HUNTERSURE LLC

PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR RESIDENTIAL FACILITIES

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____

5. a) Date Established: _____

b) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

c) For Profit _____ Non-Profit _____

6. Funding is: Medicare _____% Medicaid _____% Private Pay _____%

7. a) Desired Effective Date: _____

b) Desired Limits of Liability: $_____ / $_____

c) Desired Deductible: $_____

8. a) Gross Receipts for the Past 12 Months: $_____

b) Gross Receipts Estimated for the Next 12 Months: $_____

9. Entity is an:	Number of Licensed Beds (all locations)	Number of Occupied Beds (all locations)
Independent Living Facility (elderly)	_____	_____
Assisted Living Facility (elderly) (PLEASE COMPLETE SUPPLEMENT)	_____	_____
Alzheimer's Facility	_____	_____
Halfway House/Shelter	_____	_____
Alcohol & Drug Rehab (Adult Only)	_____	_____
Group Home for the Developmentally Disabled	_____	_____

Other (please describe) _____

10. Number of Residents by Age Category: 0-17 _____ 18-39_____ 40-65_____ 66+_____

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11. Full description of services provided:

_____

_____

12. Does the applicant have any ancillary operations not stated above? Yes _____ No _____

If yes, please provide details: _____

_____

13. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, give detail

_____

14. a) List the number and type of employees by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

b) List the number and type of independent contractors by shift:

Staff (all locations)	1st Shift	2nd Shift	3rd Shift	Staff (all locations)	1st Shift	2nd Shift	3rd Shift
Physician				Physician Assistant			
RN				Nurse Practitioner			
LPN				Social Worker			
Therapist				Counselor			
Nurses Aides				Admin/Clerical			
Pharmacist				Other (please describe)			

c. Are all individuals shown in response to Q14a & b licensed in accordance with applicable state and federal regulations?

Yes _____ No _____ If no, attach explanation.

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15. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes _____ No _____

16. a) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b) Do you question prospects about previous claims or suits? Yes _____ No _____

c) Are employees required to actively participate in continuing education? Yes _____ No _____

d) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____

e) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

17. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

18. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

_____

19. Experience owning or managing this type of facility of current ownership: _____ Years

20. Name of Administrator: _____ Employed _____ or Contracted _____

Years Licensed: _____ Full time _____ or Part-time _____

Length of time at Facility: _____

21. Name of Medical Director: _____ Employed _____ or Contracted _____

Years as Medical Director: _____ Full time _____ or Part-time _____

Length of time at Facility: _____

22. Is a resident agreement signed by all residents upon entering the facility? Yes _____ No _____
If yes, please attach a copy.

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23. Do you accept/retain any residents who are violent and/or combative and/or have suicidal tendencies and/or a history of suicidal tendencies?

Yes _____ No _____ If yes, please provide details:_____

24. Have you had any residents elope (leave the premises without the staff being aware of it) in the past 3 years?

Yes _____ No _____ If yes, please provide details:_____

25. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

Yes _____ No _____ If yes, please provide details:_____

26. What year was the facility built/updated? _____ Number of floors? _____

27. Are there smoke detectors in all bedrooms/hallways? Yes _____ No _____

If so, are they: Hardwired _____ Battery _____

28. Fire Alarm? Central _____ Local _____ None _____

29. Are there any animals on the applicant's premises? Yes _____ No _____

If yes, please provide details:_____

30. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

31. Date of last State Inspection/Survey (please attach a copy of the report): _____

32: Total # of Deficiencies during last state inspection: _____

33: Corrective Action Plan accepted by the State? Yes _____ No _____

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34. Number of complaints investigated by the State in the past 2 years: _____
(please attach a copy of any complaint report(s))

35. Number of substantiated complaints: _____

36. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

37. Give General Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

38. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes_____ No_____

If yes, please give details _____

39. Has any claim ever been made against the firm or any of its employees?

Yes_____ No_____

If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

40. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes_____ No_____ If yes, please give details _____

41. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes_____ No_____ If yes, please give details _____

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Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)