Senior Living Professional and General Liability Main Application

darwin®

K&B UNDERWRITERS
Service. Stability. Simplicity.

PLEASE PRINT, COMPLETE AND RETURN THIS APPLICATION BY EMAIL OR FAX TO:
FAX: 786-293-3669 EMAIL: SERVICE@USAINSURANCENET.COM

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY, GENERAL LIABILITY, EMPLOYEE BENEFITS LIABILITY AND SEXUAL MISCONDUCT LIABILITY COVERAGE WRITTEN ON A CLAIMS-MADE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THIS APPLICATION AND THE POLICY CAREFULLY AND DISCUSS WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THIS APPLICATION AND ANY APPLICABLE SUPPLEMENTAL APPLICATIONS WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

Please type or print clearly.

- **Answer ALL questions completely, leaving no blanks, including any Supplemental Application(s) as may be required. All questions referring to the "Applicant" means the Named Insured or any facility proposed for coverage. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **Certain questions apply on a per facility or location basis – whether you operate only a single facility or multiple facilities or locations, please provide such data separately for each facility or location on a *COVERED FACILITY SUPPLEMENTAL APPLICATION*.**
- **This form must be completed, dated and signed by the CEO, CFO, Administrator, Director of Nursing, or Risk Manager of the proposed Named Insured.**

I. GENERAL BUSINESS INFORMATION

A. Named Insured: _____

B. DBA: _____ Federal Tax ID: _____

C. Is Applicant a management company? ☐ Yes ☐ No

D. Mailing Address of Named Insured: _____ (Street) _____ (City, State) _____ (ZIP)

E. Telephone #: _____

F. Website: (if applicable) _____

G. Proposed Policy Effective Date: _____ Proposed Policy Expiration Date: _____

II. GENERAL EXPOSURE INFORMATION

A. Total Number of facilities or locations proposed for coverage? _____

(i) Is the proposed coverage intended to satisfy, either for any facility or for any additional insured, the coverage required by any state Patient Compensation Fund? ☐ Yes ☐ No

(ii) If only one (1) facility is proposed for coverage, what is the Named Insuredôs ownership percentage in such facility? If more than one (1) facility is proposed for coverage, what is the *smallest* percentage ownership interest in any such facility? _____%

B. Are all facilities licensed, as required, in all states where operating? ☐ Yes ☐ No

C. Are any facilities proposed for coverage contained within, operated by, affiliated with or owned by a licensed hospital or mental health facility? ☐ Yes ☐ No

D. APPLICANT IS (Check all that applies):

Organizational Structure:	Accreditation / Memberships:	All facilities are:
☐ Corporation	☐ Accredited by JCAHO	☐ For-profit
☐ Limited Liability Company	☐ Accredited by CCAC	☐ Not-for-profit
☐ Partnership	☐ Member of association: _____	☐ Mixed / Both
☐ Joint Venture	☐ None	
☐ Other: _____		

E. Coverage(s) Requested:

Professional Liability (select one): ☐ Claims Made

General Liability (select one): ☐ Claims Made

Employee Benefit Liability (select one): ☐ Claims Made ☐ No Coverage

Sexual Misconduct Liability (select one): ☐ Claims Made ☐ No Coverage

F. Prior Claims History or Prior Known Incidents:

(i) 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

(ii) Is the Applicant or any proposed insured 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? *(If the answer to above is Yes, please provide details on the Covered Facility Supplemental Application)* ☐ Yes ☐ No

PLEASE NOTE, WITHOUT PREJUDICE TO ANY OTHER RIGHTS OF THE UNDERWRITER / INSURER, IT IS UNDERSTOOD AND AGREED THAT, ANY CLAIM OR RELATED CLAIM THAT ARISES OUT OF ANY CLAIM, SUIT, FACT, SITUATION, INCIDENT, CIRCUMSTANCE, INVESTIGATION OR PROCEEDING, THAT IS OR REASONABLY SHOULD HAVE BEEN DISCLOSED IN RESPONSE TO THE ABOVE QUESTIONS IS EXCLUDED FROM THE PROPOSED COVERAGE.

III. EXPIRING INSURANCE INFORMATION

A. Has Applicant ever had an insurance company cancel, refuse to renew or restrict coverage through endorsements to the policy? ☐ Yes ☐ No

If the answer above is ñYesò, please indicate the reason for cancellation, non-renewal or restriction:

- ☐ Carrier withdrawal from state or line of business
- ☐ Carrier insolvency
- ☐ Claims frequency and / or severity
- ☐ Misrepresentation or fraud by Applicant
- ☐ Applicant filed suit against carrier
- ☐ Other: _____

IV. REQUESTED COVERAGE INFORMATION

A. Are all facilities proposed for coverage requesting the same limits and deductibles? ***(Note: If "No", please provide details of the different limits and deductibles on the COVERED FACILITY SUPPLEMENTAL APPLICATION)*** ☐ Yes ☐ No

B. Requested Professional Liability Primary Limits:

- ☐ $50,000 Per Claim / $150,000 Aggregate
- ☐ $100,000 Per Claim / $300,000 Aggregate
- ☐ $200,000 Per Claim / $600,000 Aggregate
- ☐ $250,000 Per Claim / $750,000 Aggregate
- ☐ $500,000 Per Claim / $1,500,000 Aggregate
- ☐ $500,000 Per Claim / $2,500,000 Aggregate
- ☐ $1,000,000 Per Claim / $2,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $3,000,000 Aggregate

C. Requested Professional Liability Each Claim Deductible:

☐ $1,000 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ Other: _____

D. Requested General Liability Primary Limits:

- ☐ $1,000,000 Per Claim / $1,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $2,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $3,000,000 Aggregate

E. Requested General Liability Each Claim Deductible:

☐ $1,000 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ Other: _____

F. Requested Employee Benefits Liability Primary Limits:

- ☐ $1,000,000 Per Claim / $1,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $2,000,000 Aggregate
- ☐ $1,000,000 Per Claim / $3,000,000 Aggregate

G. Requested Employee Benefits Liability Each Claim Deductible:

☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: _____

H. Requested Sexual Misconduct Liability Primary Limits:

☐ $250,000 Per Claim / $500,000 Aggregate ☐ $1,000,000 Per Claim / $1,000,000 Aggregate

☐ $500,000 Per Claim / $1,000,000 Aggregate

I. Requested Sexual Misconduct Each Claim Deductible:

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other: _____

J. Requested Defense Expense Treatment:

☐ Defense Expenses Erode Limit (for all Coverage Parts) ☐ Defense Expenses in addition to Limit (for all Coverage Parts other than Sexual Misconduct)

IMPORTANT NOTICES

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

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 POLICY HOLDER 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.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA 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 FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF

MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/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.

NOTICE TO NEW JERSEY APPLICANTS: 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 SUCH VIOLATION.

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 OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO WASHINGTON 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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Key Contact at Named Insured: _____

Position of Key Contact is: ☐ Risk Manager ☐ CFO ☐ CEO ☐ Other: _____

Telephone Number: _____
Email Address: _____

Signature of Applicant: _____

(Must be dated and signed by the CEO, CFO, Administrator, Director of Nursing or Risk Manager of the proposed Named Insured)

Printed Name: _____

Title: _____

Date: _____