NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

APPLICATION - HEALTH CARE FACILITY

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
   Street City County State ZIP Code
3. Location of premises: ❑ Same as mailing address
   ❑ Other _____
4. Telephone (____) _____ Fax (____) _____
5. Contract person/phone #: Inspection _____
   Accounting/Records _____
6. Business type: ❑ Individual ❑ Partnership ❑ Corporation
   ❑ Trust ❑ Other _____
7. Operating as: ❑ For Profit ❑ Nonprofit ❑ Other _____
8. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other _____
9. Part occupied by Named Insured: ❑ Entire ❑ Portion(____%) ❑ Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: ❑ General liability ❑ Professional Liability
2. Limit of Liability Desired: ❑ $100,000/$300,000 ❑ $300,000/$600,000 ❑ $500,000/$1,000,000
   ❑ $1,000,000/$1,000,000 ❑ Other _____

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Medical Payments	$5,000
Personal and Advertising Injury	Same as Occurrence Limit

3. Contractual Liability: ❑ (Attach copy of contract) No separate limit
4. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Type of firm:
   - ❑ Counseling Agency Type _____
   - ❑ Drug/Alcohol Rehab. Center Type _____
   - ❑ Halfway House Type _____
   - ❑ Mentally Handicapped Facility
   - ❑ Other _____ Type _____
   - ❑ Group Home Type _____
   - ❑ Mental Health Center
   - ❑ Physical/Occup. Rehab. Center
   - ❑ Shelter
2. Description of operations. _____

PREMISES

1. Age of building _____
2. Construction _____
3. Number of floors _____
4. Total square footage _____
5. Number of exits _____

	Yes	No
6. Central station alarm	❑	❑
7. Emergency lighting	❑	❑
8. Fully sprinklered	❑	❑

If no, describe extent of sprinklering:

_____

_____

9. Last update: Wiring _____ Plumbing _____
10. Smoke detectors in: All sleeping rooms ❑ ❑
    Halls ❑ ❑

	Yes	No
11. Has emergency evacuation plan been prepared?	❑	❑
12. Are both scheduled and unscheduled fire and emergency drills conducted?	❑	❑
13. Was building built for this purpose?	❑	❑
14. Are emergency facilities readily available?	❑	❑

If yes, describe. _____

_____

_____

15. Swimming pools	❑	❑
If yes: Do you reside at the risk location?	❑	❑
Do you carry a homeowner's policy?	❑	❑

What limits? _____

OPERATIONS

1. Does your facility: Diagnose patients/residents? ❑ Yes ❑ No
   Prescribe treatment or medications to patients/residents? ❑ Yes ❑ No
2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*

_____

_____

3. Are outpatient services provided? ❑ Yes ❑ No Number of outpatient visits annually _____
4. Number of beds _____ Average Occupancy _____ Licensed # of beds _____
5. Resident age groups (give number for each): Under 18 years _____ 18-59 years _____ Age 60 & Over _____
6. Patient admission is: ❑ Forced ❑ Voluntary

	Yes	No
7. Are patients/residents accepted on a court order?	❑	❑
8. Are there procedures in place for patient screening and acceptance?	❑	❑
9. Are current records and files maintained on each patient?	❑	❑
10. Have any patients/residents been given a probable diagnosis of having Alzheimer's?	❑	❑

If yes, how many and at what stage? _____ Stage 1 _____ All other stages _____

11. Have any patients/residents been diagnosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)?	❑	❑

12. Average length of stay for patients/residents _____

13. Are residents/patients allowed to leave premises unattended?	❑	❑

14. Number of non-ambulatory residents _____

15. Any non-ambulatory patients above the second floor?	❑	❑

16. Describe management's/administrator's education and experience. _____

_____

17. Is there a record keeping system in place that documents: Operational procedures?	❑	❑
Incidents?	❑	❑
18. Do you train new paraprofessionals (e.g. aides, homemakers?)	❑	❑

If yes, explain. _____

_____

19. Do you provide ongoing training for paraprofessionals?	❑	❑

20. Describe the duties of volunteers or students. _____

_____

21. Additional insureds (state their interests in insured's operation). _____

_____

22. Total all locations: Receipts $_____ Outpatient Visits _____
23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.)_____

_____

24. Do you sell or lease any medical equipment or other products **to others**? ❑ Yes ❑ No
    If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.

    _____

    _____ Receipts: _____

    Do you require lessees to provide certificates of insurance? ❑ Yes ❑ No
25. Do you lease or rent any equipment **from others**? ❑ Yes ❑ No

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? ❑ Yes ❑ No

2.

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

	Yes	No
a. Do you comply with minimum required staff standards for each shift?	❑	❑
b. Are all staff certified/licensed according to federal, state, or local requirements?	❑	❑
c. Are any staff working on a contract basis?	❑	❑
If yes, do you require proof of separate professional liability insurance?	❑	❑

3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:

	None	Written	Verbal
Educational background or residency program check, when applicable	❑	❑	❑
a. Previous employers check	❑	❑	❑
b. Personal references check	❑	❑	❑
c. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals	❑	❑	❑
d. Criminal background check	❑	❑	❑

e. Are copies of background checks kept on file? ❑ Yes ❑ No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
   ❑ Yes ❑ No ❑ No licensing requirements
   If no, state reasons for non-compliance and steps being taken to correct this.

   _____

   _____

   Have you had any licensing or code violations in the past three years? ❑ Yes ❑ No
   If yes, describe. _____

   _____

   Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?
   ❑ Yes ❑ No

2. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?
❑ Yes ❑ No ❑ No accreditation available
If yes, describe. _____

3. Are you a member of any professional association or organization? ❑ Yes ❑ No
Name of association or organization. _____

RISK MANAGEMENT

		Yes	No
1.	Do you have a formal written risk management program?	❑	❑
2.	Is there a designated risk management person? If no, how are these duties delegated? _____	❑	❑
3.	Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage?	❑	❑
4.	Do you have: a. Written job descriptions?	❑	❑
	b. Policies and/or procedures manual?	❑	❑
	c. Full-time administrator or medical director on staff?	❑	❑
	d. Formalized loss control and claim prevention training program?	❑	❑
	e. Emergency shelter arrangements for residents?	❑	❑
5.	Have you entered into any other contractual agreements?	❑	❑
	a. If yes, is legal advice sought to write and approve?	❑	❑
	b. Does the agreement require you to hold any third party harmless?	❑	❑

PREVIOUS EXPERIENCE

		Yes	No
1.	Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities? If yes, explain. _____	❑	❑
2.	**MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.** Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? *If yes, give name of company, date and reason.*	❑	❑

3. **PRIOR INSURANCE CARRIER AND LOSSES WHETHER COVERED BY INSURANCE OR NOT FOR THE PAST THREE FULL YEARS:**

Year	Carrier/Policy Number/ Premium	Coverage	# of Losses	Amount	Description of Losses (Use separate sheet, if necessary)

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Northfield compensates its agents, brokers and program managers, please visit this website:

http:/ / www.northlandins.com/ Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northfield Insurance Company, c/ o Law Department, 385 Washington St., St. Paul, MN 55102.