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## **ASSISTED LIVING FACILITY - LIABILITY INSURANCE APPLICATION**

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### **THE INSURANCE WE PROVIDE**

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**We, at Stuckey & Company, have tailored this Assisted Living Facility insurance policy for the specific needs of Assisted Living Facilities.**

**We fully appreciate the value of your time and thank you for providing the important information which will allow us to accurately assess the risks which you face.**

**The purpose of this insurance is to indemnify you against your liability which arises from your breach of duty.**

**You must refer to our Assisted Living Facility insurance policy which fully explains the rules governing the way we provide the cover, those things which are not covered and your obligations to us.**

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### **THIS APPLICATION FORM**

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**The purpose of this application form is for us to find out who you are and what material information specific to your circumstances for this cover. 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.**

## FACILITY DETAILS

Facility Name

Street Address

City

State

Zip Code

Facility Website Address

Administrator name

Telephone number

Is the Facility licensed by the State?

When does the license expire?

Ownership of Facility

If part of a chain, how many Facilities in the chain?

Number of licensed AL beds

Number of AL Beds Occupied

Is the Facility part of a CCRC?

If yes, number of:

SNF licensed beds

SNF occupied beds

IL units

Number of new residents in the past 12 months

Does the Facility provide any health care services to non-residents?

If yes, please explain

Has the Facility traded at a profit in the last 3 years?

If no, please attach financials

Year Facility was built

Year of last renovation or upgrade

Number of years in operation

Number of floors

Number of elevators

Number of separate buildings

If more than 1, are the transfers between buildings secure?

### CLAIMS / COMPLAINTS

Has the Facility had any regulatory actions or formal complaints against it in the last 5 years?

If yes, please attach details

Has the Facility had any liability claims, or experienced any circumstances or incidents which could give rise to a liability claim, in the last 5 years?

If yes, please attach loss runs

### RESIDENT PROFILE

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

Less than 50

50 to 65

65 to 80

Greater than 80

Average percentage of residents diagnosed with Alzheimer's or Dementia

## BUILDING FIRE PROTECTION

Please detail the Facility's fire-protections below:

Common Areas:	Heat Detectors	<input type="text"/>	Smoke Detectors	<input type="text"/>	Sprinkler System	<input type="text"/>
Hallways:	Heat Detectors	<input type="text"/>	Smoke Detectors	<input type="text"/>	Sprinkler System	<input type="text"/>
Resident Rooms:	Heat Detectors	<input type="text"/>	Smoke Detectors	<input type="text"/>	Sprinkler System	<input type="text"/>

Please indicate below how the fire detection system is routed:

Direct notification of Fire Department	<input type="text"/>	Central onsite monitoring	<input type="text"/>	Offsite monitoring	<input type="text"/>	No monitoring	<input type="text"/>
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Please indicate what the Facility's smoking policy is below:

Smoking permitted in designated indoor area(s)	<input type="text"/>	Smoke-free building with smoking allowed in designated outdoor area(s)	<input type="text"/>	No smoking allowed anywhere on the property	<input type="text"/>
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## EXIT CONTROLS

CCTV	<input type="text"/>	Wanderguard (or equivalent)	<input type="text"/>	Observed Exit	<input type="text"/>	Electronic Door Monitoring Device	<input type="text"/>
Alarms	<input type="text"/>						
Number of elopements in the last 12 months	<input type="text"/>						

**STAFF DETAILS**

Number of years of experience of administrator

Number of years with this Facility

Are all new employees subject to criminal background checks?

If yes, please indicate the types of checks performed below:

Drug screening

Fingerprints

Sexual Offender Registry

Is the licensure status of employees verified?

Are medication technicians used at the Facility?

If yes, please answer the following:

Are the medication technicians trained in state-approved programs?

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

How many hours per week of service are rendered by each of the following types of providers?

**HOURS PER DAY**  
(for all employees of each  
provider type)

RNs

LPNs/LVNs

Certified Nursing Assistants

Non-certified direct care staff (e.g. Personal Care Assistants)

Medication Technicians (if applicable)

Does the Facility use contract (aka agency, registry) staff?

If yes, is evidence of insurance requested from them?

If contract staff are used, 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

### CURRENT LIABILITY INSURANCE INFORMATION

Limit each loss

Limit overall policy

Deductible or self insured retention

Retroactive date (if claims made policy)

Premium

### COMMENTS

Please add any additional information regarding the answers given above here.

## SIGNATURES

**Please Note: 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 FILING AND SUBMITTING SURPLUS LINES FEES AND TAXES, WHERE APPLICABLE.**

**Application must be signed and dated by Applicant:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Title:** \_\_\_\_\_

**Application must be signed and dated by Agent for the Applicant:**

**Name of Agency:** \_\_\_\_\_ **Name of Agent:**

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_