623 SW 10th Avenue
Topeka, KS 66612
800.232.2259
www.kammco.com

Long-Term Care Application for Claims-Made Professional Liability and General Liability Insurance – Renewal Application

Section A: *Applicant Information*

Facility Name: _____ Tax ID Number: _____

Policy Number: _____

Street: _____ City: _____ State: _____ Zip: _____

Administrator/CEO Information

Name: _____ Phone: _____ Email: _____

Risk Manager

Name: _____ Phone: _____ Email: _____

Section B: *Limits of Insurance*

1. Do you want changes to the expiring limits? ○ Yes ○ No

   If yes, describe in the box below:

Section C: *Statistics*

1. Provide the following:

	Licensed Number	Beds*
Skilled Nursing		
Extended Care		
Assisted Living		
Independent Living		
Other, specify:		

***Beds:** Use the average number of occupied beds which is defined as the total inpatient days divided by 365 days in a year.

2. Provide the following resident census numbers:
   a. Number of Alzheimer's and Dementia Residents: _____
   b. Number of Ambulatory Residents: _____
   c. Number of Non-Ambulatory, Bed-Bound Residents: _____

3. Provide the number of residents in each of the following age ranges:

0-55:* _____ 55-65: _____ 65-74: _____ 65-74: _____ 75-84: _____ 85+ _____

Total Resident Count: _____

*Provide an explanation for any residents under the age of 55:

4. Provide the number of acquired and inherited decubitus ulcers and pressure sores, at each of the given stages.

Stage	Acquired Ulcers	Inherited Ulcers
I		
II		
III		
IV		

5. Do you provide care for any residents with the following conditions?

a. Traumatic Brain Injury ○ Yes ○ No

b. Chemical Dependency ○ Yes ○ No

c. Tube Feeding ○ Yes ○ No

d. Ventilator / Tracheostomy Services ○ Yes ○ No

e. Psychiatric/Sociopathic/Schizophrenic ○ Yes ○ No

If yes to any of the questions above, please provide an explanation below:

Section D: *Insurance and Loss History*

1. Has the applicant or any of its employees, in the last twelve (12) months, been charged with or convicted of a crime? ○ Yes ○ No

If yes, describe in the box below or attach additional sheet, as necessary.

2. Has there been any change in the status of previously reported claims? ○ Yes ○ No

If yes, provide updated loss runs for any previously reported unresolved claims. Disregard if the claims have already been reported to KAMMCO.

3. Is the applicant proposed for this insurance aware of any known losses, claims, or lawsuits that have not yet been reported? ○ Yes ○ No

If yes, please complete a *Claim Information Worksheet* for each.

4. Describe any special events sponsored by the facility (e.g., carnivals, athletic events, tournaments, etc.)

5. Describe any changes made to the facility's premises (additions, new purchases, disposal of property, new parking, property donated to the facility, etc.).

6. Does the facility have plans for any new services or operations? ○ Yes ○ No

If yes, describe below:

7. Does the facility plan to discontinue any services currently being offered? ○ Yes ○ No

If yes, describe below:

8. Has the hospital made any changes to the organizational structure (e.g., mergers, acquisitions, subsidiaries, etc.)? ○ Yes ○ No

If yes, describe below:

9. Has the facility been involved in any new contracts that include a transfer of liability or hold harmless agreement? ○ Yes ○ No

If yes, describe below:

Execution of this application by the applicant does not bind KAMMCO to issue an insurance policy, but this application shall be the basis of the contract should a policy be issued.

If a policy is issued, the policy will be issued on a claims-made basis and will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy.

The applicant represents the statements and answers made herein are true, and makes the same for the purpose of inducing KAMMCO to issue the policy for which application is hereby made. It is understood that this entire policy shall be void if, whether before or after a loss or claim, the applicant has intentionally concealed or misrepresented any material fact or circumstance concerning the insurance or subject thereof.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including authorization to every person or entity, public or private, to release to KAMMCO, any documents, records or other information bearing upon the foregoing. The undersigned further agrees that the Company and all persons or organizations may rely upon a photocopy or this authorization, which shall be of equal validity with the original.

I authorize KAMMCO to release a certificate of insurance to professional credentials verification services and/or healthcare facility medical or credentialing staff.

I understand and agree these investigations shall not be confined to information submitted in the application, but shall include any other sources of information deemed relevant by KAMMCO as may be authorized by law.

Applicant's Name

Applicant's Signature **Date**

Please return this application, along with any necessary attachments, by email to **underwriting@kammco.com** or by fax to **785.232.4704**.

If you work with a KAMMCO agent, please submit this application directly to your agent.