NEW BUSINESS RESIDENTIAL OPERATIONS APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - **Copy of current General Liability and Professional Liability insurance Declarations Page**
  - **5-year previous carrier loss runs, valued within the last 45 days**
  - **Copies of State Inspections, Complaint Investigations, and Facility License**

SECTION I - GENERAL INFORMATION – TO BE COMPLETED BY ALL APPLICANTS

1) Full name of Applicant (Including DBA's) _____

2) Mailing Address: _____
STREET CITY COUNTY STATE ZIP

3) Location Address: Check here if same as mailing: ☐ - **Please list additional locations on PAGE 11**

(1) _____
STREET CITY COUNTY STATE ZIP

(2) _____
STREET CITY COUNTY STATE ZIP

(3) _____
STREET CITY COUNTY STATE ZIP

(4) _____
STREET CITY COUNTY STATE ZIP

4) Website Address: **www.**_____

5) Telephone: _____

6) Date Established: _____

7) Years Under Current Management: _____

8) Inspection/Audit Contact Name & E-mail: _____

9) Enterprise is: ☐ For Profit ☐ Not For Profit

10) Applicant is a:

☐ Individual
☐ Corporation
☐ LLC
☐ Other
☐ Professional Associations
☐ Partnership
☐ Joint Venture

11) Is this entity owned by, associated with, or controlled by any other entity? Yes ☐ No ☐
If yes, please provide details:

_____

2035 Maywill Street, Ste. 100, Richmond, VA 23230 | (804) 289-1300 phone | (804) 673-5697 fax | kinsaleins.com

12) Please state sources and amounts of total revenue:

	Last 12 months	Next 12 months
Medicare	$_____	$_____
Medicaid	$_____	$_____
Charitable	$_____	$_____
Private Pay	$_____	$_____
Total Gross Revenue	$_____	$_____

13) Please describe in detail the nature of the applicant's operation and types of services rendered:

_____

_____

14) What type(s) of state issued license(s) does the applicant carry? _____

SECTION II - OPERATIONS – TO BE COMPLETED BY ALL APPLICANTS

Facility classification and bed census:	**Total # of Licensed Beds:**	**Total # of Occupied Beds:**	**Applicant Section Reference Note:**
Skilled Nursing & Intermediate Care	_____	_____	*(Please complete Section A below)*
Assisted Living	_____	_____	*(Please complete Section A below)*
Assisted Living – Memory Care	_____	_____	*(Please complete Section A below)*
Elderly Independent Living	_____	_____	*(Please complete Section A below)*
Home for Persons with Mental and Physical Disabilities	_____	_____	*(Please complete Section B below)*
Youth Group Home	_____	_____	*(Please complete Section B below)*
Other Group Home / Shelter / Halfway House *(Not Substance Abuse Related)*	_____	_____	*(Please complete Section B below)*
Substance Abuse Detox/Rehab/Sober Living	_____	_____	*(Please complete Section C below)*
Other (Please Specify): _____	_____	_____	*(Please complete the most relevant Section(s) below)*

Section II Operations - Sections A-C Instructions:

*Complete **each and every** that applies to the applicant's operations below.*

Each section is clearly marked with the type of operation which corresponds with the facility classifications described above.

If a section does not apply to the applicant's operation, the applicant is required to mark the N/A box in order to consider that section complete.

SECTION A – Elderly Independent / Assisted / Skilled Nursing Residential Facility Owners/Operators

Mark N/A if this section does not apply to the applicant. **N/A** ☐

Resident Census	Location 1	Location 2	Location 3
Number of Licensed beds			
Number of Occupied beds			
Number of Independently Ambulatory			
Number of Wheelchair Bound (all or most of the day)			
Number of Bedridden Residents			
Number of Dementia Residents			
Number of Alzheimer's residents: *Stage 1: No impairment through Stage 5: Moderately Severe Decline*			
Number of Alzheimer's residents: *Stage 6: Severe Decline through Stage 7: Very Severe Decline*			
Residents in each age range:	___ 0-17 ___ 18-59 ___ 60-74 ___ 75-84 ___ 85+	___ 0-17 ___ 18-59 ___ 60-74 ___ 75-84 ___ 85+	___ 0-17 ___ 18-59 ___ 60-74 ___ 75-84 ___ 85+

15) Do you currently or plan to have any beds for residents with:

Yes ☐ No ☐ Traumatic Brain Injury
Yes ☐ No ☐ Chemical Dependency
Yes ☐ No ☐ Tube Feeding
Yes ☐ No ☐ Ventilator/Tracheostomy services
Yes ☐ No ☐ Psychiatric / Sociopathic / Schizophrenic

If yes, please explain: _____

16) Do you have an internal wound care team or outside wound care consultant? Yes ☐ No ☐
If yes, please provide name and start date of the Consultant _____

17) Bedsore Information**:** Reporting Date: _____/_____/_____ **State "None", if none: _____**

Bedsore Stage	Acquired in Facility	Inherited from Another Location
Stage I or II		
Stage III		
Stage IV		

18) Are Adult Day Care services offered to non-residents Yes ☐ No ☐, if Yes provide the following information:

a. Total Number of licensed slots: _____
b. Average Daily Participants: _____
c. Any overnight stays? Yes ☐ No ☐
If yes, please explain:_____
d. Do you provide transportation to or from? Yes ☐ No ☐

19) Are call buttons or pull cords provided in each resident's room? Yes ☐ No ☐

Direct 911 Notification	Yes ☐ No ☐
Third Party Monitoring Third Party Name _____	Yes ☐ No ☐
Front Desk Notification Response protocol _____	Yes ☐ No ☐
Hall Light / Alarm	Yes ☐ No ☐
Are pull cord / call button protocols described in the resident agreement	Yes ☐ No ☐

20) Are handrails installed in hallways and bathrooms? Yes ☐ No ☐

21) Do tubs and showers have non-slip surfaces installed? Yes ☐ No ☐

22) Do individual units have cooking appliances (excluding microwaves)? Yes ☐ No ☐
If "Yes," check type: Gas ☐ Electric ☐

23) Are home health or hospice services contracted directly through the:
☐ Resident
☐ Facility - Provider name _____***(attach certificate of insurance)***
Any affiliation to the Provider? Yes ☐ No ☐

24) Does the facility have the right to transfer a resident whose needs exceed the services of the facility? Yes ☐ No ☐

25) What are the written guidelines to determine when a resident no longer qualifies for services?

_____

_____

SECTION B - Other Group Homes (Non-Elderly) Residential Facility Owners/Operators Must Complete

Mark N/A if this section does not apply to the applicant. **N/A** ☐

Resident Census	Location 1	Location 2	Location 3
Number of Licensed beds			
Number of Occupied beds			
Number of Male residents			
Number of Female residents			
Number of Independently Ambulatory			
Number of Wheelchair bound			
Number of Bedridden residents			
Number of Severely/Profoundly Retarded			
Number of Mild/Moderately Retarded			
Number of Halfway House / Abused & Battered / Homeless Shelter			
Number of Troubled Youth			
Number of Foster Care / Transitional Youth			
Other Specify):_____			
Indicate number of residents in each age range:	____ 0-17 ____ 18-59 ____ 60-74	____ 0-17 ____ 18-59 ____ 60-74	____ 0-17 ____ 18-59 ____ 60-74

26) Do you currently have or plan to have any beds for residents with:

Yes ☐ No ☐ Traumatic Brain Injury
Yes ☐ No ☐ Chemical Dependency
Yes ☐ No ☐ Tube Feeding
Yes ☐ No ☐ Ventilator/Tracheostomy services
Yes ☐ No ☐ Psychiatric / Sociopathic / Schizophrenic
If yes, please explain: _____

27) Are male and female residents separated by floor, building or other means? Yes ☐ No ☐
If no, please explain _____

28) Are minor and adult residents separated by floor, building or other means? Yes ☐ No ☐
If no, please explain _____

29) Please list any contracts in place with governmental entities: _____

30) Explain any court supervision, juvenile detention, probation, parole, or correctional exposure and restraint procedures:

_____

_____

SECTION C - Substance Abuse / Rehab / Sober Living Residential Facility Owners/Operators Complete

Mark N/A if this section does not apply to the applicant. **N/A** ☐

Resident Census	# detox beds	# non-detox beds	Avg length of stay
Early Intervention – Level (0.50)			
Outpatient Services – Level (1.00)			
Intensive Outpatient / Partial Hospitalization - Level (2.1 – 2.50)			
Clinically Managed Low-Intensity Residential Services – Level (3.10)			
Clinically Managed High-Intensity Residential Services – Level (3.30)			
Clinically Managed Medium-Intensity Residential Services – Level (3.50)			
Medically Monitored High-Intensity Inpatient Services – Level (3.70)			
Medically Managed Intensive Inpatient Services – Level (4.00)			
Sober living ONLY (**No medical services on-site**)			
Other (Please Specify):_____			
Indicate number of residents in each age range:	____ 0-17 ____ 18-59 ____ 60-74	____ 0-17 ____ 18-59 ____ 60-74	____ 0-17 ____ 18-59 ____ 60-74

31) Are residents required to be detoxed and sober prior to admission? Yes ☐ No ☐
If yes, how is this documented? _____
If yes, what is the minimum duration of sobriety required?
- ☐ ***Less*** than 72 hours
- ☐ ***More*** than 72 hours
- ☐ More than 7 days
- ☐ More than 14 days
- ☐ More than 30 days

32) Does the applicant perform any "rapid detox" or any detox under general anesthesia? Yes ☐ No ☐

33) Do any resident's receive methadone, suboxone, or similar? If yes, how many? _____ Yes ☐ No ☐

34) Do the applicant's intake procedures include drug tests and blood tests? Yes ☐ No ☐
Is a licensed employee responsible for intake and approving residents? Yes ☐ No ☐
If yes, provide the name and license designation for that employee _____

35) What is the average length of stay for each resident? _____

36) Has ANY resident died at the facility in the last 24 months? If yes, provide comprehensive details. Yes ☐ No ☐
(Use the supplement information sheet if more space is needed).
_____

37) Does any insured have any contractual relationship or ownership interest with any other substance abuse operation? If yes, please explain? Yes ☐ No ☐
_____
_____

SECTION III - PREMISES INFORMATION – TO BE COMPLETED BY ALL APPLICANTS

Description	Location 1	Location 2	Location 3	Location 4
Type of Construction:				
No. of Stories:				
Square Footage:				
Date Built:				
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

38) Do any of the Applicant's locations have any:

a. Exposure to flammables, explosive, chemicals? Yes ☐ No ☐
b. Catastrophe exposure? Yes ☐ No ☐
c. Exposure to radioactive materials? Yes ☐ No ☐

If yes, Please explain: _____

SECTION IV - STAFF – TO BE COMPLETED BY ALL APPLICANTS

Indicate the number of Employed and contracted staff	Employed	Contracted	Insured Elsewhere?	Coverage Requested?
Administrators			Yes ☐ No ☐	Yes ☐ No ☐
Physicians			Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant			Yes ☐ No ☐	Yes ☐ No ☐
DON/ADON			Yes ☐ No ☐	Yes ☐ No ☐
Nurses (NP, RN, LPN)			Yes ☐ No ☐	Yes ☐ No ☐
Nurse Aides			Yes ☐ No ☐	Yes ☐ No ☐
Resident Assistants			Yes ☐ No ☐	Yes ☐ No ☐
Psychiatrists			Yes ☐ No ☐	Yes ☐ No ☐
Psychologists			Yes ☐ No ☐	Yes ☐ No ☐
Social Workers			Yes ☐ No ☐	Yes ☐ No ☐
Therapists (PT/OT/ST/DT)			Yes ☐ No ☐	Yes ☐ No ☐
Students/Volunteers			Yes ☐ No ☐	Yes ☐ No ☐
Pharmacists			Yes ☐ No ☐	Yes ☐ No ☐
Other (Specify):_____			Yes ☐ No ☐	Yes ☐ No ☐

39) Please provide the name and qualifications of the medical director: _____

40) Are all above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

41) Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

42) What is the staff turnover ratio? _____%

43) Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

- ☐ Check of educational background, or residency program, when applicable.
- ☐ Check of previous employers (☐ In writing ☐ By Telephone)
- ☐ Criminal background check (☐ STATE ☐ FEDERAL)
- ☐ Drug / Alcohol / Abuse Screening (circle all that are used)

44) Does the facility maintain 24 hour awake staff? Provide your 8 or 12 hour shift staff to resident ratio: Yes ☐ No ☐

8 Hour Shift Structure	Staff : Resident Ratio	12 Hour Shift Structure	Staff : Resident Ratio
7:00am – 3:00pm		7:00am – 7:00pm	
3:00pm – 11:00pm		7:00pm – 7:00am	
11:00pm – 7:00am			

SECTION V - ADMISSION POLICIES – TO BE COMPLETED BY ALL APPLICANTS

45) Does a qualified licensed medical professional conduct assessments for all new residents? Yes ☐ No ☐

If yes, provide name and designation of the medical professional_____

Years experience in position _____ Years experience in facility _____

Mark which of the following are included in the resident assessment:

- ☐ History of prior illness and injuries
- ☐ Current medications
- ☐ Disorientation/Cognition Limitations
- ☐ History of Wandering / Elopement
- ☐ Mobility limitations / Required assistance
- ☐ History of falls
- ☐ Skin assessment
- ☐ Combativeness
- ☐ Psychiatric history

46) Provide the name & years of experience for the following:

a. Director of Nursing _____ Years of experience _____
b. Facility Administrator _____ Years of experience _____

47) Do you accept residents who are considered a threat to themselves or others? Yes ☐ No ☐

48) Do you have any residents that have contemplated, threatened, attempted, or committed suicide? If yes, explain _____ Yes ☐ No ☐

49) Is a current physical required for admission? Yes ☐ No ☐

How often is the care plan updated? _____

50) Does each resident have their own attending physician? Yes ☐ No ☐

If no, who performs the attending physician role? _____

SECTION VI - MONITORING AND RISK MANAGEMENT – TO BE COMPLETED BY ALL APPLICANTS

51) Do any third-party providers render services at any of your locations? Yes ☐ No ☐
If yes, please explain _____

52) Do you provide any day services or other services to non-residents whether onsite or offsite? Yes ☐ No ☐
If yes, please explain _____

53) Does the insured provide care to family members residing on the premise? Yes ☐ No ☐
If yes, how many? _____ Please explain _____

54) Are residents allowed to leave the premises unattended? Yes ☐ No ☐

55) What precautions are used to keep track of residents?
- ☐ Sign out procedure
- ☐ Bed checks
- ☐ All exit doors alarmed
- ☐ Locked unit for residents prone to wandering
- ☐ Other (Please describe): _____

56) Have any residents eloped from your facility in the past **3 years**? Yes ☐ No ☐
If yes, how many? _____
Details? _____

57) In the past **24 months** has any resident fallen and suffered a fracture, been hospitalized or died as a result of the fall? ***If yes, please provide details (attach additional pages as needed):*** Yes ☐ No ☐

Resident name:	Date of	Injury:	Current	Current Location:

58) Are medications administered by staff? If yes, by whom _____ Licensed as:_____ Yes ☐ No ☐
Are the medications kept in a locked area? Yes ☐ No ☐

59) Are there an "incident reporting" procedures in place? Yes ☐ No ☐
If yes, are all incident reports reviewed by the risk manager and medical director? Yes ☐ No ☐

60) Are resident records kept for the entirety of the resident's stay and a minimum of 2 years after they leave? Yes ☐ No ☐
If no, please explain? _____

61) Is this a non-smoking facility? If no, what is smoking policy:_____ Yes ☐ No ☐

62) Please describe any onsite bodies of water (pool/lake/pond/ocean), animal(s), or other activities (trampoline/ropes course)
_____

63) State Inspection:

(Please attach copies of State Inspections & Complaint Investigations for the last 36 months)

Total # of State Inspection, Surveys or Complaint Investigations in the last 36 months? _____

Total # of Deficiencies: _____

Were all Corrective Action Plan accepted by State: Yes ☐ No ☐

Total # of substantiated complaints: _____

Total # of Fines in the last 2 years: _____

SECTION VII - COVERAGE AND LOSS HISTORY – TO BE COMPLETED BY ALL APPLICANTS

Please list Professional Liability insurance carried for each of the past three years:

Professional Liability Claims Made Retroactive Date? _____

Insurer	Dates covered	Limits of Liability Per claim/ Agg	Deductible	Premium	Occurrence or Claims – Made?

Please list General Liability insurance carried for each of the past three years:

General Liability Claims Made Retroactive Date? _____

Insurer	Dates covered	Limits of Liability Per claim/ Agg	Deductible	Premium	Occurrence or Claims – Made?

64) Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? Yes ☐ No ☐

65) Has the applicant or any of its employees ever been charged with, or convicted of a crime other than minor traffic violation? Yes ☐ No ☐

66) Has the applicant or any of its employees ever been diagnosed or treated for alcoholism drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

67) Has any insurance company ever rescinded, cancelled, non-renewed, or declined any similar insurance for the applicant? *If yes, please provide a detailed explanation* Yes ☐ No ☐

68) Has any claim or suit ever been made against the applicant **OR** any other person proposed for this insurance? **(Complete Supplemental Claims form for each.)** Yes ☐ No ☐

69) Have there been any claims or do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation? Yes ☐ No ☐

70) Is the applicant or any person proposed for in this insurance aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? **(Complete Supplemental Claims form for each.)** Yes ☐ No ☐

71) Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a claim or suit? **(Complete Supplemental Claims form for each.)** Yes ☐ No ☐

PROVIDE DETAILS FOR ALL "YES" ANSWERS TO QUESTIONS 67-71 IN THE SUPPLEMENTAL INFORMATION SECTION AND/OR THE SUPPLEMENT CLAIM FORM ATTACHED BELOW - ATTACH ADDITIONAL PAGES AS NEEDED

SUPPLEMENTAL INFORMATION

Use the remainder of this page as needed or to address questions referenced within the application

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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 insurance act, which is a crime.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. <u>Attach additional sheets if necessary for adequate explanation.</u> All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: _____ Age: _____ Sex: _____
Incident ☐ Claim ☐
Date reported to insurance company: _____
Name of insurance company: _____
Date of incident and your treatment: _____
Allegations / Circumstances:

_____
_____
_____

Additional Defendants: _____
What is the present condition of the patient?

_____
_____

<u>STATUS OF CLAIM</u>

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
Did you want to settle? ☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment: $_____

Name and address of the attorney assigned to your case: _____
_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?
Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____
_____
_____

Signature: _____ Date: _____

Printed Name: _____