



**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



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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	
		<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
		<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
		<input type="checkbox"/> Active	<input type="checkbox"/> Inactive
		<input type="checkbox"/> Active	<input type="checkbox"/> 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:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
License:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Association memberships: _____



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- 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



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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:	<p>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.</p> <p>a. What are the total numbers of units? ____</p> <p>b. What are the total numbers of residents at full occupancy? ____</p> <p>c. Are there common dining facilities? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>d. Do individual units have cooking appliances (excluding microwaves)? <input type="checkbox"/>Yes <input type="checkbox"/>No If "Yes," check type: <input type="checkbox"/>Gas <input type="checkbox"/>Electric</p> <p>e. Is there a daily mechanism to keep track of residents? <input type="checkbox"/>Yes <input type="checkbox"/>No If "Yes," explain procedure: ____</p> <p>f. Are Residents allowed to have home health care aides?</p> <p>g. Are the aides contracted independently? <input type="checkbox"/>Yes <input type="checkbox"/>No Through facility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>h. Are there licensed nursing personnel on staff? <input type="checkbox"/>Yes <input type="checkbox"/>No What hours are they available? ____ What services do they provide? ____</p>



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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



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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	1 st shift	2 nd shift	3 rd 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



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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



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- 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:	<input type="checkbox"/> Social (80911)	Total Participants: _____
	<input type="checkbox"/> 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.)



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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	<input type="checkbox"/> Yes <input type="checkbox"/> No		Developmentally Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ventilation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alzheimer's/Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		Chemical Dependency Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Nursing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Speech Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Dietary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
X-Ray	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Medical Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Social Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Recreational Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Barber/Beautician	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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



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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



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- 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? _____



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- 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: _____



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- 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:



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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.)



Leo
Risk Services

**CNA HEALTHCARE AGING SERVICES
NEW BUSINESS SUPPLEMENTAL APPLICATION**

Print : Applicant Name & Title

Authorized Signature of Applicant

Date

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