Ponce de Leon LTC Risk Retention Group Inc.

475 West Town Place, St. Augustine, FL 32092

Small Assisted Living Facilities (15 beds and under)
Application for Professional Liability and General Liability Insurance

Each question must be fully answered. **If not applicable, please state "NA"**
(Complete a separate application for each location)

Carmona Insurance Group:
Limits Requested:

Requested effective date:_____

☐ $ 50,000/$150,000

PART I - GENERAL INFORMATION

1. Name of Applicant: _____
(Include full legal entity and all trade names. Attach a separate sheet if necessary)
2. Mailing: _____City, State, Zip:_____
3. Name of facility: _____
4. Physical address: _____City, State, Zip:_____
5. Telephone #: (____) _____Fax #:(____) _____
6. Number of years this facility has been:
Operating _____ Owned by present owners_____
7. Do you belong to: ☐ FALA
8.

	NAME	YEARS IN POSITION AT THIS FACILITY	YEARS OF EXPERIENCE IN THIS POSITION
ADMINISTRATOR			

9. Organizational structure of this facility (check all that apply):
a- ☐Individual ☐Corporation ☐Partnership ☐Joint Venture ☐LLC ☐Other
b- ☐For Profit ☐Not For Profit
10. Applicant's interest in facility is: ☐Owner ☐Lessor ☐Management Company ☐Tenant ☐Other
11. Provide information for each type of license this facility holds and attach a copy of each:

TYPE OF LICENSE HELD	NUMBER OF RESIDENTS UNDER LICENSE
Standard Assisted Living	
Limited Nursing Services	
Extended Congregate Care	
Limited Mental Health	

12. If utilizing the limited mental health license and the facility has a mix of resident types, how are behaviors monitored to prevent resident-on-resident abuse?_____
_____
13. How are staff members made aware of residents admitted under the various licenses in order to complete the required documentation needed based upon state regulations?_____
_____

14. If utilizing an ECC or LNS license, do you have a designated licensed nurse on staff? ☐Yes ☐No
If a designated licensed nurse is not on staff, how do you fulfill the requirement to provide nursing supervision?_____

15. Has license ever been revoked or suspended? ☐Yes ☐No
If so, please provide details:_____

PART II – CURRENT INSURANCE

1. Does the facility currently carry general liability and professional liability insurance? ☐Yes ☐No

If so, please provide:

a. Carrier name:_____

b. Policy effective and expiration dates:_____to_____

c. ☐Occurrence coverage or ☐claims made coverage? If claims made, retroactive date:_____

d. Deductible amount: $_____if none, so state.

e. Expiring premium: $_____

2. If the current carrier is not offering renewal, please attach a copy of the non-renewal notice.

3. Please provide information regarding your prior insurance coverage for last 5 year period:

_____

PART III - RESIDENT CENSUS

1.

CENSUS INFORMATION	BUILDING 1	BUILDING 2
Number of licensed beds		
Number of occupied beds		
Number of residents suffering from dementia (include Alzheimer's patients)		
Number of senile residents		
Number of fully mentally functioning residents		
Number of independently ambulatory residents		
Number of residents requiring assistance with ambulation		

2. Any other services provided in addition to licensed beds? **PLEASE LIST AND DESCRIBE**

_____

AGE GROUP	NUMBER OF DESIGNATED / LICENSED BEDS	NUMBER OF OCCUPIED BEDS
Under 21yrs		
21-49 yrs		
50-65 yrs		
65yrs +		

Recreational facilities – List if Any:

_____

PART IV – ELOPEMENT

1. Do you conduct wandering risk assessments upon admission? ☐Yes ☐No

2. Are all exit doors at all locations alarmed? ☐Yes ☐No

If no, please explain_____

3. Have any residents eloped from your facility in the last 3 years?_____

If Yes- How Many? a)_____b) any harm to resident?_____ c) resident still in the facility?_____
d) explain what happened for each elopement_____
e) any procedures changed because of the elopement? _____

PART V – STAFFING- Per location

1.

STAFF ON DUTY	1ST SHIFT	2ND SHIFT	3RD SHIFT
RNs			
LPNs			
CNAs			
Resident Assistants			
Medication Aides			
Administrators			
Other (describe)			

2. Are prior employment histories of all employees checked? ☐Yes ☐No
By what method?_____

3. Are criminal background checks performed on all employees? ☐Yes ☐No

4. Is drug testing performed on all employees? ☐Yes ☐No

PART VI - PREMISES INFORMATION

	Building 1	Building 2
Building construction type		
Date of construction		
Area	#_____ sq. ft.	#_____ sq. ft.
Number of floors		
Smoke detectors in all bedrooms and hallways?	☐Yes ☐No ☐Hardwired ☐Battery	☐Yes ☐No ☐Hardwired ☐Battery
Fire alarms	☐Central ☐Local ☐None	☐Central ☐Local ☐None
Fully sprinklered building? If not, %age sprinklered	☐Yes ☐No ___ %	☐Yes ☐No ___ %
Pool? If yes, fenced, self-locking gate?	☐Yes ☐No ☐Yes ☐No	☐Yes ☐No ☐Yes ☐No

Does staff perform regular fire drills?_____ How often_____

PART VII - SMOKING POLICIES AND PROCEDURES

1. Are any residents allowed to smoke unattended: ☐Yes ☐No
If yes, under what circumstances: _____

2. Are residents allowed to possess their own matches or lighters? ☐Yes ☐No
If yes, under what circumstances? _____

3. Are there any designated smoking areas? ☐Yes ☐No
If yes, specify the location of the smoking areas: _____

PART VIII - CLAIMS HISTORY

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you? ☐Yes ☐No

2. **ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS**

3. Is the applicant facility, or any other person for whom insurance is being requested aware of any circumstances, events or occurrences which may result in a claim? ☐Yes ☐No
If yes, provide full details (use separate sheet, if necessary). _____

4. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ☐Yes ☐No
If yes, fully describe circumstances and follow up action taken (use separate sheet, if necessary). _____

FRAUDULENT PRACTICES
(817.234, FLORIDA STATUTES)

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 of the third degree.

I/We herby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____ _____
Signature of Applicant or Authorized Representative Date (mm/dd/yyyy)

_____ Producer: _____
(Print Name, Title)

Underwriting Management Corp.
Member - U.S. RE Group

Ponce de Leon LTC Risk Retention Group, Inc.

Claims Verification Statement

It is mandatory that this section be completed and signed as part of your application package. *Failure to complete and sign will result in your application being declined.* This section will form part of your application.

1) Have you ever been uninsured or failed to maintain continuous Professional Liability and General Liability Insurance during the past 5 years?

   Yes:_____ No:_____

   If yes, what period: From:_____ To:_____
   From:_____ To:_____
   From:_____ To:_____

2) During the past 5 years, have any claims been presented to your current or prior Insurance carrier? Yes:_____ No:_____

   ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR 5 YEARS. *MUST BE VALUED WITHIN THE LAST 90 DAYS*.

3) During the past 5 years, have there been any claims made against the applicant **(during any period where you were uninsured)?** This would include any request for records or a written demand for monies.

   Yes:_____ No:_____

   If yes, provide complete details. Use separate sheet if necessary.

   _____
   _____
   _____
   _____

4) Is the applicant's facility or any other person for whom insurance is being requested, aware of any facts, incidents, acts, events or occurrences that a prudent person reasonably believes **may result in a claim**(s) being made against you?

Yes:_____ No:_____

If yes, provide complete details. Use separate sheet if necessary.

_____

_____

_____

5) Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?

Yes:_____ No:_____

If yes, provide complete circumstances and follow up action taken.

_____

_____

_____

Any person who knowingly and with the intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/We agree that this application shall be the basis of the contract with the insurance company.

_____/_____ _____

Applicants Signature/Title Date

Uni-Ter
Underwriting Management Corp.
Member - U.S. RE Group

Ponce de Leon LTC Risk Retention Group, Inc.

Condition of Binding Coverage

As a requirement to become an insured member of the Ponce de Leon LTC Risk Retention Group, Inc. the **insured** must implement the Risk Management and the Claims Management Protocols that were included with the application packet. Failure to implement and follow these protocols may result in the **denial** of a claim or the **cancellation** of the policy with the Ponce de Leon LTC Risk Retention Group, Inc.

Coverage cannot be bound until this form has been completed, signed and received by Uni-Ter Underwriting Management Corp.

Insured:_____

As a condition of binding and accepting coverage with The Ponce de Leon LTC Risk Retention Group, Inc., effective this day _____, 20____, I/We agree to implement the Risk Management and Claims Management Protocols. I/We understand that failure to implement and follow these protocols may result in the **denial** of a claim or the **cancellation** of coverage.

ACCEPTED:

_____/_____ _____

Signature/Title **Date**

As of 1/1/2010

Dated:_____

Signature:

By:_____

Printed Name of Person or Entity

Name:_____

Title:_____

Address:_____

Office Telephone:_____

Office Fax:_____

IN WITNESS WHEREOF, the Shareholders and the Corporation, by its authorized officers, have executed this Agreement as of the date(s) indicated below.

PONCE DE LEON LTC RISK RETENTION GROUP, INC.

By: _____
_____, President

Dated: _____

NOTE: The identity of the Shareholder set forth below should be identical to the named insured on the Insurance Application filed concurrently herewith.

FOR INDIVIDUAL SHAREHOLDERS

_____
Name of Shareholder (please print)
Social Security Number:_____

_____
Signature

_____
Name of spouse, joint tenant or tenant-in-common, if applicable
Social Security Number:_____

_____
Signature

Date and place of execution:

Date:_____
Place:_____

FOR CORPORATE, PARTNERSHIP OR TRUST SHAREHOLDERS

_____
Name of Shareholder (please print)
Taxpayer I.D. Number:_____

By:_____

_____
Name (please print)

_____
Title

Date and place of execution:

Date:_____
Place:_____

December 8, 2009

SCHEDULE A

SHAREHOLDERS