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 – New Business

Application Instructions and Information:

- Answer all questions fully and accurately.
- If you need more space for any response, use the Comments Section at the end of this application or attach additional pages.
- Be sure to sign and date the application where indicated.
- All required forms and applications are available online at www.kammco.com.
- Incomplete applications or missing information may delay the underwriting process.

Section A: *Applicant Information*

Facility Name: _____ Tax ID Number: _____

Facility "Doing-Business-As" (DBA) Name, if applicable: _____

Facility Address:

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

Mailing Address, if different from facility address:

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

Administrator Contact Information

Name: _____ Email: _____ Phone: _____

Risk Manager Contact Information

Name: _____ Email: _____ Phone: _____

Director of Nursing Contact Information

Name: _____ Email: _____ Phone: _____

1. Facility Type (check all that apply):

☐ Skilled Nursing Facility ☐ Home Plus

☐ Assisted Living Facility ☐ Residential Healthcare

☐ Independent Living ☐ Other, specify: _____

2. Applicant is (check all that apply):

☐ Medicare-Certified ☐ Licensed or Appointed by the State Board of Health

☐ Medicaid-Certified ☐ Healthcare Safety Professional-Certified

☐ Accredited by the Joint Commission

3. Legal Entity Type (check all that apply):

☐ For-Profit ☐ Partnership ☐ Hospital-Affiliated

☐ Not-For-Profit ☐ Religiously-Affiliated ☐ Continuing Care Retirement Center (CCRC)

☐ Individual ☐ Corporation

Section B: *Requested Coverage*

1. Requested Effective Date of Coverage: _____

2. Select your requested limits of liability. Limits are expressed as per claim / annual aggregate.

☐ Professional Liability: $ _____ / $ _____

☐ General Liability: $ 1,000,000 / $ 3,000,000

☐ Employee Benefit Liability: $ 250,000 / $ 250,000

☐ Umbrella Coverage*: $ _____ / $ _____ **Requests for umbrella coverage must include complete loss run information*

Section C: *Resident and Census Information*

1. Select the level of care authorized by the applicant facility's license. If the license does not specify a level of care, select the option that best reflects the primary level of care provided by the facility:

Level of Care	License Number	Beds*
☐ Skilled Nursing		
☐ Assisted Living		
☐ Independent Living		
☐ Extended		
☐ Residential Healthcare		
☐ Home Plus		

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

2. Does the applicant facility provide home health services? ○ Yes ○ No

If yes, what is the number of annual visits?: _____

Provide a description of services provided:

3. Provide the number of residents in each of the following age ranges: ○ Yes ○ No

Under 30: _____ 30-65: _____ 66-75: _____ 76-85: _____ 86-95: _____ Older than 96: _____

Section D: *Prior Coverage and Loss History*

1. Name of your current insurance carrier: _____

   a. Your current policy period from start to expiration date: _____ to _____

   b. Your current policy's professional liability limit: $ _____

      Coverage Basis: ○ Occurrence ○ Claims-made

   c. Your current policy's general liability limit: $ _____

      Coverage Basis: ○ Occurrence ○ Claims-made

2. Has the applicant facility been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? ○ Yes ○ No

   If yes, include an explanation in the Comments Section at the end of this application.

3. Has the applicant facility been the subject of any license suspension or revocation, or been placed under probation? ○ Yes ○ No

   If yes, include an explanation in the Comments Section at the end of this application.

4. Has any insurance company ever canceled, non-renewed, or declined to accept the applicant facility's professional or general liability insurance? ○ Yes ○ No

   If yes, include an explanation in the Comments Section at the end of this application.

Section E: *General Information*

1. How long has the facility been operating?: _____

2. How long has the facility been owned by the present owners?: _____

3. Is the applicant owned by a management company? ○ Yes ○ No

   If yes:

   a. Name of the management company: _____

   b. Number of years this facility has been operating under this management company: _____

   c. Name of the management company's professional liability carrier: _____

Section F: *Administration and Staff*

MEDICAL DIRECTOR

1. Name of the Medical Director with professional credentials: _____

2. Is the Medical Director: ☐ Employed ☐ Contracted ☐ Other, specify: _____

3. Length of time the Medical Director has been with the facility: _____

4. Medical Director's specialty: _____

5. Number of hours per month, on average, the Medical Director is onsite at the facility: _____

6. Does the Medical Director have direct patient contact? ○ Yes ○ No

7. Please provide the Medical Director's insurance carrier and limits of liability:
   a. Insurance Carrier: _____
   b. Limits of Liability: _____

8. Is the Medical Director involved in credentialing the facility's medical staff? ○ Yes ○ No

9. Is the Medical Director an active participant in the facility's quality improvement program? ○ Yes ○ No

10. Is the Medical Director responsible for hiring and firing? ○ Yes ○ No

DIRECTOR OF NURSING

1. Name of the Director of Nursing with professional credentials: _____

2. Length of time the Director of Nursing has been with the facility: _____

3. Length of time the Director of Nursing has been in that position: _____

FACILITY ADMINISTRATOR

1. Is there a licensed Administrator on staff? ○ Yes ○ No

   If yes,
   a. Length of time the Administrator has been with the facility: _____
   b. Length of time the Administrator has been in that position: _____

   If no,
   a. Who assumes the administrative duties? _____
   b. Their length of time with the facility: _____
   c. Their length of time working in an administrative capacity: _____

RISK MANAGER

1. Name of the Risk Manager with professional credentials: _____ ○ Yes ○ No

2. Length of time the Risk Manager has been with the facility: _____

3. Length of time the Risk Manager has been in that position: _____

ADDITIONAL STAFFING QUESTIONS

1. Are nursing agencies or registries utilized at the facility? ○ Yes ○ No

   If yes, how many agencies and registries does the facility utilize?: _____

2. Is a complete shift staffed exclusively by temporary staff? ○ Yes ○ No

3. Are criminal background checks conducted on:

   a. All employees? ○ Yes ○ No

   b. Licensed staff only? ○ Yes ○ No

   c. Direct care staff only? ○ Yes ○ No

   d. Volunteers? ○ Yes ○ No

   e. Independent contractors or agency staff? ○ Yes ○ No

4. Select each registry or database the facility uses to conduct background checks:

   ☐ State databases ☐ Multi-state databases ☐ Federal databases

   ☐ Sex offender registry ☐ Abuse or neglect registry

5. Are background checks repeated again after an individual is hired? ○ Yes ○ No

   If yes, identify the rate at which background checks are repeated:

   ☐ Annually ☐ Every two years ☐ Other, specify: _____

6. Describe below how positive findings are reviewed and approved?

7. Are staffing agencies required to certify criminal background screenings for agency personnel? ○ Yes ○ No

8. Has the facility had any allegations, incidents, or claims involving employee misconduct, abuse, neglect, or theft within the past five (5) years? ○ Yes ○ No

   If yes, explain below. Attach additional sheets, if necessary.

9. Are state nurse registries checked for new hires? ○ Yes ○ No

10. Please indicate staffing by shift.

Category	*1st Shift*	*2nd Shift*	*3rd Shift*	*Annual Turnover Percentage*
RN				
LPN				
CNA/Personal Caregiver				
Agency				
Pool				

Section G: *Underwriting*

1. Are written procedures in effect for incident reporting? ○ Yes ○ No

2. What is the name and title of the person responsible for reviewing incident reports and determining if correction action is necessary?:

   Name: _____ Title: _____

3. Is a nursing assessment conducted for new patients? ○ Yes ○ No

   If yes, which of the following areas are assessed during the nursing assessment?

   ☐ Skin breakdown / Decubiti ☐ Mobility limitations ☐ Required assistance

   ☐ History of prior injuries ☐ Current medications ☐ Disorientation

4. Are wound photographs taken for all residents with existing skin impairments? ○ Yes ○ No

   If yes,

   a. Are photographs taken upon admission? ○ Yes ○ No

   b. Are photographs taken when clinically indicated? ○ Yes ○ No

5. Is consent obtained from the resident, or a responsible party, prior to photographing wounds? ○ Yes ○ No

6. Are nursing assessment protocols in place for the following?

   a. Elopement ○ Yes ○ No

   b. Falls ○ Yes ○ No

   c. Cognitive impairment ○ Yes ○ No

   d. Nutritional deficiency ○ Yes ○ No

   e. Wounds ○ Yes ○ No

   f. Pressure injuries ○ Yes ○ No

7. Is the dispensing of medications properly controlled with each patient dose recorded? ○ Yes ○ No

8. Who determines if a patient must be transferred to another facility for further diagnosis or treatment?

Section H: *General Liability Coverage*

Complete this section only if general liability coverage is desired.

1. Provide the following building description(s):

	Building 1	**Building 2**	**Building 3**	**Building 4**
Type of Construction				
Number of Stories				
Total Beds				
Date Built				
Use of Building				

2. Does the applicant facility have an auxiliary electrical supply system? ○ Yes ○ No

3. Are handrails provided in hallways and bathrooms? ○ Yes ○ No

4. Are bathtubs and showers equipped with nonslip surfaces? ○ Yes ○ No

5. Are all skilled or intermediate care patient beds equipped with sidewalls? ○ Yes ○ No

6. Are there bodies of water present onsite? ○ Yes ○ No

If yes, describe below:

7. Is the facility used for activities and services by those other than residents? ○ Yes ○ No

If yes, include an explanation in the Comments Section at the end of this application.

8. Are any fundraising events sponsored by the facility or its auxiliary? ○ Yes ○ No

If yes, describe the types of events (i.e., carnivals tournaments, etc.) and the number per year.

9. Is any new construction or renovation to existing structures planned for the next 12 months. ○ Yes ○ No

If yes:

a. Estimated cost of planned construction or renovation: _____

b. Briefly describe the nature of the new construction or renovation:

10. Answer the following if the facility has **Independent Living Facilities**: ○ Yes ○ No

a. Do individual units have cooking appliances (e.g., stove or oven)? ○ Yes ○ No

b. Is there a daily mechanism to keep track of residents? ○ Yes ○ No

If yes, describe below:

c. Are there licensed nursing personnel on staff? ○ Yes ○ No

If yes:

i. What hours are they available?: _____

ii. Describe the services they provide:

d. Are there written guidelines that stipulate the types of residents able to live within the facility? ○ Yes ○ No

If yes, how often are residents reassessed for adherence to guidelines? _____

11. Evacuation

a. Does the facility have a written emergency evacuation plan? ○ Yes ○ No

b. Does the plan include arrangements for transportation and temporary shelter? ○ Yes ○ No

c. How often are evacuation and fire drills conducted each year for each shift?

☐ Monthly ☐ Quarterly ☐ Annually ☐ Other (specify): _____

12. Does the facility have a written patient safety policy? ○ Yes ○ No

Section I: *General Liability Coverage – Claims History*

1. Provide the general liability loss history, currently valued, from your carrier from the last five (5) years. ○ Yes ○ No

2. Are you aware of any circumstances which may result in a general liability claim or lawsuit being made or brought against the facility? ○ Yes ○ No

If yes, attach a sheet with an explanation.

Section J: *Comments Section*

Section Letter(s) and Question Number(s)	Explanation

The undersigned applicant for insurance hereby authorizes applicant's present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any claim of professional liability, to release to KAMMCO, upon its request, information regarding closed, pending, or anticipated claims and any underwriting or other information which, in the judgment of any such carrier, attorney, or KAMMCO, may have a bearing upon applicant's acceptability to KAMMCO as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which applicant is, or has been, a member; all hospitals in which applicant now holds, or has held, staff privileges; any state licensing board in any state which applicant has practiced; the Department of Health and Environment, or any other similar agency in which applicant has practiced or resided; and any and all physicians having information regarding the undersigned, to release to KAMMCO, upon its request, any information any such person or entity may have which, in the judgment of any such person or entity or KAMMCO, may have a bearing upon applicant's acceptability to KAMMCO as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees and KAMMCO, its directors, officers, employees, agents, and members from any liability arising out of the release, or use, of any information released, or furnished, pursuant to the authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned further agrees that KAMMCO and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name of CEO or Authorized Representative

Title

Signature

Date Signed

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.

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Claim Information Worksheet

Make additional copies, if necessary.

No Claims: ☐ *(A signature is required, regardless of claim history)*

Applicant's Name (First, MI, Last): _____

Patient's Name (First, MI, Last): _____

Allegation:

Date of Incident (MM/DD/YYYY): _____ Date Reported (MM/DD/YYYY): _____

Insurance Carrier: _____ Location of Incident: _____

Was a Lawsuit Filed? ○ Yes ○ No Are or were you the primary defendant? ○ Yes ○ No

Additional Defendants: _____

Please describe your involvement in the patient's care:

Claim Status:

○ Open ○ Closed: _____
Date Closed (MM/DD/YYYY)

If **OPEN**, indicate the reserve amount. *(Required):* _____

If **CLOSED**, indicate the following:

a. Method of closing: ○ Dismissed ○ Settled ○ Judgment

b. Amount of settlement or judgement paid on your behalf: _____

I understand the information submittedherein becomes part of my Professional Liability Insurance Application as submitted.

_____ _____
Signature Date

Please email this form, along with your application, to **underwriting@kammco.com**.
If you work with a KAMMCO agent, please submit this document directly to your agent.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they