol & Drug Rehab (Adult Only)	_____	_____
Group Home for the Developmentally Disabled	_____	_____
Other (please describe) _____		

10. Number of Residents by Age Category: 0-17 \_\_\_\_\_ 18-39 \_\_\_\_\_ 40-65 \_\_\_\_\_ 66+ \_\_\_\_\_

# HUNTERSURE LLC

11. Full description of services provided:

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12. Does the applicant have any ancillary operations not stated above? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

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13. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, give detail

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14. a) List the number and type of employees by shift:

Staff (all locations)	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Staff (all locations)	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

b) List the number and type of independent contractors by shift:

Staff (all locations)	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Staff (all locations)	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

c. Are all individuals shown in response to Q14a & b licensed in accordance with applicable state and federal regulations?

Yes \_\_\_\_\_ No \_\_\_\_\_

If no, attach explanation.

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15. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, at what limits? \$ \_\_\_\_\_ / \$ \_\_\_\_\_

If no, is coverage desired with shared limits on this policy? Yes \_\_\_\_\_ No \_\_\_\_\_

16. a) Do you conduct pre-employment screening and investigation? Yes \_\_\_\_\_ No \_\_\_\_\_
- b) Do you question prospects about previous claims or suits? Yes \_\_\_\_\_ No \_\_\_\_\_
- c) Are employees required to actively participate in continuing education? Yes \_\_\_\_\_ No \_\_\_\_\_
- d) Do you prepare job descriptions and instructional manuals for your staff? Yes \_\_\_\_\_ No \_\_\_\_\_
- e) Do you have a written incident/occurrence reporting policy and procedures? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Applications _____	Criminal Background Checks _____
Drug / HIV/ Hepatitis Testing _____	Licenses Held _____
Education/Training/Competence _____	Multi-State Registry _____

18. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

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19. Experience owning or managing this type of facility of current ownership: \_\_\_\_\_ Years

20. Name of Administrator: \_\_\_\_\_ Employed \_\_\_\_\_ or Contracted \_\_\_\_\_

Years Licensed: \_\_\_\_\_ Full time \_\_\_\_\_ or Part-time \_\_\_\_\_

Length of time at Facility: \_\_\_\_\_

21. Name of Medical Director: \_\_\_\_\_ Employed \_\_\_\_\_ or Contracted \_\_\_\_\_

Years as Medical Director: \_\_\_\_\_ Full time \_\_\_\_\_ or Part-time \_\_\_\_\_

Length of time at Facility: \_\_\_\_\_

22. Is a resident agreement signed by all residents upon entering the facility? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please attach a copy.

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23. Do you accept/retain any residents who are violent and/or combative and/or have suicidal tendencies and/or a history of suicidal tendencies?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please provide details: \_\_\_\_\_

24. 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: \_\_\_\_\_

25. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please provide details: \_\_\_\_\_

26. What year was the facility built/updated? \_\_\_\_\_ Number of floors? \_\_\_\_\_

27. Are there smoke detectors in all bedrooms/hallways? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, are they: Hardwired \_\_\_\_\_ Battery \_\_\_\_\_

28. Fire Alarm? Central \_\_\_\_\_ Local \_\_\_\_\_ None \_\_\_\_\_

29. Are there any animals on the applicant's premises? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

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

	YES	NO
Has the applicant or have any of the above employees:	_____	_____
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. Date of last State Inspection/Survey (please attach a copy of the report): \_\_\_\_\_

32: Total # of Deficiencies during last state inspection: \_\_\_\_\_

33: Corrective Action Plan accepted by the State? Yes \_\_\_\_\_ No \_\_\_\_\_

# HUNTERSURE LLC

34. Number of complaints investigated by the State in the past 2 years: \_\_\_\_\_  
 (please attach a copy of any complaint report(s))

35. Number of substantiated complaints: \_\_\_\_\_

36. Give Professional Liability coverage for last five years for the firm:

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 five years for the firm:

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

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

38. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details \_\_\_\_\_

39. Has any claim ever been made against the firm or any of its employees?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

40. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please give details \_\_\_\_\_

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

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)

**SUPPLEMENT FOR ASSISTED LIVING FACILITIES**  
**(TO BE COMPLETED ALONG WITH THE APPLICATION FOR RESIDENTIAL FACILITIES)**

1. Is an assessment conducted for new patients?

Yes \_\_\_\_\_ No \_\_\_\_\_

If " Yes, " does this assessment include evaluation of & # of residents who have the following:

Full body skin breakdown/Decubitus Ulcer	Yes _____	No _____	
Mobility limitations	Yes _____	No _____	
History of prior injuries/falls	Yes _____	No _____	Number of residents: _____
Required assistance	Yes _____	No _____	
Disorientation	Yes _____	No _____	Number of residents: _____
Current medications	Yes _____	No _____	
Wandering Risk	Yes _____	No _____	Number of residents: _____
Cognitive Assessment	Yes _____	No _____	

2. Who completes your pre-admission assessments? \_\_\_\_\_

3. Have you denied any possible admissions due to high acuity? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how many in the last two years? \_\_\_\_\_

If so, what were the conditions that led you to deny them? \_\_\_\_\_

4. Do you conduct pre-admission assessments in person? Yes \_\_\_\_\_ No \_\_\_\_\_

5. How often do you reassess your residents? \_\_\_\_\_

6. What is the system for identifying when a resident needs to be transferred to another level of care (i.e. – nursing home)?

\_\_\_\_\_

7. Do residents have their own attending physician? Yes \_\_\_\_\_ No \_\_\_\_\_

If " No, " who performs the role of the attending physician? \_\_\_\_\_

How many residents utilize the Medical Director as their attending physician? \_\_\_\_\_

8. How many residents are in a wheelchair most or all of the day or are bedridden? \_\_\_\_\_

9. Do any residents currently have, or are being evaluated for, Alzheimer's? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how many and at what level:

		Description	Number of Residents
1	Normal Adult	No functional decline.	
2	Normal Older adult	Personal awareness of some functional decline.	
3	Early Alzheimer's Disease	Noticeable deficits in demanding job situations.	
4	Mild Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.	
5	Moderate Alzheimer's	Requires assistance in choosing proper attire.	
6	Moderately Severe Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.	
7	Severe 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.	

10. Are all non-ambulatory/Alzheimer's patients located on the ground floor?    Yes \_\_\_\_\_ No \_\_\_\_\_

11. Does your facility have a policy clearly identifying the types of dementia/Alzheimer's residents your staff is capable of providing care to?

Yes \_\_\_\_\_ No \_\_\_\_\_

If " Yes, " please explain policy: \_\_\_\_\_

12. Are all exit doors at all locations alarmed?            Yes \_\_\_\_\_ No \_\_\_\_\_

If " No, " please explain: \_\_\_\_\_

13. Does your facility have a locked unit(s) for residents prone to wandering?    Yes \_\_\_\_\_ No \_\_\_\_\_

14. What system is in use? \_\_\_\_\_

15. How many residents have eloped from your facility in the last 3 years? \_\_\_\_\_

16. Is the unit dose medication system used by the facility?                            Yes \_\_\_\_\_ No \_\_\_\_\_

If not, what system is used? \_\_\_\_\_

17. Who is responsible for administering medications to the residents in the facility? \_\_\_\_\_





18. If your facility uses the medication aide to administer medication, what system do you have in place to ensure medications are administered according to manufacturers' recommendations and industry standards?

Yes \_\_\_\_\_ No \_\_\_\_\_

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Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date

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



**SUPPLEMENT FOR HIRED & NON-OWNED AUTO COVERAGE**

**IF HIRED & NON-OWNED AUTO SUB-LIMITS ARE DESIRED:**

1) Sub-limits requested: \$100,000/\$300,000 \_\_\_\_\_ \$1,000,000/\$1,000,000 \_\_\_\_\_  
\$250,000/\$500,000 \_\_\_\_\_ Other: \_\_\_\_\_

2) Does the applicant check all driver's MVRs & require that all employees carry automobile insurance with limits no less than required by the employee's state of residence?

Yes \_\_\_\_\_ No \_\_\_\_\_

3) Has any hired & non-owned auto claim ever been made against the firm or any of its employees, or is the applicant aware of any circumstances which may result in any claim?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach details

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Please Print Title

Signature: \_\_\_\_\_  
Name Date

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



**SUPPLEMENT FOR SEXUAL ABUSE COVERAGE**

**IF SEXUAL ABUSE SUB-LIMITS ARE DESIRED:**

1) Sub-limits requested: \$100,000/\$300,000 \_\_\_\_\_ \$1,000,000/\$3,000,000 \_\_\_\_\_  
\$250,000/\$500,000 \_\_\_\_\_ Other: \_\_\_\_\_

2a) Are there written guidelines regarding sexual misconduct?

Yes \_\_\_\_\_ No \_\_\_\_\_

b) If no, are you willing to draw up & implement written guidelines within 30 days of binding?

Yes \_\_\_\_\_ No \_\_\_\_\_

3) Has any sexual abuse/misconduct claim or any other allegation of abuse ever been made against the firm or any of its employees, or is the applicant aware of any circumstances which may result in any claim?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach details

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Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date

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