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Application for Institutional Care Facilities

1. Name of applicant _____
 Street address _____
 City _____ State _____ Zip _____
 Date established _____ Phone # for inspection _____ Agent phone # _____

2. Individual Corporation Partnership Professional Association Non-profit Corporation
 Other (Explain) _____

3. List all names which you or the corporation have operated under during the past 4 years, if different from above

3a. Is applicant engaged in, owned by, associated with or involved in any other enterprise? Yes No
 If yes, provide details _____

4. Is facility run by an outside management company? Yes No
 If yes, describe contractual relationship _____

4a. Do you provide consultant services for or manage any other facilities? Yes No
 If yes, describe _____

5. List all losses and amounts paid or reserved that have been incurred by these entities. Add pages, if needed.

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

6. Attach Copies of:
- a. Currently valued (within last 3 months), hard copy, Company loss runs for the last 5 years.
 - b. Current State License
 - c. Most recent state inspection report with state approved plan of corrections, if deficiencies are noted.
 - d. Insured's guidelines/procedures for care of Alzheimer's or senile dementia patients.
 Include details of training and certification required of staff to handle such patients.
 - e. Emergency Evacuation Plan

7a. Licensed bed capacity _____
 Has license ever been revoked or suspended? Give details: _____

8. Will temporary clients be accepted? Yes No
 If yes, what additional staffing provisions will be made if the condition of the client is above what facility is licensed for? _____

9. Other operations (if any)

<input type="checkbox"/> Counseling (outpatient)	Number of visits _____
<input type="checkbox"/> Day care (other than for residents)	Number of persons _____
<input type="checkbox"/> Home healthcare service/agency	Amount of receipts _____
<input type="checkbox"/> Psychiatric Clinic	
<input type="checkbox"/> Other (describe) _____	Type of conditions treated _____

10. Type of facility

<input type="checkbox"/> Nursing home for senile or aged	Number of beds _____
<input type="checkbox"/> Alcohol or drug treatment	_____
<input type="checkbox"/> Psychiatric facility	_____
<input type="checkbox"/> Group home for mentally challenged	_____
<input type="checkbox"/> Shelter for runaways, abused spouses, foster homes	_____
<input type="checkbox"/> Sub-acute care	_____
<input type="checkbox"/> Other (provide full details below) _____	_____

11. Patient breakdown by age group

0 – 10 years _____	36 to 50 years _____
11 to 17 years _____	51 to 65 years _____
18 to 35 years _____	Over 65 years _____

12. What precautions are taken to keep track of patients?

Sign out procedure? Yes No Alarms on doors? Yes No

Other (please describe) _____

13. Do any patients work full or part time or attend school or workshops? Yes No

If yes, describe activities? _____

14. Indicate total number of employed personnel: _____

Total number and types of independent contractors: _____

	1 st Shift	2 nd Shift	3 rd Shift	Residing on Premises
(A) MD's	_____	_____	_____	_____
(B) RN's	_____	_____	_____	_____
(C) LPN's	_____	_____	_____	_____
(D) Nurses Aides	_____	_____	_____	_____
(E) Psychologists	_____	_____	_____	_____
(F) Therapists	_____	_____	_____	_____
(G) Counselors	_____	_____	_____	_____
(H) Other (specify)	_____	_____	_____	_____

15. Are any of the above required to maintain their own professional coverage? Yes No

Limits required? _____ How is coverage verified? _____

15a. Are background checks made with all prior employers and educational institutions? Yes No

Does background check include Police record? Yes No

(If either answer is "No", refer risk to Company.)

15b. Do you want employees covered as additional insureds? (There is a premium charge). Yes No

(NOTE: The policy already protects *you* for the acts of your employees.)

16. List medication administered and in what form given: (e.g. methadone, given in pill form) _____

17. Describe therapy other than drugs used in the course of treatment: (e.g. group therapy, individual counseling, shock treatment, etc.) _____

18. What floors are the nonambulatory patients on? _____ How many on each floor? _____

Are physical or chemical restraints used? Yes No If yes, describe _____

18a. How many patients do you have of the following types? Do not count same patient in more than one class.

	Ambulatory	Nonambulatory
1. Seriously mentally impaired (e.g. Alzheimer's, senile)	_____	_____
2. Skilled Care	_____	_____
3. Intermediate Care	_____	_____
4. Somewhat mentally impaired (e.g. mentally challenged)	_____	_____
5. Aged but mentally and physically fully functional	_____	_____
6. Drug or alcohol detoxification patients	_____	_____
7. Drug or alcohol rehabilitation patients	_____	_____
8. Has a communicable disease (e.g. AIDS)	_____	_____
9. Other - specify _____	_____	_____
Totals (Totals must not exceed total number of patients.)	_____	_____

19. What other services (such as beauty care, podiatry, dentistry) are provided by staff or independent contractor? _____

20. BUILDING INFORMATION:
- (A) Construction of building? _____
 - (B) Number of stories? _____
 - (C) Year built? _____
 - (D) Built as a nursing home? Yes No
 - (E) Is building sprinklered? Yes No Fully or Partially sprinklered?
If partially, what percentage? _____%
 - (F) Has an emergency evacuation plan been prepared? Yes No
 - (G) Are all rooms and halls equipped with smoke detectors? Yes No
 - (H) What is the total square footage of the building? _____
 - (I) Any swimming pools? Yes No Describe protection and use: _____
 - (J) Is building equipped with fire alarm? Yes No Central Station Local Station
 - (K) Is smoking permitted? Yes No
 - (L) Are there designated smoking areas? Yes No
 - (M) Distance to the nearest fire station? _____ Nearest hydrant? _____
 - (N) Temperature of hot water? _____
 - (O) Are handrails in bathrooms and hallways? Yes No
 - (P) Are bathtubs and showers equipped with non-skid surfaces? Yes No

21. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? If yes, please provide details. Yes No

22. Has applicant, or any other person for whom coverage is being requested, had any liability application denied, If yes, provide details. Yes No

23. Limits of insurance requested:
- | | | |
|--|----------|--------------------------------|
| General Aggregate Limit (Other than Products – Completed Operations) | \$ _____ | |
| Products – Completed Operations Aggregate Limit | \$ _____ | |
| Personal and Advertising Injury Limit | \$ _____ | any one person or organization |
| Each Occurrence Limit | \$ _____ | |
| Damage to premises rented to you | \$ _____ | any one premises |
| Medical Expense Limit (up to \$5,000 limit available) | \$ _____ | any one person |
| Each Professional Incident Limit (if applicable) | \$ _____ | |
24. Policy effective date: from _____ to _____

**IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 25 THROUGH 29.
If not desired, please sign application at bottom of page.**

25. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? Yes No
If yes, provide details. _____
-
26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No
If yes, provide details. _____
-
27. Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there? Yes No
If yes, provide details. _____
-
28. Does your facility do background checks on all employees and volunteers? Yes No
Describe types of checks done (prior employer, police, etc.) _____
-
29. Sexual Molestation sub limit wanted:
 \$25,000/50,000 \$50,000/100,000 \$100,000/300,000

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes 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.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____