

RRG Supplemental Application

This application must be completed and signed by the applicant. Please include with the application.

- ACORD application
- Named insured/location list
- Recently valued carrier loss runs with descriptions (5 years minimum)
- Company financials
- Brochures/advertising materials or website
- Expiring policy
- Copy of facility license
- Additional insured list

Corporate/parent information

Corporate/parent name: _____

Corporate address: _____ City: _____ State: _____ Zip: _____

Corporate structure: Individual Partnership Corporation LLC

Your business is: For-profit Not-for-profit

Affiliations: Religious affiliation Hospital affiliation

Total number of facilities owned/managed: _____ (If more than one, provide list of owned/managed facilities insured separately)

Are all facilities owned/managed included in this submission? Yes No

Are there any plans for new construction, mergers, acquisitions, sale of assets or business during the next 12 months? Yes No

Applicant/facility information

Facility name: _____ Website: _____

Facility address: _____ City: _____ State: _____ Zip: _____

Federal Employer ID#: _____ Years under current management: _____

Is the facility managed by a third-party management company? Yes No

a. If "Yes", please provide name of management company: _____

b. Years under current management: _____

Facility licensure information

Has any facility had its license suspended, revoked or placed on probation in the last five (5) years? Yes No

Has Medicare or Medicaid Certification been revoked or suspended in the last five (5) years? Yes No

Has any facility been the subject of federal/state fines, sanctions or civil monetary penalty against it or any of its staff? Yes No

If the answer to any of the above questions is "Yes," please provide details in a separate attachment.

Do any facilities participate in a State Compensation Fund (IN, KS, LS, NE, NM, PA, SC and WI)? Yes No

Prior carrier and claims history

PL:

Prior carrier: _____ Occurrence Claims-made

Program type: _____ Deductible Self-insured retention

Effective date: _____ Claims-made retro date: _____

Expiring premium: _____ Deductible/retention amount: _____

GL:

Prior carrier: _____ Occurrence Claims-made

Program type: _____ Deductible Self-insured retention

Effective date: _____ Claims-made retro date: _____

Expiring premium: _____ Deductible/retention amount: _____

Claims history and prior known incidents

Has any claim, suit or regulatory proceeding been made against the Applicant, or any facility proposed for coverage, at any time during the past five (5) years? Yes No

Is the Applicant or any facility proposed for coverage aware of any fact, circumstance, incident or loss which has occurred after the proposed retroactive date, which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? Yes No

This includes but is not limited to (please select all that apply):

Death of a client, patient or resident other than natural causes Yes No

Incident resulting in hospitalization or transfer of a client, patient or resident Yes No

Injury to a client, patient or resident that required medical care Yes No

Incident that generated a formal complaint or notice from a state, federal or licensing agency Yes No

Elopement or unauthorized escape or absence of a client, patient or resident Yes No

Complications from improper medication or improper dosage Yes No

Request for medical records or other information related to a client, patient or resident Yes No

If the answer to any of the above is "Yes", please provide details on separate attachment.

Did the liability policies from the applicant's prior insurance carrier(s) specify that a claim will be considered to have been made when the earlier notice of an occurrence or incident was first provided to the insurer? Yes No

Are all resident related incident reports reviewed by the DON and Administrator? Yes No

Are incidents trended and presented to the quality/risk management committee & board of trustees? Yes No

Classification

Resident services	Total licensed beds	Average occupancy
Sub-acute		
Skilled care		
Intermediate care		
Assisted living		
Memory care		
Personal care		
Independent living	Total # of units: _____	
Post-acute care		

Please indicate the percentage of residents by age range (100%):

Under 18 _____ 18 to 55 _____ 56 to 75 _____ Over 75 _____

Are facilities approved for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "Yes", please indicate the number of beds:	
Are facilities approved for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "Yes", please indicate the number of beds:	
Private Pay	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "Yes", please indicate the number of beds:	

If facilities are multi-story buildings, are the non-ambulatory residents on the lower floors (1st or 2nd)? Yes No

Do any facilities operate as a managed care provider? Yes No

Non-resident services	Client information	Annual revenue
Home health care (social)	Total annual visits: _____	
Home health care (medical)	Total annual visits: _____	
Adult day care (social)	Total number licensed: _____	
Adult Day Care (medical)	Total number licensed: _____	
Hospice	Annual number of clients: _____	
Meals on Wheels	Annual number of meals: _____	
Pharmacy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Open to public: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child day care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Open to public: <input type="checkbox"/> Yes <input type="checkbox"/> No Average attendance: _____	
PACE: <input type="checkbox"/> Yes <input type="checkbox"/> No (Program of All-Inclusive Care for the Elderly)	If "Yes", please complete a PACE supplemental application	

Are any of the above non-resident services provided by independent contractors? Yes No

Are independent contractors required to provide proof of insurance? Yes No

Behavioral health	Number of residents, age < 65	Number of residents, age > 65
Addiction issues		
Bipolar disorder		
Post-traumatic stress disorder		
Developmental disabilities		
Schizophrenia		
Methadone maintenance		
Traumatic brain injury		
Criminal justice referred		

Do all facilities have a formalized behavioral health program provided by outside mental health expert(s)? Yes No

Do all facilities have a formalized behavioral health program provided by in-house resources? Yes No

Do all facilities have a formalized behavioral health program? Yes No

Are Behavioral Health Residents separate from the rest of the population at all facilities? Yes No

Nursing services rendered/activities of daily living services (ADL's) rendered

Indicate the number of current residents who receive the following types of nursing services:

Classification	Number of residents
Catheter care	
Ostomy care	
Diabetes care (including insulin injections)	
Medication injections	
Medication administration	
Enemas or suppositories	
Continence care	
Wound care	
Anticoagulation monitoring	
On-premises dialysis care	
Ventilator patient care	
Chemical dependency treatment	
Mobility (ambulating, transferring to wheelchairs, etc.)	
Bowel and bladder management	

Administration

Name of administrator: _____ License number: _____ State: _____

Year started as administrator: _____ Year started at this facility: _____

Full-time at this facility? Yes No

Staffing

Category	1 st shift				2 nd shift				3 rd shift			
	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF	SNF	ALF	MC	ILF
RN												
LPN/LVN												
CNA												
Agency												
Pool												

Do facilities maintain the same staffing levels on each shift on weekends/holidays as on weekdays? Yes No

If the answer to the above is "No", please provide details: _____

Total number of employees: _____

Total employee turnover for the prior 12 months is _____%

Are background checks performed on all staff for the following items?

- a. Licensure type and status Yes No
- b. Work history and education Yes No
- c. National criminal records Yes No
- d. Driving records/MVRs Yes No

Do you verify nursing licenses upon hire and annually? Yes No

Is there a formal, documented assessment process to measure staff competency skills? Yes No

Are regularly scheduled in-service education programs available for all staff/employees? Yes No

Volunteers

What is the total number of volunteers? _____

Is there a formal screening and orientation process for volunteers? Yes No

Are background checks performed on volunteers? Yes No

Medical director

Name of medical director: _____ License number: _____ State: _____

Medical specialty: _____ Employment: Employee Contractor

Year started as medical director: _____ Year started at this facility: _____

Consultants/independent contractors and services

Services	Provided?	# Employed	# Contracted	Contract in place?	Certificates of insurance on file?
Physicians	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wound care	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical records	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Barber/beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Services	Provided?	# Employed	# Contracted	Contract in place?	Certificates of insurance on file?
Home health	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social services	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transport/ridesharing	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident abuse/sexual abuse and molestation questionnaire

Do all employees and volunteers undergo a comprehensive background check including the following? Yes No

- a. Social Security number Yes No
- b. Residency information Yes No
- c. Present and previous work history Yes No
- d. State/county criminal search Yes No

Does resident assessment include cross check of National Sex Offender Registry prior to admission? Yes No

Do facilities have a Resident Abuse and Sexual Abuse Policy that is reviewed annually with each employee/volunteer? Yes No

Do facilities have a Resident Abuse and Sexual Abuse policy that includes reporting and investigating procedures that require contacting local or state authorities? Yes No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires notification of appropriate family member of alleged instance of resident or sexual abuse? Yes No

Do facilities have a Resident Abuse and Sexual Abuse policy that requires the immediate suspension/termination of employees or volunteers suspected or involved in resident abuse? Yes No

Is the Applicant or any proposed insured for coverage aware of any fact, circumstance, incident or loss related to **Resident Abuse or Sexual Abuse** which has occurred in the past five (5) years which is not yet a claim but is likely to result in a claim that would be subject to the coverage requested? Yes No

If the answer to the above is "Yes", please provide details on separate attachment.

Risk Management

Is there a risk management program implemented throughout all facilities? Yes No

Is there a designated risk manager? Yes No

Name: _____

Is it their primary role? Yes No

How long have they been working at this facility? _____

Is there a formal safety program which includes evaluation and reduction of exposures relating to the following?

- a. Life safety Yes No
- b. Employees/service provider Yes No
- c. Hazardous materials Yes No
- d. Environment Yes No

Are exits controlled and alarmed to the central security desk or nurses' station? Yes No

Is an electronic monitoring device used as part of elopement prevention practices? Yes No

Is a monthly review of drug regimens performed? Yes No

Is there an automatic medication dispensing system in place? Yes No

Do facilities have a formal grievance procedure in place to address resident/family complaints? Yes No

Infection control

Have any facilities been cited for the Tags F880, F881 , F882, F883, F945 on CMS surveys within the past three (3) years? Yes No

If "Yes", please identify the facility and date of citation and include a copy of the plan of correction (or paste in the space below) for each:

Have any facilities had an outbreak of Norovirus, Scabies, Influenza, COVID-19, Legionella, Methicillin-resistant staphylococcus aureus (MRSA), Hepatitis B or C, or a Superbug (antibiotic resistant bacteria), etc. within the past three (3) years? Yes No

If "Yes", please identify the location and the date of such outbreak.

It is hereby agreed that the particulars and statements contained in this application, and any material submitted therewith, are the basis of the policy and are to be considered as incorporated into and constituting a part of the policy. Any material misrepresentation or failure to disclose information in response to the questions in this application shall render the policy null and void at the insurer's option. The undersigned hereby declares that the statements and particulars in this application are true and that no material facts have been suppressed or misstated. The undersigned agrees that this application shall be the basis of the policy of insurance, and any policy issued will be in reliance upon the truth of such statements and particulars. The undersigned understands that misrepresentation or failure to disclose material information may result in the voiding of coverage under the policy. Any material change in the information provided in this application must be reported to the insurer immediately. Failure to do so may result in the adjustment or cancellation of any policy issued based on this application. The undersigned agree that if after the date of this "Application" and prior to the effective date of any policy based on this "Application", any occurrence, event, incident or other circumstance should render any of the information contained in the "Application" inaccurate or incomplete, then the undersigned shall notify the "Insurer" of such occurrence, event, incident or circumstance and shall provide the "Insurer" with information that would compete, update or correct such information. In such event, the "Insurer" in its sole discretion may modify or withdraw any outstanding quotation.

FRAUD WARNING: 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 conceals for the purpose 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. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT, or WA.)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an "Application" for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: 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 insurer files a statement of claim or an "Application" containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an "Application" for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose 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. 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 five thousand dollars and the stated value of the claim for each such violation.

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 a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

NOTICE TO RHODE ISLAND 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.

FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON): Any person who intentionally presents a materially false statement in an "Application" for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON): 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.

NEW YORK FRAUD WARNING: 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 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 five thousand dollars and the stated value of the claim for each such violation.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance and solvency guarantee funds are not available for your risk retention group.

APPLICANT NAME AND TITLE: _____

APPLICANT SIGNATURE: _____ DATE: _____

PRODUCER SIGNATURE: _____ DATE: _____

AGENCY NAME: _____

A POLICY CANNOT BE ISSUED UNLESS THIS "APPLICATION" IS PROPERLY SIGNED AND DATED. For purposes of creating a binding contract of insurance by this "Application" or in determining the rights and obligations under such contract in any court of law, the parties acknowledge that a signature reproduced by either digital signature, electronic signature, facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.