



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				
Total Square Feet				

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
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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.



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

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 submitted herein 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.

**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) _____	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.)
	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 ☐	
	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
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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