Name Of Insurance Company
To Which Application Is Made: ______________________________
(herein called the Company)

BUNKER HILL
NURSING HOME, ASSISTED LIVING, AND RETIREMENT APARTMENT APPLICATION

Name of Applicant: ______________________________

Producer: ____________________ **Phone:** ____________ **Fax:** __________

Agency: ____________________ **E-Mail:** ______________________

Expiration: ____________________ **FEIN #**______________________

Name of Person To Be Contacted For Inspection: ____________________ **Phone:** ______________

MANDATORY ITEMS *TO BE COMPLETED AND ENCLOSED*

1. **Bunker Hill Application** ....
2, **ACORD Applications: (√)** ....**Umbrella Auto Crime IM**
3, **Financial Statements (Income, Balance Sheet, Cash Flow)** ....
4. **Copy of Last Inspection by Department of Human Services**............................
5. **Copy of Company Loss Reports** ....
   (5 years or more, if available, Company Generated, Currently Valued)
6. **Resumes for Administrators and Owners** ....
7. **Care Plan for Any Acquired Stage III or Stage IV Pressure Sores** ....
8. **Copy of License** ....
9. **Brochures** ....

Remember, the more comprehensive and complete the information you provide, the better the quote!

BUNKER HILL
9821 Katy Freeway, Suite 850
Houston, Texas 77024-1206
Phone: (713) 935-7400
Fax: (713) 467-8238
www.bunkerhillinsurance.com

BUNKER HILL
9821 Katy Freeway, Suite 850, Houston, Texas 77024-1206 (713) 935-7400

NURSING HOME, ASSISTED LIVING, AND RETIREMENT APARTMENT APPLICATION

GENERAL INFORMATION - ALL LOCATIONS

(1) a. Insured: ______________________________
(As it would appear on the policy)
Mailing Address: ______________________________

City: ______________ County: ______________ State: ________ Zip: ______

Phone: ______________ Fax: ______________ E-Mail: ______________

b. Other Named Insureds: (Attach additional page if necessary)

	Name	**Interest**
1.		
2.		
3.		

(List all entities to be insured and interest)

(2) Policy Period: ____/____/____ 12:01 A.M. to ____/____/____ 12:01 A.M.

(3) a. Applicant is: ___ ***Individual*** ___ ***Partnership*** ___ ***Corporation*** ___ ***Other*** ______________

b. Applicant's interest in facility is: ____ ***Owner*** _____ Lessee ____ Tenant
____ ***Non-Profit*** _____ Mgmt. Co.
If non-profit, affiliation is: ______________________________

c. Officers of operating corporation or general partners:

Name	Title	Active	Inactive
		[ ]	[ ]
		[ ]	[ ]
		[ ]	[ ]

d. Is there a management company involved in the administration of the facility? ***[ ] Yes*** [ ] No

e. If Yes, name of the Management Company: ______________________________

f. Does the management company have any common ownership with Named Insured? ***[ ] Yes*** [ ] No

g. Does the management company manage any other facilities? ***[ ] Yes*** [ ] No
If Yes, give Names, locations and types: ______________________________

h. Does the facility own any other operation? [ ]Yes ***[ ]No***

(4) Insured Experience: ***Date business was originally started:*** ______________
Number of years insured has owned/operated facility(s): ____/____
Number of Years managed by present management, if applicable: ________

REQUIRED:
Year each facility was acquired: Loc.#1 ______ Loc.#2 ______ Loc.#3 ______
Loc.#4 ______ Loc.#5 ______ Loc.#6 ______

PRESENT CARRIER INFORMATION

Coverage	Name of Carrier	Policy #	Expiration Date	Years Insured	Annual Premium
Property/Crime/IM					$
General/Professional Liab.					$
Automobile					$
Umbrella/Limit $___ Million					$
Workers' Compensation					$

a. Been insured with Producer? [ ] Yes [ ] No
What coverages? ________________________ When? ______________

b. Does present liability policy have a per location aggregate? [ ] Yes [ ] No
If yes, limit: $________________________

c. Does present liability policy exclude sexual and physical abuse? [ ] Yes [ ] No

d. Does present liability policy exclude punitive damages? [ ] Yes [ ] No

e. Does present liability policy have a deductible? [ ] Yes [ ] No
If yes, amount: $____________________

f. Requested Coverage Form: Occurrence ___ Claims Made ___
If Claims Made, provide retroactive date: ____________________

FIVE YEAR LOSS HISTORY

(1) Has the Applicant (include owners, managers, partners or administrators) ever:
(If yes, attach complete explanation.)

a. Been involved in any personal or business bankruptcy? [ ] Yes [ ] No
b. Been arrested, charged or convicted of any civil or criminal violations? [ ] Yes [ ] No
c. Had insurance cancelled or nonrenewed in the last three years? [ ] Yes [ ] No
d. Has the applicant ever been sued by, or had a request for records from the law firm of Wilkes McHugh? [ ] Yes [ ] No

(2) Is applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? [ ] Yes [ ] No
If yes, describe: ____

____

(3) ***LOSS HISTORY: REQUIRED; Submit Insurance Carrier Currently Valued Hard Copy Loss Data, summarized by year, for last five years. Verify that loss run includes all locations applicant is requesting coverage for, and identify losses to locations.***

Explanation of large losses: ____

____

____

____

____

LOCATIONS

Loc. # _____ DBA Name: ____ No. & Street: ____________________________
City: _________________________________ County: _____________________________ State: ____________ Zip: __________

Loc. # _____ DBA Name: ____ No. & Street: ____________________________
City: _________________________________ County: _____________________________ State: ____________ Zip: __________

Loc. # _____ DBA Name: ____ No. & Street: ____________________________
City: _________________________________ County: _____________________________ State: ____________ Zip: __________

(If necessary, submit additional sheet.)

PROPERTY LIMITS & COVERAGES

	Location # ____ Bld. # _____	Location # ____ Bld.. # _____	Location # ____ Bld.. # _____
A. Describe Occupancy			
B. Total Square Footage			
C. 1. Total Building Value	$	$	$
2. Business Personal Property	$	$	$
3. Business Income	$	$	$
Total Values (add 1+2+3)	$	$	$
Property Rating Bureau File #			

D. Other Coverages

____ Inland Marine/Fine Arts, (Attach ACORD App.)
____ Crime/Fidelity (Attach ACORD App.)
____ Builder's Risk (Attach ACORD App.)
____ EDP (Attach ACORD App.)
____ Machinery & Equipment
____ Other Describe: __________________

E. Certificates Property Certificates Required: (List Name, Address, and Interest)

Name Address Interest

1. ____
2. ____
3. ____
4. ____
5. ____

(Attach separate list if necessary)

F. Additional Insureds

Name Interest

1. ____
2. ____
3. ____
4. ____
5. ____

(Attach separate list if necessary)

BUNKER HILL PROPERTY - UNDERWRITING DATA

		Loc. #__________ Bldg. #__	Loc. #__________ Bldg. #__	Loc. #________ Bldg. #
1)	Year of Construction:	__________	__________	__________
2)	Construction (Brick Veneer, Masonry, etc.):	__________	__________	__________
3)	Number of Stories for the building:	__________	__________	__________
4)	Protection Class Code or Description:	__________	__________	__________
5)	Was Building Built for Occupancy Used?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
6)	Distance to Fire Department:	________ Miles	________ Miles	________ Miles
	Distance to Fire Hydrants:	________ Feet	________ Feet	________ Feet
7)	% of Building Sprinklered:	__________ **%**	__________ **%**	__________ **%**
	Type System (Wet, Dry:)	__________	__________	__________
8)	Type Fire Alarm (Central, Local):	__________	__________	__________
	Smoke Detectors?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
	Heat Change Indicators?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
9)	Type Wiring (Copper or Aluminum):	__________	__________	__________
	Date Updated:	__________	__________	__________
10)	Type Heating System (Electric, Gas, Steam):	__________	__________	__________
	Type Cooling System (Central, Window):	__________	__________	__________
11)	Separate Hot Water for Utility/Bathing?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
	Are there Tempering Valves?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
12)	Type Cooking Stove (Gas, Electric):	__________	__________	__________
	Is Stove Vented Outside?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
	Have Hood and Grease Filter?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
	Are Filters Cleaned (Monthly, Quarterly)?	__________	______	______
	Is Hood Protected with Automatic System?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
13)	Is There a Basement?	[ ]Yes [ ]No	[ ]Yes [ ]No	[ ]Yes [ ]No
14)	Type Roof and Year Replaced:	_____/_____	_____/_____	_____/_____
15)	Describe Adjacent Buildings, North	__________	__________	__________
	Other Exposures: East	__________	__________	__________
	Distances (ft.): South	__________	__________	__________
	West	__________	__________	__________
16)	Miles from Coast (Hurricane Areas Only):	________ Miles	________ Miles	________ Miles
17)	Is New Construction Planned Within 12 Mo.?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
	If so, Cost:	$__________	$__________	$__________
	Start Date/End Date	_____/_____	_____/_____	_____/_____
18)	What Type of Pipes are used in your Water or Sewage System? (PVC/Iron/Copper)	__________	__________	__________
19)	Has any Building ever had Foundation Damage?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***

If yes, describe: ____

20)	Has any Building ever had Broken Pipes around the vicinity of the Foundation?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***

If yes, describe the damage and explain when and how it has been corrected:________________________

I. **License**

Is operation licensed by the state? ***[ ] Yes*** [ ] No Date: ________/____________

Type of License(s): ____

Licensed Medicare? ***[ ] Yes*** [ ] No Receipts as part of Revenue ________%

Licensed Medicaid? ***[ ] Yes*** [ ] No Receipts as part of Revenue ________%

Licensed Private Pay? ***[ ] Yes*** [ ] No Receipts as part of Revenue ________%

Joint Commission on Accreditation of Health Care Organizations (JCAHO) - approved? ***[ ] Yes*** [ ] No

REQUIRED: Provide Copy of License(s).

II. **State Department of Health**

A. If state provides rating on home, indicate last rating: ____________________

B. In the past three years, has any location been placed under vendor hold, recommended contract cancellation, proposed decertification or had any other sanctions or fines by the state Quality Standards or Licensing Division? [ ]Yes ***[ ]No***

If Yes, describe reason & corrective action: ____

Is any location now under any waivers from the Quality Standards Board? [ ]Yes ***[ ]No***

If yes, describe: ____

C. Are there any current investigations, aside from routine surveys, into the applicant's operations by any other government agency/body? [ ]Yes ***[ ]No***

REQUIRED: Provide Copy of Most Recent State Full Book Inspection. Date of last inspection: ___/___/_____

III. **Employment**

A. Hiring Procedures / Administration and Staff

1. How are workers recruited? ____

Check which of the following are obtained, verified, and filed as a part of your employee screening and hiring process: Applications Experience/References Multi-State Registry Drug Testing Driving Rec (MVR) Education & Competency Criminal Background Checks Licenses/Annual Confirmation

2. Is documentation maintained in employee file? ***[ ]Yes*** [ ]No
3. Do you have formal job descriptions for all positions? ***[ ]Yes*** [ ]No
4. Are all Nurse Aides certified prior to employment? ***[ ]Yes*** [ ]No

If not, describe certification process:____

5. Average professional turnover _________% Average non-professional turnover: ______%
6. Is any part of your workforce unionized? ***[ ]Yes*** [ ]No

If "yes", please describe:____

B. Employee Benefits Provided: Health Care 401K Section 125 Life Insurance

C. Do you have written procedures in place to provide employee benefits? ***[ ] Yes*** [ ] No

NOTE: Employee Benefits Liability, if available, requires written procedures.

D. Nurse Registry / Temporary Agency

1. Do you use a nurse registry/temporary agency? ***[ ] Yes*** [ ] No
2. If Yes, approximate % of payroll ___________% Annual Cost $_________________
3. Department(s) where temps are used: ____
4. Shifts when temps are used: _______________ _______________ _______________
5. Do you obtain a certificate of insurance from the agency for:

a. Professional Liability? ***[ ] Yes*** [ ] No b. Workers' Compensation? ***[ ] Yes*** [ ] No

6. How are temps identified in the facility? ____

IV. **Security**	**Loc. # ________ Bldg. # ________**	**Loc. # ________ Bldg. # ________**	**Loc. # ________ Bldg. # ________**
1) Exits:			
Equipped with Exit Alarms?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Equipped with Panic Doors?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Equipped with Cameras?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
2) Are Guards Used? (If yes, Attach Contract)	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Are They Armed?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Who do you contract with?	________	________	________
3) Are the Premises Fenced?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
If yes, Please Circle:	Partial Total	Partial Total	Partial Total

V. **Other Services** Do you provide any other than nursing/retirement services? [ ] Yes ***[ ] No***

If yes, (√) and indicate approximate receipts for services furnished: $ ____________________

√ **SERVICE**	**RECEIPTS**	√ **SERVICE**	**RECEIPTS**	√ **SERVICE**	**RECEIPTS**
Home Health Care	$ ________	Meals on Wheels	$ ________	Child Care #______	$ ________
Adult Day Care	$ ________	Other ________	$ ________	Counseling	$ ________
Other ________	$ ________	Other ________	$ ________	Other ________	$ ________

	EMPLOYED	**CONTRACTED**	**LIMITS OF LIABILITY**
a. Physicians	[ ]Yes [ ]No	[ ]Yes [ ]No	
b. Dentists	[ ]Yes [ ]No	[ ]Yes [ ]No	
c. Podiatrists	[ ]Yes [ ]No	[ ]Yes [ ]No	
d. Chiropracdtors	[ ]Yes [ ]No	[ ]Yes [ ]No	
e. Psychologists/Psychiatrists	[ ]Yes [ ]No	[ ]Yes [ ]No	
f. Occupational Rehabilitation	[ ]Yes [ ]No	[ ]Yes [ ]No	
g. Therapists	[ ]Yes [ ]No	[ ]Yes [ ]No	
h. Pharmacist	[ ]Yes [ ]No	[ ]Yes [ ]No	

VI. **Retirement and Apartment (only)**	**Loc. # Bldg. # ________**	**Loc. # Bldg. # ________**	**Loc. # Bldg. # ________**
CHECK IF SECTION NOT APPLICABLE:	**[ ] N/A**	**[ ] N/A**	**[ ] N/A**
Is There a Swimming Pool?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
Fenced?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Diving Board?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
Other Bodies of Water?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
If Yes, Describe: ______________________			
Is There a Pharmacy Used by Non-Residents?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
Is There a Beauty Shop Used by Non-Residents?	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***	[ ]Yes ***[ ]No***
Is There an Emergency Lighting System?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Are There Emergency Call Buttons in Each Apartment?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
If Yes, How Are They Monitored?______________			
Are There Common Dining Facilities?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Do Individual Apartments have Cooking Appliances?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
If Yes, Please Check Type:: [ ] Gas [ ] Electric			
Is There Assistance in Medication?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
If Yes, Describe:______________________			
Is There Medical Personnel on Staff?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
How Do You Check on Residents?______________			

VII. **Automobile, Watercraft and Aircraft**

1.	Do You Own or Lease Any Vehicles? If Yes: # Private Passengers ________ # Vans ________ # Pickups	1. ***[ ] Yes*** [ ] No
2.	Do You Desire a Quotation for Owned Automobiles? If Yes, (a) Submit ACORD Application with Driver List, Auto Schedule, and MVR's.	2. ***[ ] Yes*** [ ] No
3.	Do Employees Transport Patients in Their Own Automobiles? If Yes, Reasons: ______________________ Avg. Frequency	3. [ ] Yes ***[ ] No***
4.	Do You Own or Lease Any Watercraft? If Yes, Describe:	4. [ ] Yes ***[ ] No***
5.	Do You Own or Lease Any Aircraft? If Yes, Describe: ______________________	5. [ ] Yes ***[ ] No***

BUNKER HILL
PROFESSIONAL LIABILITY UNDERWRITING DATA

	Loc. # _______ Bldg.# _______		Loc. # _______ Bldg.# _______		Loc. # _______ Bldg.# _______	
1. Number of Beds/Apts. by Type:	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
a. No. of Nursing Home Beds Licensed a.	_______	_______	_______	_______	_______	_______
b. No. of Assisted Living Beds Licensed b.	_______	_______	_______	_______	_______	_______
c. No. of Independent Living and Apartments c.	_______	_______	_______	_______	_______	_______
d. Other (MH, MR, DD, etc.) d.	_______	_______	_______	_______	_______	_______
Total Number of Beds/Apts.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
2. Number of Residents by Class:	Occupied Beds:		Occupied Beds:		Occupied Beds:	
a. Geriatric (55 Years & Older)	a. _______		a. _______		a. _______	
b. Non-Geriatric (19-54 Years)	b. _______		b. _______		b. _______	
c. Adolescents (12-18 Years Old)	c. _______		c. _______		c. _______	
d. Pediatric (0-11 Years Old)	d. _______		d. _______		d. _______	
e. Apartments Occupied	e. _______		e. _______		e. _______	
Total Number of Residents ***(Must equal total of #3 Occup.)***	[ ]		[ ]		[ ]	
3. Number of Residents by Type:	Occupied Beds:		Occupied Beds:		Occupied Beds:	
a. Ambulatory (Include Walkers & Canes)	a. _______		a. _______		a. _______	
b. Non-Ambulatory (Wheelchair/Geriatric)	b. _______		b. _______		b. _______	
c. Bedfast (Immobile) - 1st Floor	c. _______		c. _______		c. _______	
d. Bedfast (Immobile) - Upper Floors	d. _______		d. _______		d. _______	
Total Number of Residents ***(Must equal total of #3 Occup.)***	[ ]		[ ]		[ ]	
4. Number of Residents by Type Reimbursement:	Occupied Beds:		Occupied Beds:		Occupied Beds:	
a. Medicaid/Other State Programs	a. _______		a. _______		a. _______	
b. Medicare	b. _______		b. _______		b. _______	
c. Private Pay	c. _______		c. _______		c. _______	
Total Number of Residents ***(Must equal total of #3 Occup.)***	[ ]		[ ]		[ ]	
5. Number of Residents by Level of Care:	Occupied Beds:		Occupied Beds:		Occupied Beds:	
a. AIDS /HIV	a. _______		a. _______		a. _______	
b. Spinal/Head Injuries	b. _______		b. _______		b. _______	
c. Wound Management / Short Stay Post Op	c. _______		c. _______		c. _______	
d. Mental Illness (Schizophrenia, etc.)	d. _______		d. _______		d. _______	
e. Decubiti / Pressure Sores *(Submit Skin Assessment Report)*	e. _______		e. _______		e. _______	
f. Tube Feeding	f. _______		f. _______		f. _______	
g. Ventilator / Respirator	g. _______		g. _______		g. _______	
h. Developmentally Disabled	h. _______		h. _______		h. _______	
i. Alzheimers / Wanderers	i. _______		i. _______		i. _______	
j. General Geriatric / Dementia	j. _______		j. _______		j. _______	
k. Assisted Living	k. _______		k. _______		k. _______	
l. Independent Living / Apartments	l. _______		l. _______		l. _______	
m. Other	m. _______		m. _______		m. _______	
Total Number of Residents ***(Must equal total of #3 Occup.)***	[ ]		[ ]		[ ]	
6. Employees by Type:						
Number of RN's	_______		_______		_______	
Number of LVN's	_______		_______		_______	
Total Number of Employees	_______		_______		_______	
Is a Medical Director Required by the State?	***[ ]Yes***	[ ]No	***[ ]Yes***	[ ]No	***[ ]Yes***	[ ]No
Is a physician available on-call on a 24-hours basis?	[ ]Yes	[ ]No	[ ]Yes	[ ]No	[ ]Yes	[ ]No

9. Skin Assessment

a. Do you complete regular skin assessment reports? ***[ ]Yes*** [ ]No

b. How often are reports completed? Weekly Bi-weekly Monthly Other ______________________

c. Who reviews skin assessment reports?____

d. Please indicate your number of decubitus ulcers in the chart below for the reporting period of : ____/____/

e. Do you have a written policy/procedure to investigate alleged resident abuse and neglect? ***[ ]Yes*** [ ]No

Location #________			Location #________			Location #________		
Stage	Acquired Ulcers	Inherited Ulcers	Stage	Acquired Ulcers	Inherited Ulcers	Stage	Acquired Ulcers	Inherited Ulcers
I			I			I		
II			II			II		
III			III			III		
IV			IV			IV		

Note: Submit care plan for residents with acquired Stage III or IV Ulcers.

10. Staffing

Staff at Location # _________:
Administrator:____ Years Experience: ______ Years at Location: _______
Director of Nursing (DON):____________________________ Years Experience: ______ Years at Location: _______
Asst. Director of Nursing: ____________________________ Years Experience: ______ Years at Location: _______

Staff at Location # _________:
Administrator:____ Years Experience: ______ Years at Location: _______
Director of Nursing (DON):____________________________ Years Experience: ______ Years at Location: _______
Asst. Director of Nursing: ____________________________ Years Experience: ______ Years at Location: _______

Staff at Location # _________:
Administrator:____ Years Experience: ______ Years at Location: _______
Director of Nursing (DON):____________________________ Years Experience: ______ Years at Location: _______
Asst. Director of Nursing: ____________________________ Years Experience: ______ Years at Location: _______

11. Transfer

A. Describe the current transfer policy in the event a resident requires hospitalization. ______________________________
____
____

B. Is there a current transfer agreement in place between the applicant and nearest hospital? [ ]Yes [ ]No

C. Who makes the determination to transfer?____

12. Elopements

A. Indicate the number of elopements that have occurred at each location over the past two years. ________________

B. Were the elopements preventable? [ ]Yes [ ]No

C. Was harm caused to the resident(s) involved? [ ]Yes [ ]No

If "yes", please describe. ____

	Loc. # _______ Bldg. #	**Loc. # _______ Bldg. #**	**Loc. # _______ Bldg. #**
13. Wanderers			
Number of Patients that Wander:	____________	____________	____________
Are Exits Equipped with Electric Devices to Monitor Wanderers? If yes, what type? ______________________	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
Secure Unit for Alzheimers Patients? Describe Security: ______________________	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
14. Type Rooms			
% of Private Rooms	____________	____________	____________
% of Semi-Private Rooms	____________	____________	____________
Do any nursing care rooms have more than two occupants?	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No	***[ ]Yes*** [ ]No
If yes, number of rooms with more than two occupants:	____________	____________	____________
Maximum number of occupants per room:	____________	____________	____________
15. Restraints			
Number of residents in restraints:	____________	____________	____________
Do you have a written policy/procedure regarding the use of physical and chemical restraints?	____________	____________	____________
Who monitors procedures?	____________	____________	____________

APPLICATION NOTICE:

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY OR INSURE ANY SERVICES. BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

EACH PROPOSED INSURED REPRESENTS THAT THE STATEMENTS SET FORTH IN THE APPLICATION ARE TRUE AND CORRECT, AND THAT REASONABLE EFFORTS HAVE BEEN MADE TO OBTAIN INFORMATION SUFFICIENT FOR ACCURATE PROPOSED INSURANCE. IT IS FURTHER AGREED THAT EACH POLICY, OR RENEWAL THEREOF, IF ISSUED, IS ISSUED IN RELIANCE UPON THE TRUTH OF THE REPRESENTATIONS AND INFORMATION IN THE APPLICATION.

EACH PROPOSED INSURED UNDERSTANDS AND AGREES THAT ANY INSURANCE POLICY ISSUED BY THE COMPANY MAY BE VOIDED IF THIS APPLICATION CONTAINS ONE OR MORE MISREPRESENTATIONS OR OMISSIONS, PROVIDED HOWEVER THAT SUCH MISREPRESENTATIONS OR OMISSIONS ARE MATERIAL TO THE ACCEPTANCE OF THE RISK BY THE COMPANY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.

UMBRELLA NOTICE:

THE LIMIT OF LIABILITY OF THE UMBRELLA OR EXCESS POLICY, IF ISSUED, MAY BE REDUCED OR COMPLETELY EXHAUSTED BY CLAIM COSTS AND/OR LEGAL DEFENSE, IF APPLICABLE. IN SUCH EVENT, THE COMPANY SHALL NOT BE LIABLE FOR ANY JUDGMENT, SETTLEMENT, CLAIM COSTS OR LEGAL DEFENSE COSTS WHICH ARE IN EXCESS OF THE LIMITS OF LIABILITY STATED IN THE POLICY.

STATE NOTICES:

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS 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 FINES AND CONFINEMENT IN PRISON.

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 POLICYHOLDER 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 AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: 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 IN 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 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.

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 NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK 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 EACH SUCH VIOLATION.

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: WARNING: 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 (365:15-1-10, 36 §3613.1).

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 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 INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED(S) CERTIFIES THAT HE/SHE IS THE DULY AUTHORIZED REPRESENTATIVE(S) OF EACH PROPOSED INSURED

Applicant Signature	**Title**	**Date**

(PLEASE SIGN ALL ACCOMPANYING “ACORD” APPLICATIONS AS WELL.)

Account Name:_______________________________ **Eff. Date:**____________________

BUNKER HILL
CRIME COVERAGE SUPPLEMENTAL APPLICATION

AUDITS	Yes	No
1. Are annual financial audits by an independent CPA conducted?	☐	☐
2. Is inventory audited?	☐	☐
3. What kind of opinion did CPA give on most recent audited financials? ☐ Clean ☐ Qualified ☐ Compilation Only		
CHECK SIGNING		
4. Are all checks stamped "for deposit only" upon receipt?	☐	☐
5. Are two, hand-affixed, signatures (countersignature) required on checks? ☐ All? ☐ Over $1,000? ☐ Over $5,000?	☐	☐
If no, name/title of who signs: ____________________		
6. If mechanically affixed signatures are used, by computer or otherwise, how many people are authorized to use? #__________		
7. Is the person who edits/verifies/approves the issued checks the same as the person who issues them?	☐	☐
ACCOUNTING CONTROLS		
8. Is money (cash/checks) deposited the same day collected? If no, when?__________	☐	☐
9. How many people handle/count the money? #__________		
10. Are employees who are authorized to reconcile bank account statements permitted to handle deposits or sign checks without countersignature?	☐	☐
11. Are bank accounts reconciled: ☐ Monthly ☐ Quarterly ☐ Annually		
12. Do different people perform each of the following functions? a. Money (cash/checks) receipts, b. disbursements, c. deposits, d. bank account reconciliations	☐	☐
If no, explain: ____________________		
BURGLARY AND ROBBERY		
13. Is a safe used? If yes, for what? ____________________	☐	☐
14. Is a burglar alarm in use? ☐ Central Station? ☐ Local?	☐	☐
15. Are deposits made: ☐ By Mail? ☐ Directly at bank?		

CURRENT COVERAGE

Company ____________________ Employee Theft (Dishonesty) Limit $__________

Forgery or Alteration Limit: $__________ Money Inside/Outside Limit $__________ / $__________

ERISA Covered Plan Name: ____________________

Claims in Past 5 Years: ____________________

Completed by: ____________________ **Date:** _____/_____/_____