Member Companies of Western World Insurance Group

☐ Western World Insurance Company
☐ Tudor Insurance Company
☐ Stratford Insurance Company

Application
For
Institutional Care Facilities

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1. Name of Applicant: ______
Street address: ______
City: ______ State: ______ Zip: ______
Applicant's Web Site address: ______
Date established: ______ Phone # for inspection: ______ Agent phone #: ______

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Professional Association ☐ Non-profit Corporation
☐ Other (Explain): ______

3. List all names which you or the corporation have operated under during the past 4 years, if different from above.
______
______

3a. Is applicant engaged in, owned by, associated with or involved in any other enterprise? ☐ Yes ☐ No
If yes, provide details: ______

4. Is facility run by an outside management company? ☐ Yes ☐ No
If yes, describe contractual relationship: ______

4a. Do you provide consultant services for or manage any other facilities? ☐ Yes ☐ No
If yes, describe ______

5. List all losses and amounts paid or reserved that have been incurred by these entities. Add pages, if needed.

Year	Insurance Company	Policy Number and Premium	Loss Paid & Reserved	Loss Description

6. a. Are you licensed? ☐ Yes Number: ______ ☐ No If no, why not? ______
______
b. Has license every been revoked or suspended? Give details: ______
______
c. Licensed bed capacity: ______

7. Attach copies of:
a. Currently valued (within last 3 months), hard copy, Company loss runs for the last 5 years.
b. Current State License.
c. Most recent state inspection report with state approved plan of corrections, if deficiencies are noted.
d. Insured's guidelines/procedures for care.
Include details of training and certification required of staff to handle patients.
e. Emergency Evacuation Plan.

8. Will temporary clients be accepted? ☐ Yes ☐ No
If yes, what additional staffing provisions will be made if the condition of the client is above what facility is licensed for? ______
______

9. Other operations (if any):

- ☐ Counseling (outpatient) — Number of visits: ____________
- ☐ Day care (other than for residents) — Number of persons: ____________
- ☐ Home healthcare service/agency — Amount of receipts: ____________
- ☐ Psychiatric Clinic — Type of conditions treated: ____________
- ☐ Other (describe): ____________

10. Type of facility:

	Number of beds
☐ Alcohol or drug treatment	
☐ Shelter for runaways, abused spouses, foster homes	
☐ Sub-acute care	
☐ Other (provide full details below):	

11. Patient breakdown by age group:

0 – 10 years		36 to 50 years	
11 to 17 years		51 to 65 years	
18 to 35 years		Over 65 years	

12. What precautions are taken to keep track of patients? ____________
Sign out procedure? ☐ Yes ☐ No Alarms on doors? ☐ Yes ☐ No
Other (please describe): ____________

13. Do any patients work full or part time or attend school or workshops? ☐ Yes ☐ No
If yes, describe activities: ____________

14. Indicate total number of employed personnel: ____________
Total number and types of independent contractors: ____________

	1st Shift	2nd Shift	3rd Shift	Residing on Premises
(A) MD's				
(B) RN's				
(C) LPN's				
(D) Nurses Aides				
(E) Psychologists				
(F) Therapists				
(G) Counselors				
(H) Other (specify):				

15. Are any of the above required to maintain their own professional coverage? ☐ Yes ☐ No
Limits required: ____________ How is coverage verified? ____________

15a. Are background checks made with all prior employers and educational institutions? ☐ Yes ☐ No
Does background check include Police record? ☐ Yes ☐ No
(If either answer is "No", refer risk to Company.)

15b. Do you want employees covered as additional insureds? (There is a premium charge). ☐ Yes ☐ No
(NOTE: The policy already protects *you* for the acts of your employees.)

16. List medication administered and in what form given: (e.g. methadone, given in pill form) ____________

17. Describe therapy other than drugs used in the course of treatment: (e.g. group therapy, individual counseling, shock treatment, etc.) ______________________________

____

18. What floors are the nonambulatory patients on? ______________ How many on each floor? ______________

Are physical or chemical restraints used? ☐ Yes ☐ No If yes, describe: ______________________________

____

____

18a. How many patients do you have of the following types? Do not count same patient in more than one class.

		Ambulatory	Non-Ambulatory
1.	Seriously mentally impaired (e.g. Alzheimer's, senile)		
2.	Skilled Care		
3.	Intermediate Care		
4.	Somewhat mentally impaired (e.g. mentally challenged)		
5.	Aged but mentally and physically fully functional		
6.	Drug or alcohol detoxification patients		
7.	Drug or alcohol rehabilitation patients		
8.	Has a communicable disease (e.g. AIDS)		
9.	Other - specify ______________________________		
	Totals (Totals must not exceed total number of patients.)		

19. What other services (such as beauty care, podiatry, dentistry) are provided by staff or independent contractor?

____

20. BUILDING INFORMATION:

(A) Construction of building? ______________________________

(B) Number of stories? ______________________________

(C) Year built? ______________________________

(D) Built as a nursing home? ☐ Yes ☐ No

(E) Is building sprinklered? ☐ Yes ☐ No ☐ Fully or ☐ Partially sprinklered?
If partially, what percentage? ________%

(F) Has an emergency evacuation plan been prepared? ☐ Yes ☐ No

(G) Are all rooms and halls equipped with smoke detectors? ☐ Yes ☐ No

(H) What is the total square footage of the building? ______________________________

(I) Any swimming pools? ☐ Yes ☐ No Describe protection and use:

(J) Is building equipped with fire alarm? ☐ Yes ☐ No ☐ Central Station ☐ Local Station

(K) Is smoking permitted? ☐ Yes ☐ No

(L) Are there designated smoking areas? ☐ Yes ☐ No

(M) Distance to the nearest fire station? ______________ Nearest hydrant? ______________

(N) Temperature of hot water? ______________________________

(O) Are handrails in bathrooms and hallways? ☐ Yes ☐ No

(P) Are bathtubs and showers equipped with non-skid surfaces? ☐ Yes ☐ No

21. Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ Yes ☐ No
If yes, please provide details.

____

____

22. Has applicant, or any other person for whom coverage is being requested, had any liability application denied? ☐ Yes ☐ No
If yes, provide details. ______________________________

____

23. Limits Of Insurance Requested:

General Aggregate Limit (Other than Products – Completed Operations)	$ ________	
Products – Completed Operations Aggregate Limit	$ ________	
Personal and Advertising Injury Limit	$ ________	any one person or organization
Each Occurrence Limit	$ ________	
Damage to Premises Rented to You (up to $50,000 limit available)	$ ________	any one premise
Medical Expense Limit (up to $5,000 limit available)	$ ________	any one person
Each Professional Incident Limit (if applicable)	$ ________	

24. Effective Dates Desired: From ____________________ To ____________________

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 25 THROUGH 29. If not desired, please sign application at bottom of page.

25. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
If yes, provide details. ____

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
If yes, provide details. ____

27. Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there? ☐ Yes ☐ No
If yes, provide details. ____

28. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
Describe types of checks done (prior employer, police, etc.): ____

29. Sexual Molestation sub limit wanted:
☐ $25,000/50,000 ☐ $50,000/100,000 ☐ $100,000/300,000

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes 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.

Applicant's Signature: ______________________________ Date: ____________________

Title: ______________________________ Producing Agent: ____________________