XINSURANCE

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854

HEALTHCARE SERVICES APPLICATION

A. General Information

Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

_____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

_____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other: _____

Is this a new business? ☐ Yes ☐ No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

_____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

_____

_____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

_____

_____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

B. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor ever had a claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? ☐ Yes ☐ No

If the standard markets are declining placement, please explain why: _____

_____

C. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	**2**	**3**
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	$	$	$

D. Desired Insurance

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate
☐	$50,000/$100,000	☐	$25,000/$50,000/$100,000
☐	$150,000/$300,000	☐	$75,000/$150,000/$300,000
☐	$250,000/$1,000,000	☐	$100,000/$250,000/$1,000,000
☐	$500,000/$1,000,000	☐	$250,000/$500,000/$1,000,000
☐	Other: _____	☐	Other: _____

Identify all contracted medical professional services performed for you and the minimum medical professional liability limits required.

Pharmacy $_____

Respiratory Therapy $_____

Physical Therapy $_____

Other $_____

Self-Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

E. Business Activities

1. Person providing accounting and tax services:
   a. Name: _____
   b. Mailing Address: _____
   c. City: _____ State: _____ Zip: _____
   d. E-Mail: _____
   e. Business Telephone Number: _____ Fax: _____
2. Last Year's Gross Receipts: $ _____
3. The applicant has been:
   a. Licensed or approved by State Board of Health ☐ Yes ☐ No
   b. Accredited by JCAHO ☐ Yes ☐ No

   If no, please explain on another sheet of paper.
4. Number of years that this facility has been operating: _____
5. Number of years with the present owner: _____
6. Number of years with the current management: _____
7. Please provide copies of all licenses held by your facility.
8. Has your license been suspended, revoked or placed on probation within the last 5 years: ☐ Yes ☐ No
9. Facility Classification:

	NUMBER OF BEDS	NUMBER OF BEDS OCCUPIED
Skilled Care Services Professional nursing care - 24 hours per day by licensed nurses. Skilled care services include some of the following: -medical administration -tube feeding -other procedures ordered -injections –catheterizations by physicians		
Intermediate Care Services Nursing care during the day shift, 7 days per week, by licensed nurses. No complex nursing care such as IV's, tube feedings, etc. Assistance with activities of daily living such as walking, bathing, dressing and eating. Some		

assistance with administering medications		
Residential Care Services/Assisted Living Residents are ambulatory with possible minor disorders, providing assistance with the activities of daily living. Residents are eligible for incidental health care services, including assistance with medications.		
Independent Living Residents are of retirement age and in general good health. They occupy their own apartment or condominium. Residents do not receive any health care services or assistance with medications. They do however have access to skilled, intermediate nursing care within the facility.		

10. Do you allow patients that have Alzheimer's? ☐ Yes ☐ No

11. Do you allow patients that have severe dementia? ☐ Yes ☐ No

12. Was this facility initially constructed to be a residential home? ☐ Yes ☐ No

    If yes, when was it converted into an assisted living facility? _____

13. Recreation Facilities:

    ☐ None ☐ Swimming Pool ☐ Exercise/Weight Room ☐ Sauna/Hot Tub

    ☐ Tennis/Racquetball ☐ Other: _____

14. Are the recreational facilities used by anyone other than your residents? ☐ Yes ☐ No

    If yes, describe: _____

    _____

15. Patient/Resident Profile:

AGE GROUP	AVERAGE DAILY NUMBER	% NON AMBULATORY
Less than 26		
26-49		
50-65		
Over 65		

16. What is the maximum length of stay for those under the age of 26: _____ days

17. Indicate the name of the Administrator and provide a brief summary of administrative experience: _____

    _____

    _____

18. Do you employ a medical director? ☐ Yes ☐ No

    If yes, briefly describe the director's medical qualifications. _____

    _____

19. Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No

    If yes, how many: _____

20. If a medical director isn't employed, who is responsible for overseeing the medical services provided?

    _____

    _____

21. Employee Profile (please indicate the number of each kind of employee):

EMPLOYEE CLASSIFICATION	1ST SHIFT	2ND SHIFT	3RD SHIFT
Physicians			
RNs			
LPNs			
Nurse's Aides			
Other			
Non Medical			
Total			

22. Give a summary of the procedures you use when hiring a medical professional at your facility: _____

23. If an individual has had a previous medical professional claim, how would it affect your hiring of that person?

24. Do you require evidence of acceptable health for all new patients to your facility? ☐ Yes ☐ No

25. What security measures are used to control unauthorized entrance to your facility?_____

26. Do you have a written emergency evacuation plan? ☐ Yes ☐ No

    If yes, please include a copy.

27. Do all patients have their own attending physician? ☐ Yes ☐ No

    If no, who performs this role?_____

28. Are written orders from an attending physician required for:

    a. All drugs or medicines? ☐ Yes ☐ No

    b. Special dietary requirements? ☐ Yes ☐ No

    c. Any other specific therapy/treatment? ☐ Yes ☐ No

29. How often are physicians required to update their patients' charts? Every _____ days

30. Is nursing assessment conducted for new patients? ☐ Yes ☐ No

    If yes, does this evaluation include:

    a. Mobility limitations? ☐ Yes ☐ No

    b. History of prior injuries? ☐ Yes ☐ No

    c. Required assistance? ☐ Yes ☐ No

    d. Disorientation ☐ Yes ☐ No

31. Do you require a physician on-site or on-call on a 24 hour basis ☐ Yes ☐ No

32. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

33. Is smoking permitted in patient rooms? ☐ Yes ☐ No

If yes, explain the rules applicable to smoking in your facility. _____

_____

34. Are there alarms on exit doors to alert the staff that patients may be leaving the premise without proper authorization? ☐ Yes ☐ No

If no, how is this controlled? _____

_____

34. The following information is needed for each building used for patient or resident occupancy. If you have more than one building please attach copies of this information for each building.
Location Name: _____ Year Built: _____
Construction Type: _____ No. of Stories: ____ Fire Protection Class: _____

35. Was this building originally designed for nursing home occupancy? ☐ Yes ☐ No

If no, what was the original purpose and occupancy: _____

_____

36. Does this building meet applicable 1994 NFPA life safety codes? ☐ Yes ☐ No

37. Smoke Detectors are located:

- ☐ None
- ☐ Entire Facility
- ☐ Common areas
- ☐ Hallways
- ☐ Patient or resident rooms
- ☐ Other: _____

Areas protected by approved automatic sprinkler system:

- ☐ None
- ☐ Entire facility
- ☐ Common Areas
- ☐ Hallways
- ☐ Patient Rooms
- ☐ Other: _____

38. When was the last time that this building's electric, heating, and plumbing systems were last inspected or updated?

	ELECTRIC	HEATING	PLUMBING
Qualified Inspection			
Replaced or Updated			

39. When was this building last inspected by the:

Local fire authorities: _____ State Department of Health: _____

(If the inspection was completed in the last three years, please include a copy)

40. Are there at least two exits on every floor? ☐ Yes ☐ No
41. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No
42. Are bathtubs and showers equipped with non-slip surfaces? ☐ Yes ☐ No
43. Are all skilled and intermediate beds equipped with side rails? ☐ Yes ☐ No
44. Are you planning any new construction during the next 12 months? ☐ Yes ☐ No

If yes, please describe: _____

_____

45. Have you had any professional or general liability claims made in the last five years? ☐ Yes ☐ No

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name