Kaigler & Company 7028 Church St. East Brentwood, TN 37027
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ASSISTED LIVING APPLICATION

FULL NAME OF INSURED (S):

LOCATION:

Proposed effective date: From to
12:01 A.M. Standard Time at the address of the Applicant

Applicant is: Individual Corporation Partnership Joint Venture Other (Specify)

Is the business currently in or currently considering bankruptcy? Yes No

1. Is the above Named Insured the parent company and sole owner of each location listed above, if not provide details:

2. Operating as: Profit Non-Profit Total number of beds: # Licensed: # Occupied:

3. Named Insured is: Building Owner Tenant General Lessee

4. Are there any other occupants of the premises? Yes No If yes, *identify:*

5. Officers and general partners Titles

6. How many years has the facility been in business under the current ownership?

7. How many years experience does the current ownership have in health facilities?

8. What professional or industry association(s) is the facility a member in good standing?

9. Name of Administrator:
   (a) How long at this facility?
   (b) Experience as Administrator or Assistant Administrator: years

10. Who is in charge when Administrator is absent? (name and title)

11. Is the facility certified for: Medicare? Yes No
    Medicaid? Yes No
    Other? Yes No Explain:

12. Number of residents in each category? Private Pay: Medicare:
Medicaid: Other: Explain:

13. Gross annual receipts of the facility (including Medicare and Medicaid): $

14. Please attach the most recent copies of state and county inspections. Are there any deficiencies uncorrected? Yes No

15. License information:
   (a) Please attach all licenses required for this facility's operation.
   (b) Is licensing conditional, provisional or temporary? Yes No
   If yes, PLEASE ATTACH EXPLANATION.
   (c) Has license ever been revoked? Yes No If yes, please explain:

16. Patient / Resident Age Groups

Age group	Number of Patients / Residents	% Non-Ambulatory
Under 50		
50 – 65		
Over 65		

17. State approximate division of residents (MUST add to 100%):

% Surgical
% Mentally ill/mentally disabled
% Developmentally disabled
% Senile or Aged
% Drug addicts
% Alcoholics
% Alzheimer
% AIDS/HIV*
*Complete question 50
% Any other Classes
Explain:

18. Physical features of risk:
Construction of building: Square footage of building:
Number of Floors: Are any non-ambulatory residents above second floor?
Year built: Age and type of heating system:
Age and type of wiring: Date if remodeled:
Purpose for which building was originally constructed:
Number of fire extinguishers on premises: Tagged/inspected: Number of fire escapes:
Any swimming pools? Yes No If yes, is it fenced? Yes No
Are residents allowed to use the pool? Yes No If yes, what security measures are taken?

Is staff trained in CPR and emergency training for water emergencies? Yes No
What is the ratio of staff to residents when pool is in use?
Equipped with sprinkler system? Yes No Where?
All rooms and halls equipped with smoke detectors? Yes No
Equipped with fire alarm? Yes No Central station or Local alarm
Are there alarms or monitors or exit doors to prevent residents from leaving the premises without authorization?
Yes No If no, how is ingress/egress monitored?
What security measures are used to control unauthorized entrances to the facility?

Are doors equipped with panic hardware? Yes No
Distance to nearest fire station? Distance to nearest fire hydrant?
Are handrails provided in hallways and bathrooms? Yes No
Are bathtubs and showers equipped with nonskid surfaces? Yes No

Does facility have tempering valves to control the temperature of residents' water? Yes No
If yes, how often are they checked?
Temperature of hot water: F
Are there separate hot water systems for utility and bath areas? Yes No
Does the home have emergency lighting? Yes No
Where are the powered equipment, such as lawn mowers, and fuel stored?
Are there any underground storage tanks? Yes No
What is the overall condition of the property including maintenance and housekeeping?
Excellent Good Average Fair Poor
Cooking: Gas Electric None
If none, describe food service:

Is stove vented outside with hood and grease filter?	Yes	No
Are filters clean?	Yes	No
Are hood and cooking surfaces directly protected with automatic extinguishing system?	Yes	No
Are all cooking surfaces directly protected?	Yes	No
Is automatic fuel shutdown interlocked to system?	Yes	No
Is there any deep fat frying?	Yes	No

19. Emergency procedures:

1. Written emergency evacuation plan?	Yes	No
2. Does plan include advance arrangement including transportation and emergency shelter?	Yes	No
3. Are evacuation procedures posted in all parts of your facility?	Yes	No
4. Are drills conducted regularly for each shift?	Yes	No
5. Is the entire staff familiar with the emergency evacuation plan?	Yes	No
6. Is the plan filed with the local fire department?	Yes	No

20. Classify number of employees by shift:

	1st Shift	2nd Shift	3rd Shift
Physicians, interns, residents			
Graduate nurses / RN			
Practical nurses / LPN			
Nurses' aides			
Student nurses			
Physical therapists			
Inhalation therapists			
Dieticians			
Beauticians/barbers			
Respiratory therapists			
Social worker			
Speech therapists			
Recreational therapists			
Occupational therapists			
X – ray technicians			
Lab technicians			
Maintenance/security			
Special technicians			
Dentists			
Administrative			
Kitchen			
Housekeeping			
Laundry			
Other			

Total number of employees Full-time: Part-time:

Staff turnover: % last twelve (12) months

21. Physicians:
(a) Residents are expected required to have their own physician.
(b) Does facility employ or contract any of the following?

	EMPLOYED			**CONTRACTED**		
Psychologists	Yes	No	If yes, how many?	Yes	No	If yes, how many?
Dentists	Yes	No	If yes, how many?	Yes	No	If yes, how many?
Psychiatrists	Yes	No	If yes, how many?	Yes	No	If yes, how many?
Physicians	Yes	No	If yes, how many?	Yes	No	If yes, how many?

(c) What are the duties of the contracted physicians?
(d) What are the average hours per week for all contracted physicians?
(e) Does insured obtain and maintain evidence of Professional Liability coverage for contracted professionals?
(f) What minimum limits are required?

22. Are pre-employment physicals required? Yes No

23. Is prior employment history checked? Yes No

24. Is English the primary language of all professional staff? Yes No If no, what procedures does the insured have in place to ensure the staff is fluent enough in English to provide adequate care?

Does the facility provide in-service training in languages other than English? Yes No

25. Does applicant have Workers Compensation coverage in force? Yes No

26. Does applicant lease employees? Yes No If yes, explain:

27. Does the facility ever use a nurse registry or other temporary services to provide any staff? Yes No
(a) If yes, are they covered by their own Workers Compensation? Yes No
(b) If yes, do they have their own Professional Liability Coverage? Yes No
(c) Are certificates of insurance obtained? Yes No
What are the limits?
(d) Is the registry or service licensed? Yes No

28. Do nurses make outside calls? Yes No If yes, describe:

29. Does applicant provide outpatient hospice care? Yes No If yes, describe:

30. Are physicians or RNs private practitioners (independent contractors) or actual employees of Insured?

31. Does the facility maintain it's own:

Barber/beauty shop	Yes	No
Pharmacy	Yes	No
Gift Shop	Yes	No

(a) Do the operators have their own professional liability? Yes No
(b) If no, complete and return Professional Application.

32. Are there any volunteers or volunteer programs? Yes No Types of tasks performed:

Number of volunteers by shift: 1st 2nd 3rd

33. Explain arrangement for medical emergencies (M.D. on call, transfer arrangement with hospital, etc.):

34. Is there a residents' council? Yes No How often does it meet?
Is there a family council? Yes No How often does it meet?

35. Are employees taught to lift using proper techniques? Yes No
    (a) Are Hoyer Lifts being used? Yes No
    (b) Are Gait Belts being used? Yes No

36. Are all wheelchairs equipped with locks for the wheels? Yes No

37. Is there a regular extermination program by an outside firm? Yes No
If yes, who?
How often?
Is certificate of insurance on file? Yes No

38. Does the facility control the possession of smoking materials? Yes No If yes, how:

Please provide a copy of the facility smoking Policy.

39. Are there established visiting hours? Yes No If yes, what are they:

40. Previous history:

Year	Losses Paid	Losses Reserved	Description
Current			
1st Prior			
2nd Prior			
3rd Prior			
4th Prior			
5th Prior			

41. Have any claims during the past five years ever been made or suit brought against the applicant because of any alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's Operation?

Yes No If yes, date: Brief description:

42. During the past three years has any company ever cancelled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri) Yes No

If yes, explain:

REQUIRED ATTACHMENTS

ACORD Application
Resumes of Administrator and Charge Nurse, if applicable
Copy of Current State License To Operate
Copy of most recent state inspection with the facility's plan of corrections, if required
12 months audited financials
At Least Five (5) Years, currently valued, Hard Copy Loss Runs
Admission / Discharge / Eviction Criteria
Assessment / Evaluation / Services
Fall Prevention Program, if applicable
Elopement Program, if applicable

NOTE: WILL NOT BE ABLE TO CONSIDER FOR QUOTATION WITHOUT THIS APPLICATION FULLY COMPLETED AND THE ABOVE ATTACHMENTS

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the Information contained herein shall be the basis of the contract should a policy be issued.

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.

APPLICANT'S SIGNATURE DATE

NAME OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT

Phone: Fax:

IMPORTANT NOTICE: As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Assisted Living

Supplemental Guide Requirement:

Insureds Name:

Assisted Living Checklist:

Yes	No	N/A	Is the facility clean and odor free?
Yes	No	N/A	Are the building and grounds well cared for and attractive?
Yes	No	N/A	Do the residents have access to an outdoor area?
Yes	No	N/A	Does the facility have a good reputation in the community?
Yes	No	N/A	Can it furnish broker with a list of references?
Yes	No	N/A	Is there public transportation nearby?
Yes	No	N/A	Is there a senior center, community center, or other amenities close by?
Yes	No	N/A	Is the location near the residents' physician or a cooperating hospital?
Yes	No	N/A	Is there a security checkpoint at the entrance?
Yes	No	N/A	Is there an up-to-date safety inspection notice posted?
Yes	No	N/A	Is the main door locked at night?
Yes	No	N/A	Do residents have keys to the main door?
Yes	No	N/A	Are exits clearly marked and left unlocked from the inside?
Yes	No	N/A	Is the facility equipped with alarm system?
Yes	No	N/A	Are warning signs displayed when floors are being cleaned to prevent falls?
Yes	No	N/A	Is the lighting adequate in hallways and common areas?
Yes	No	N/A	Are there perimeter alarms on all exits to prevent confused residents from wandering?
Yes	No	N/A	Is the facility equipped with a "wandergard" system?
Yes	No	N/A	Is there a registered nurse on duty at all times?
Yes	No	N/A	If not, is one on call, if needed?
Yes	No	N/A	Is there a physician on call for resident?
Yes	No	N/A	Are all staff certified in their field of work?
Yes	No	N/A	Does staff have training in personal care? CPR?
Yes	No	N/A	Are units private?
Yes	No	N/A	Do all units have bathrooms?
Yes	No	N/A	Is the bathroom equipped for wheelchair access?
Yes	No	N/A	Is there a kitchenette in each unit?
Yes	No	N/A	Is there an emergency call button in each unit?
Yes	No	N/A	Is there an individual assessment of need?
Yes	No	N/A	Does the facility offer personal care?
Yes	No	N/A	Does the facility offer medication management?
Yes	No	N/A	Is there help with injections or medical equipment?

Yes	No	N/A	Do residents have assistance at mealtime? (e.g., cutting up food, monitoring swallowing)
Yes	No	N/A	Is there a routine daily check-in by phone?
Yes	No	N/A	Do residents have access to a pharmacy?
Yes	No	N/A	Do residents have help arranging medical appointments or additional health services?
Yes	No	N/A	Is there assistance and supervision for people with dementia?
Yes	No	N/A	Transportation for medical appointments?
Yes	No	N/A	Non-medical transportation (for shopping, outings)?
Yes	No	N/A	Housekeeping assistance and laundry?
Yes	No	N/A	Shopping assistance or grocery delivery?
Yes	No	N/A	Beauty shop or barber services?
Yes	No	N/A	The ability to hire additional nighttime or live-in help, if needed?
Yes	No	N/A	Are there menus available for review?
Yes	No	N/A	Is food served at the right temperature?
Yes	No	N/A	Are special diets and food preferences accommodated?
Yes	No	N/A	Can meals be delivered to a resident's room?
Yes	No	N/A	Are guest meals available?
Yes	No	N/A	Is there a schedule of activities posted?
Yes	No	N/A	Is therapeutic recreation provided (e.g., exercise or yoga)?
Yes	No	N/A	Do residents participate in planning the activities?
Yes	No	N/A	Do residents have access to worship services of their choice?
Yes	No	N/A	Is there a grievance procedure to handle complaints in a timely manner?
Yes	No	N/A	Do residents have the right to come and go as they please?
Yes	No	N/A	Are guests welcome at any time?
Yes	No	N/A	Is it clear under what conditions the facility can evict / discharge a resident?

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