CNA HEALTHCARE AGING SERVICES
NEW BUSINESS SUPPLEMENTAL APPLICATION

This application must be completed and signed by the applicant. In addition, the following must be attached to the application.

The following are required for all levels of care:

- Accord Applications: ☐ Property ☐ Auto ☐ General Liability ☐ Crime ☐ Inland Marine ☐ Electronic Data Processing ☐ Umbrella

- Signed Statement of Values
- Aging Services Business Interruption Worksheet (if applicable) or latest 12 Month profit and loss statement
- Current valued loss reports of prior carriers (5 years minimum)
- Current audited financial statement (income, balance sheet, cash flow) with management notes
- Photo and facility diagram/plot plan
- Brochures and/or advertising materials
- Facility web site URL
- Resumes for Administrator & Director of Nursing (DON)
- Copy of facility license
- State survey reports - last 2 years (Include all statements of deficiencies and Corrective Action Plans)
- Substantiated Complaint Survey(s) and Corrective Action Plans if complaint is within the last 2 years

The following are required for Subacute/Skilled Nursing Facility/Intermediate

- Residents Utilization Guide Case Matrix Reports with number of hours by RUG category for last 12 months

The following are required for Subacute/Skilled/Intermediate/Assisted Living Facility:

Facility:

- Current CMS Forms 671 Facility Staffing & 672 Resident Census
- Copy of facility's Skin/Wound Protocol
- Equip Quality Monitor Report for the past two six-month periods

Effective Date: _____

Prior Carrier: _____ Expiring Premium: $_____

Claims-Made _____ Occurrence _____

Claims-Made Retro Date: _____

1. Did the liability policies from the prior carrier(s) specify that a claim will be considered to have been made when the earlier notice of an occurrence or incident was first provided to the insurer? ☐Yes ☐ No

2. Are there any interruptions of claims-made coverage from the proposed retroactive date? ☐ Yes ☐ No

3. Have all legal proceedings, suits, investigations, or claims against any proposed insured during the past 3 years been reported to the prior carrier(s)? ☐ Yes ☐ No

4. Is the undersigned, or any person who is given responsibility by the applicant to give or receive notice of a claim or notice of a possible future claim, aware of any actual or alleged incident or circumstance that has not already been reported to its insurer, that he or she has reason to believe could result in a future claim? ☐ Yes ☐ No

I. Corporate/Parent Information

1. Corporate/Parent Name: _____

   Corporate Address: _____

   City: _____ State: __ Zip: _____

2. **Description of Corporate/Parent (check all that apply):**

   ☐ For-Profit ☐ Not-for-Profit Religious Affiliated? ☐Yes ☐No ☐ ACO
   ☐ Individual ☐ Partnership ☐ Corporation ☐ Hospital Affiliated ☐ CCRC
   ☐ JCAHO Accredited ☐ CCAC Accredited

3. Years parent company has been under present ownership: ___

4. Total number of facilities owned: ____

5. Is the parent company managed by a management company? ☐Yes ☐No

   If "Yes," provide the name of management company: _____

   How many years in place with this management company? ___ *Provide a copy of the management contract.*

6. List the Officers of the Operating Corporation or General Partners:

Name	Title	Status
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive
		☐ Active ☐ Inactive

7. Are there any plans for mergers, acquisitions, sale of assets or business, change in services during the next 12 months?

   ☐Yes ☐ No

II. Applicant/Facility Information

For multiple location accounts, complete the Multiple Location Worksheet.

8. Facility Name: _____

   Facility Address: _____

   City: _____ State: __ Zip: _____

   Federal Employer ID #: _____ Provider ID: _____

   Contact Name: _____ Telephone: (___) ___-____

   Email Address: _____ Fax: (___) ___-____

9. In the past three (3) years, has any insurance carrier cancelled or refused coverage that is similar to that being applied for here? ☐Yes ☐No

   If "Yes," explain: _____

10. In the past five (5) years, has any claim or suit been made against you for alleged medical professional malpractice, error or mistake? ☐Yes ☐No

    If "Yes," explain. Attach list with comments.

11. How many years has the facility been under: Present ownership? ___ Present management? ___

12. Are all applicable permits up to date? ☐Yes ☐No

    If "No," explain: _____

III. Subsidiaries

13. List all subsidiaries. Additional list attached? ☐Yes ☐No

Name	Location	Description of Operations

IV. Facility Credentials

14. List facility information below:

    a. License and Accreditation Information:

	Type/Number	Expiration Date	Restrictions?	Provisions?
License:			☐Yes ☐No	☐Yes ☐No
License:			☐Yes ☐No	☐Yes ☐No

    b. Association memberships: _____ _____ _____ _____

c. Date of last inspection/survey: __/__/____

d. Number of deficiencies: Total: ____ D, E, F, G deficiencies: ____ F, H, I, J, K, L deficiencies: ____

e. Was a Corrective Action Plan accepted by the State? ☐Yes ☐No

f. How many complaints were investigated in the past three (3) years? _____

How many complaints were substantiated? _____

g. Is facility approved for Medicare? ☐Yes ☐No If "Yes," # of beds: _____
Is facility approved for Medicaid? ☐Yes ☐No If "Yes," # of beds: _____

h. Has the facility had its license suspended, revoked or been placed on probation in the past 5 years? ☐Yes ☐ No

i. Has Medicare or Medicaid Certification been revoked or suspended in the last 5 years? ☐ Yes ☐ No

j. Has a state or federal agency fined this facility in the last 5 years? ☐ Yes ☐ No

V. Classification

15. **Select only the level of care reflected in the facility license**. If the license is not specific with respect to type of care, select the one level that best reflects the primary medical services provided by this facility.

Please indicate total licensed beds (If Independent Care, skip to "Independent Care" section).

Sub Acute:	Total Licensed Beds: ____ Average Occupancy: ____
Skilled Nursing:	Total Licensed Beds: ____ Average Occupancy: ____
Intermediate Care:	Total Licensed Beds: ____ Average Occupancy: ____
Assisted Living/Adult Care:	Total Licensed Beds: ____ Average Occupancy: ____
Memory Care:	Total Licensed Beds: ____ Average Occupancy: ____
Personal Care:	Total Licensed Beds: ____ Average Occupancy: ____
Independent Care:	Residents of retirement age, total self- care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full time caretaker on premises. a. What are the total numbers of units? _____ b. What are the total numbers of residents at full occupancy? _____ c. Are there common dining facilities? ☐Yes ☐No d. Do individual units have cooking appliances (excluding microwaves)? ☐Yes ☐No If "Yes," check type: ☐Gas ☐Electric e. Is there a daily mechanism to keep track of residents? ☐Yes ☐No If "Yes," explain procedure: _____ f. Are Residents allowed to have home health care aides? g. Are the aides contracted independently? ☐Yes ☐No Through facility? ☐Yes ☐No h. Are there licensed nursing personnel on staff? ☐Yes ☐No What hours are they available? _____ What services do they provide? _____

16. Show the percentage of residents by age range:

___ < 30 ___ = 30-64 ___ = 65-74 ___ =75-84 ___ =85-94 ___ >94

17. If any residents are under 64, please explain: _____

18. Additional general liability exposures.

a. Swimming Pools

(i) Is there a swimming pool? (80901) ☐Yes ☐No

(ii) Is it open to the public? ☐Yes ☐No

(iii) Is the pool locked when not in use? ☐Yes ☐No

(iv) Is the pool fenced? ☐Yes ☐No

(v) Is a full-time lifeguard on duty? ☐Yes ☐No

(vi) Is there a diving board/sliding board? ☐Yes ☐No

(v) Are there depth markings? ☐Yes ☐No

(vi) Is there a daily maintenance procedure in place? ☐Yes ☐No

b. Are there other bodies of water present? ☐Yes ☐No

If "Yes," describe: _____

c. Are there saunas and/or hot tubs? (80902) ☐Yes ☐No

If "Yes," how many? _____

Is there an attendant on duty? ☐Yes ☐No

If "Yes," how many hours per day is the attendant on duty? _____

d. Are there tennis/racquetball/handball courts? (80903) ☐Yes ☐No

If "Yes," how many? _____

e. Are there exercise/weight rooms? (80904)
If "Yes," how many: _____

Is there an attendant on duty? ☐Yes ☐No

If "Yes," how many hours per day is the attendant on duty? _____

Are there treadmills? ☐Yes ☐No

f. Are there indoor parking facilities? (80910) ☐Yes ☐No

If "Yes," how many parking spaces: _____

g. Is there a Community Center? (80922) ☐Yes ☐No

If "Yes," how many square feet in area: _____

If "Yes", is the facility used for activities other than by residents? ☐Yes ☐No

If "Yes," describe: _____

h. Is there a restaurant open to the public? ☐Yes ☐No

Gross receipts: $_____

Is liquor served? ☐Yes ☐No

i. Is alcohol served with dinner or at a happy hour? ☐ Yes ☐ No

If "Yes", is there a charge?

j. Are pets allowed? ☐ Yes ☐ No

If "Yes", are vaccinations required and kept on record by the facility? ☐ Yes ☐ No

VI. Administrator/Executive Director

19. Name of Administrator: _____ License Number: _____ State: __

20. Length of time at this facility: _____ Length of time as Nursing Home Administrator (NHA): _____

Full time at this facility? ☐Yes ☐No Number of hours at this facility per week? _____

VII. Nurse Staffing

21. Director of Nursing (DON):

Name: _____ Professional credentials: ☐RN ☐LPN

Length of time at this facility: _____ Length of time as DON: _____

22. a. Total # of nurse employees: _____

b. By category:

Category	1st shift	2nd shift	3rd shift	Turnover %
RN				%
LPN/LVN				%
CNA/Personal Caregiver				%
Agency				%
Pool				%

c. Do you require nurses to carry malpractice coverage? ☐Yes ☐No
d. Do you obtain and review nurses' certificates of malpractice insurance? ☐Yes ☐No
e. Do you verify nursing licenses upon hire and annually? ☐Yes ☐No
f. Do you verify nursing assistant certification upon hire and annually? ☐Yes ☐No
g. Are background checks completed for agency and pool employees? ☐Yes ☐No
h. Prior years turnover rate _____%

VIII. Physicians and Medical Director

23. Number of physicians: Employed: _____ Affiliated: _____ Contracted: _____

24. Do you obtain and review physicians' certificates of malpractice insurance? ☐Yes ☐No

25. Do you require limits of liability comparable to your own? ☐Yes ☐No

If "No," define the differences in limits: _____

26. a. Are the physicians credentialed? ☐Yes ☐No

b. Do credentialing activities include

(i) Verification of current professional license? ☐Yes ☐No

(ii) Verification of current DEA license? ☐Yes ☐No

27. Name of Medical Director: _____ License Number: _____ State: __

License Number: _____ State: __

28. Length of time as Medical Director: _____ Medical Specialty: _____

☐ Full time at this facility ☐ Part-time at this facility Number of hours at this facility per week: _____

29. Does the Medical Director also act as the attending physician to any residents? ☐Yes ☐No

If "Yes," how many: _____

30. Is there an evaluation of the Medical Director's performance? ☐Yes ☐No

If "Yes," define: _____

31. Is the Medical Director:

a. involved in credentialing facility medical staff? ☐Yes ☐No

b. an active participant in the facility quality improvement program? ☐Yes ☐No

c. involved with peer review of physicians? ☐Yes ☐No

32. Is a physician on site or on call on a 24-hour basis? ☐Yes ☐No

IX. Staff/Employee Selection and Hiring

33. Is there a formal, documented assessment process to measure staff competency skills? ☐Yes ☐No

34. Do you conduct an orientation and regularly scheduled in-service education programs for all staff/employees? ☐Yes ☐No

35. Describe background verification checks on new employees:

a. work history? ☐Yes ☐No

b. education? ☐Yes ☐No

c. criminal record? ☐Yes ☐No

d. driving record - Motor Vehicle Record (MVR) when appropriate? ☐Yes ☐No

e. drug testing? ☐Yes ☐No

X. Non-Resident Services

36. Please indicate the annual number of visits or clients for the following

Home Health Care ☐Yes ☐No # of Home Health Care visits or clients per year: _____

Is home health care provided by independent contractors? ☐Yes ☐No

Describe home health care services: _____

Adult Day Care

Adult Day Care:	☐ Social (80911) Total Participants: _____ ☐ Enhanced (Mentally Challenged) (80912) Total Participants: _____ Social – Services include but not limited to recreational activities (crafts, music, games, shopping trips), intergenerational programs, promotion of wellness and socialization programs, educational programs Medical – Services include but not limited to/for the same as social, yet will also include additional services such as medication supervision; medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, Physical Therapy (PT), speech and Occupational Therapy (OT); the mentally challenged, cognitively impaired, developmentally disabled, chronically ill

Hours of Operation: _____

# of Employees: _____

Do you provide transportation to and from your facility? ☐Yes ☐No

Do you provide transportation to and from events? ☐Yes ☐No

Is a physical examination performed by a physician prior to admission? ☐Yes ☐No

If "Yes," describe: _____

Are medical services provided? ☐Yes ☐No

If "Yes," describe: _____

PACE (Program of All Inclusive Care for the Elderly) ☐ Yes ☐ No

If "Yes", how many participants? _____ (Please complete a PACE questionnaire.)

Children Day Care total licensed #) x Average Occupancy: x Hours of Operation: _____

# of employees: _____ # of children: _____ # of employees children: _____

Do you provide any transportation for children? ☐Yes ☐No

If "Yes," describe: _____

Respite Care: ☐Yes ☐No If "Yes," # per year: ____

Hospice Care (80931): ☐Yes ☐No If "Yes," # per year: ____

Rehabilitation Services: ☐Yes ☐No If "Yes," # per year: ____

Describe in-house rehabilitation services: _____

Are rehabilitation services available to non-residents? ☐ Yes ☐ No

37. Do you provide the following services?

Service	Provided?	# of Residents	Service	Provided?	# of Residents
IV Infusion Therapy	☐Yes ☐No		Developmentally Disabled	☐Yes ☐No	
Ventilation Therapy	☐Yes ☐No		Alzheimer's/Dementia	☐Yes ☐No	
Physical Therapy	☐Yes ☐No		Psychiatric Care	☐Yes ☐No	
AIDS	☐Yes ☐No		Chemical Dependency Treatment	☐Yes ☐No	

38. Do you provide any other services to your residents or the community? ☐Yes ☐No

If "Yes," describe**:** _____

XI. Consultants/Independent Contractors and Services

39. Indicate which of the following services are (1) contracted to you at this facility, (2) if a contract is in place and (3) limits of liability:

Services	Is service provided?	Is a contract in place?	Limits of Liability
Physicians	☐ Yes ☐No	☐ Yes ☐No	$
Dental	☐ Yes ☐No	☐ Yes ☐No	$
Nursing	☐ Yes ☐No	☐ Yes ☐No	$
Mental Health	☐ Yes ☐No	☐ Yes ☐No	$
Pharmaceutical	☐ Yes ☐No	☐ Yes ☐No	$
Physical Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Occupational Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Speech Therapy	☐ Yes ☐No	☐ Yes ☐No	$
Dietary	☐ Yes ☐No	☐ Yes ☐No	$
X-Ray	☐ Yes ☐No	☐ Yes ☐No	$
Medical Records	☐ Yes ☐No	☐ Yes ☐No	$
Laboratory	☐ Yes ☐No	☐ Yes ☐No	$
Social Services	☐ Yes ☐No	☐ Yes ☐No	$
Recreational Services	☐ Yes ☐No	☐ Yes ☐No	$
Transportation	☐ Yes ☐No	☐ Yes ☐No	$
Barber/Beautician	☐ Yes ☐No	☐ Yes ☐No	$
Food	☐ Yes ☐No	☐ Yes ☐No	$
Laundry	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$
Other: _____	☐ Yes ☐No	☐ Yes ☐No	$

40. Have certificates of insurance been obtained from independent contractors? ☐Yes ☐No

Are these reviewed annually? ☐Yes ☐No

If "Yes," are limits of liability the same as your limits of liability? ☐Yes ☐No

If "No," explain: _____

XII. Volunteers

41. a. What is the total number of volunteers? _____

b. What are the primary sources for volunteers? _____

c. Is there a formal screening and orientation process for volunteers? ☐Yes ☐No

Explain: _____

d. Are roles & responsibilities of volunteers clearly communicated to staff and volunteers? ☐Yes ☐No

e. Do volunteers assist with resident feeding? ☐Yes ☐No

f. Are background checks performed on volunteers? ☐ Yes ☐ No

XIII. Risk Management

42. Is there a risk management program implemented throughout this facility? ☐Yes ☐No

43. Is there a designated risk manager? ☐Yes ☐No
If "Yes," indicate risk manager's name: _____
How long has the risk manager been in that position? _____

44. a. Is there an "incident reporting" policy? ☐Yes ☐No
b. Are all incident reports reviewed by the risk manager and medical director? ☐Yes ☐No
c. Are incidents trended and presented to the quality/risk management committee? ☐Yes ☐No

45. a. Is there a formal safety program? ☐Yes ☐No
b. Does it include evaluation and reduction of exposures relating to:
(i) Life safety? ☐Yes ☐No
(ii) Employees? ☐Yes ☐No
(iii) Hazardous materials? ☐Yes ☐No
(iv) Environment? ☐Yes ☐No

46. a. Is there a formal preventive maintenance program? ☐Yes ☐No
b. Is responsibility for the program assigned to one individual? ☐Yes ☐No
c. Does the program include:
(i) Evaluation of all electrical devices/equipment brought into the facility? ☐Yes ☐No
(ii) Scheduled evaluations of equipment and devices including electrical supply? ☐Yes ☐No
(iii) Retention of maintenance and inspection records? ☐Yes ☐No

47. What security measures are used to control unauthorized entrances and exits from the facility? _____

48. a. Are Wander Guards or similar devices used as part of elopement prevention practices? ☐Yes ☐No
If "Yes," provide type: _____
b. Are Wander Guard devices for residents and building maintained and inspected according to manufacturer's specifications? ☐Yes ☐No
c. Number of elopements in past three years: _____

49. Are nursing assessment protocols in place to identify residents at risk for:
a. Elopement? ☐Yes ☐No
b. Falls? ☐Yes ☐No
c. Cognitive Impairment? ☐Yes ☐No
d. Nutritional Deficiency? ☐Yes ☐No

50. Is monthly review of drug regimens performed? ☐Yes ☐No
If "Yes," by whom? _____

51. a. How are medications stored? Distributed? _____

    b. Are records kept on drug supplies and dispersal? ☐Yes ☐No

    c. What is the maximum value of medications on hand? $_____ Type: _____

52. a. Is a licensed pharmacist on staff? ☐Yes ☐No

    b. Is an outside pharmacy used? ☐Yes ☐No

53. a. Are admission, discharge and transfer criteria established? ☐Yes ☐No

    b. Who ensures compliance with these established criteria? _____

    c. Does facility have a readmissions protocol with a local hospital? ☐ Yes ☐ No

    If "Yes", describe _____

54. Does facility have advance written consent from resident or guardian that allows medical care be provided when necessary? ☐Yes ☐No

55. a. Does facility have a written procedure for reporting resident abuse? ☐Yes ☐No

    b. Who is responsible for the investigation? _____

    c. Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse? ☐Yes ☐No

56. Does facility have a formal grievance procedure in place to address resident/family complaints? ☐Yes ☐No

    If "Yes, " explain how the process: _____

57. Does the facility have electronic medical records? ☐ Yes ☐ No

    If "Yes", what back-up services are in place? _____

XIV. Additional Property/Life Safety Information

58. **Construction**

a. Type of construction: _____ Year built: ____ # of floors: ____ # of elevators: __

b. Date of inspection: Electrical: _____ Plumbing: _____ HVAC: _____

c. Was the building constructed for this occupancy? ☐Yes ☐No

If "No," please explain: _____

d. Have there been any water damage incidents in the past five (5) years? ☐Yes ☐No

If "Yes," have they been corrected? ☐Yes ☐No

If "Yes," describe: _____

e. Are all vertical openings (stairwells, elevators, dumbwaiters, etc.) protected and enclosed with self-enclosing doors and wall structures having a minimum 1-hour fire rating? ☐Yes ☐No

If "No," please explain: _____

f. Type of wiring (copper or aluminum): _____ Type of roof: _____

Type of pipe used in your water or sewerage system (PVC/Iron/Copper): _____

g. Has your building ever sustained foundation damage? ☐Yes ☐No

If "Yes," describe: _____

h. (i) Is there a scheduled service to clean heating and ventilation ducts? ☐Yes ☐No

(ii) How often are ducts cleaned? _____

i. Is the building equipped with lightning rods? ☐ Yes ☐ No

j. Is your operation equipped with a back-up generator? ☐ Yes ☐ No

(i) Is the generator equipped to power up the entire facility/campus? ☐ Yes ☐ No

(II) What type of fuel is used to power the generator? _____

(III) How many day supply of fuel is there for this generator? ____

59. **Occupancy**

a. Are there other occupancies in the building not related to resident care? ☐Yes ☐No

If "Yes," describe: _____

b. Is there a facility "no smoking" policy in effect? ☐Yes ☐No

c. Are smoking materials (including matches/lighters) restricted from a resident's room? ☐Yes ☐No

d. Is there a policy regarding medical marijuana? ☐ Yes ☐ No

If "Yes", describe _____

e. Are smoking residents supervised and/or in designated areas? ☐Yes ☐No

f. How many exits (other than front doorway) are there? _____

g. Are these equipped with panic alarms? ☐Yes ☐No

h. Do alarms ring into central security desk or nurses station? ☐Yes ☐No

i. Are there at least two remote exits on each floor? ☐Yes ☐No

60. **Protection**

a. Is risk protected (100%) throughout including bind attic spaces by an automatic sprinkler system and have these systems been tested by a qualified contractor with results documented? ☐Yes ☐No

If not 100%, please advise which areas are not protected: _____

If not tested, please explain: _____

b. Are all alarm signals monitored by a UL-approved central station or the responding fire department? ☐Yes ☐No

c. Is there a written emergency plan covering fire, natural disasters and threats: ☐Yes ☐No

If "Yes," do employees receive instruction training regarding this plan? ☐Yes ☐No

d. Has the fire department pre-planned emergency procedures at this location: ☐Yes ☐No

If "Yes," indicate the last date when these procedures were update: _____

e. When was facility last inspected by local fire authorities: _____

f. Is there a bulk medical gas distribution system piped in the building? ☐Yes ☐No

If "Yes," are emergency shutoffs provided? ☐Yes ☐No

If "No," is there storage of individual tanks? ☐Yes ☐No

If "Yes," are these tanks on rolling carts? ☐Yes ☐No

Are they properly chained? ☐Yes ☐No

g. In cooking areas (other than independent living units), is there a fire suppression system ? ☐Yes ☐No

(i) Is there a hood and grease filter? ☐Yes ☐No

(ii) What is the frequency of cleaning (i.e. monthly/quarterly)? _____

(iii) Do you use an outside contractor for cleaning? ☐Yes ☐No

(iv) Is the area equipped with an automatic fuel shutoff? ☐Yes ☐No

h. Are hardwire smoke detectors in resident rooms/apartments? ☐Yes ☐No

i. Who is the sprinkler manufacturer and what type of sprinkler heads are used? _____

j. If a multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? ☐Yes ☐No

k. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions? ☐Yes ☐No

l. Is video surveillance used? ☐Yes ☐No
If "Yes," describe extent of use: _____

m. Are fire drills conducted regularly? ☐Yes ☐No
If "Yes," describe: _____

n. Are emergency call buttons in each room/unit? ☐Yes ☐No

o. Are intercoms or bells provided for each resident room? ☐Yes ☐No

p. Are personal emergency response devices provided? ☐ Yes ☐ No

q. Are handrails provided in hallways and bathrooms? ☐Yes ☐No

r. Are bathtubs/showers equipped with non-slip surfaces? ☐Yes ☐No

61. **Exposure**

a. How many miles is the facility located from the coast? _____ miles

b. Is risk located in a federally classified earthquake zone? ☐Yes ☐No

If "Yes," what zone? _____

c. Is risk located on a fault? ☐Yes ☐No

d. Is risk in a flood zone? ☐Yes ☐No

If "Yes," what zone? _____

XV. Commercial Automobile

62. Do you contract with a transport service (i.e. ambulance, buses, vans) to transport residents? ☐Yes ☐No

If "Yes," what is the name of the transport service? _____

Contact Name: _____ Telephone Number: ( ) -

63. Do employees transport residents in their own automobiles? ☐Yes ☐No

If "Yes," describe: _____ Average frequency: _____

a. Do you require them to carry minimum insurance limits? ☐Yes ☐No

If "Yes," what limits are required? $_____

64. a. Do you have any Commercial Driver's License vehicles? ☐Yes ☐No

b. How many: _____

65. Do volunteers operate any vehicles? ☐Yes ☐No

66. Are driving records reviewed annually? ☐Yes ☐No

67. Do you have a Department of Transportation number? ☐ Yes ☐ No

If "Yes", please provide your number: _____

WARRANTY:

I HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF MY ABILITY AND DECLARE THAT, TO THE BEST OF MY KNOWLEDGE, THE STATEMENTS SET FORTH HEREIN ARE TRUE AND CORRECT. MY SIGNING OF THE APPLICATION DOES NOT BIND THE INSURANCE COMPANY TO ISSUE AN INSURANCE POLICY, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED. I FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID MY PROTECTION SHOULD A POLICY BE ISSUED.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 OR INCOMPLETE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (FOR DISTRICT OF COLUMBIA RESIDENTS ONLY: 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.) (FOR FLORIDA RESIDENTS ONLY: 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.) (FOR LOUISIANA RESIDENTS ONLY: 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.) (FOR MAINE RESIDENTS ONLY: 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.) (FOR NEW YORK RESIDENTS ONLY: 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.) (FOR OKLAHOMA RESIDENTS ONLY: 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.) (FOR PENNSYLVANIA RESIDENTS ONLY: 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.) (FOR PUERTO RICO RESIDENTS ONLY: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD, PRESENTS FALSE INFORMATION IN AN INSURANCE REQUEST FORM, OR WHO PRESENTS, HELPS OR HAS PRESENTED A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, WILL INCUR A FELONY, AND UPON CONVICTION WILL BE PENALIZED FOR EACH VIOLATION WITH A FINE OF NO LESS THAN FIVE THOUSAND DOLLARS ($5,000) NOR MORE THAN TEN THOUSAND DOLLARS ($10,000); OR IMPRISONMENT FOR A FIXED TERM OF THREE (3) YEARS, OR BOTH PENALTIES. IF AGGRAVATED CIRCUMSTANCES PREVAIL, THE FIXED ESTABLISHED IMPRISONMENT MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS; IF ATTENUATING CIRCUMSTANCES PREVAIL, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.) (FOR TENNESSEE RESIDENTS ONLY: PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.) (FOR OREGON RESIDENTS ONLY: 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 OR INCOMPLETE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.) (FOR VERMONT RESIDENTS ONLY: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.) (FOR WASHINGTON RESIDENTS ONLY: 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.)

Print : **Applicant Name & Title** **Authorized Signature of Applicant** **Date**

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