

MINNESOTA JOINT UNDERWRITING ASSOCIATION  
 445 MINNESOTA STREET SUITE 514  
 SAINT PAUL, MN 55101

**INSTITUTIONAL CARE FACILITIES APPLICATION**

1. NAME OF APPLICANT \_\_\_\_\_

2. MAILING ADDRESS  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_  
 EMAIL \_\_\_\_\_ WEB ADDRESS \_\_\_\_\_  
 FEDERAL ID # \_\_\_\_\_ STATE UNEMPLOYMENT # \_\_\_\_\_

4. \_\_\_\_INDIVIDUAL\_\_ CORPORATION \_\_\_\_PARTNERSHIP \_\_\_\_OTHER(EXPLAIN)  
 \_\_\_\_\_  
 \_\_\_\_\_

5. LIST FULL NAMES OF OWNERS OR PARTNERS  
 \_\_\_\_\_ SSN \_\_\_\_\_  
 \_\_\_\_\_ SSN \_\_\_\_\_

6. HAS APPLICANT HAD PREVIOUS INSURANCE FOR THIS ENTERPRISE?  YES  NO  
 (IF YES, PLEASE COMPLETE THE FOLLOWING)

INSURANCE COMPANY	POLICY PERIOD	LIMITS OF LIABILITY PREMIUM	OCCURRENCE OR CLAIMS MADE	TYPE OF COVERAGE

7. IS APPLICANT ENGAGED IN, OWNED BY, ASSOCIATED WITH OR INVOLVED IN ANY OTHER ENTERPRISE?  YES  NO  
 (IF YES, PROVIDE FULL DETAILS) \_\_\_\_\_  
 \_\_\_\_\_

8. PROVIDE DETAILS OF LICENSING OR CERTIFICATION NEEDED FOR THIS OPERATION:  
 \_\_\_\_\_  
 \_\_\_\_\_

9. LIST ANY PROFESSIONAL ASSOCIATIONS IN WHICH YOU ARE A MEMBER: \_\_\_\_\_  
 \_\_\_\_\_

10. TYPE OF FACILITY
- NURSING HOME \_\_\_\_\_ %
  - ALCOHOLIC OR DRUG TREATMENT \_\_\_\_\_ %
  - PSYCHIATRIC OUTPATIENT CLINIC \_\_\_\_\_ %
  - GROUP HOME \_\_\_\_\_ %
  - FOSTER HOMES \_\_\_\_\_ %
  - OTHER (PROVIDE FULL DETAILS BELOW) \_\_\_\_\_ %

11. TYPE OF OPERATION
- INPATIENT # OF LICENSED BEDS \_\_\_\_\_ CURRENT OCCUPANCY \_\_\_\_\_
  - OUTPATIENT # OF CLIENTS \_\_\_\_\_
  - HALFWAY HOUSE # OF LICENSED BEDS \_\_\_\_\_ CURRENT OCCUPANCY \_\_\_\_\_
  - GROUP HOME # OF LICENSED BEDS \_\_\_\_\_ CURRENT OCCUPANCY \_\_\_\_\_
  - FOSTER HOME # OF LICENSED BEDS \_\_\_\_\_ CURRENT OCCUPANCY \_\_\_\_\_

12. PATIENT BREAKDOWN BY AGE GROUP

UNDER 18 YEARS \_\_\_\_\_ 36 TO 50 YEARS \_\_\_\_\_ OVER 65 YEARS \_\_\_\_\_  
18 TO 35 YEARS \_\_\_\_\_ 51 TO 65 YEARS \_\_\_\_\_

13. ARE PATIENTS ALLOWED TO LEAVE PREMISES UNATTENDED?  YES  NO  
(IF YES, EXPLAIN) \_\_\_\_\_

14. INDICATE THE NUMBER OF PERSONNEL

(a) MDs DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
(b) RNs DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
(c) LPNs DAY \_\_\_\_\_ NIGHT \_\_\_\_\_  
(d) PSYCHOLOGISTS \_\_\_\_\_  
(e) THERAPISTS \_\_\_\_\_  
(f) COUNSELORS \_\_\_\_\_

15. FACILITY: CO-ED \_\_\_\_\_ SINGLE SEX \_\_\_\_\_

16. WHAT FLOORS ARE NON-AMBULATORY PATIENTS ON? \_\_\_\_\_

17. HOW MANY ON EACH FLOOR? \_\_\_\_\_

18. ARE RESTRAINTS USED?  YES  NO  
(IF YES, DESCRIBE PROCEDURES /PERCENTAGE OF PATIENTS NORMALLY RESTRAINED)

19. IS PHYSICIAN EVALUATION AND WRITTEN NOTICE FROM PHYSICIAN (EXCEPT IN AN EMERGENCY)  
REQUIRED FOR USE OF CHEMICAL OR PHYSICAL RESTRAINTS?  YES  NO

20. IS PATIENT'S LEGAL REPRESENTATIVE/GUARDIAN REQUIRED TO APPROVE THE USE OF CHEMICAL  
OR PHYSICAL RESTRAINTS IN WRITING?  YES  NO

21. WHAT PRECAUTIONS ARE TAKEN TO KEEP TRACK OF PATIENTS? \_\_\_\_\_

22. SIGN OUT PROCEDURES  YES  NO

23. ALARMS ON DOORS TO PREVENT CLIENTS FROM WANDERING FROM THE HOME?  YES  NO

24. ELECTRONIC MONITORING OF PATIENTS WITH SENILITY OR ALZHEIMERS?  YES  NO

25. DOES PATIENT CONTROL THE POSSESSION OF SMOKING MATERIALS?  YES  NO  
DESCRIBE PROCEDURES \_\_\_\_\_

26. IF THIS IS NURSING HOME, ADVISE DEGREE OF CARE PROVIDED

SKILLED CARE  INTERMEDIATE CARE  BASIC CARE

**Skilled Care:** Professional nursing care – hours by licensed nurses. A registered nurse provides care during the day shift. LPN coverage is required during other shifts. Skilled nursing care including some or all of the following: medication administration, injections, tube feedings, catheterizations, or other procedures ordered by physician.

**Intermediate Care:** Nursing Care during the day shift, 7 days per week, by either registered or licensed practical nurses. No complex nursing (IV's, Tube Feeding, etc.). Assistance with activities of daily living (i.e. walking, bathing, dressing, eating). Some assistance in medication administration.

**Basic Care:** Home for Aged or Group Home residents are provided protective environments and are responsible for their own care. Group Homes are for trainable retarded persons. Residents of Homes fro the Aged must be ambulatory.

27. ARE ANY OTHER TYPE OF SERVICES PROVIDED, EITHER BY STAFF OR INDEPENDENT CONTRACTOR,  
SUCH AS BEAUTICIAN SERVICES, PODIATRIST, DENTISTS, ETC.? (PROVIDE DETAILS)

28. DO YOU REQUIRE AND MAINTAIN CERTIFICATES OF INSURANCE FROM ALL INDEPENDENT  
CONTRACTORS?  YES  NO

29. **PRIOR CLAIM INFORMATION:** DURING THE PAST (3) THREE YEARS, HAVE ANY CLAIMS BEEN PRESENTED TO YOUR CURRENT OR PRIOR INSURANCE CARRIER?

(IF YES, SEE BELOW)

GIVE FULL DETAILS. INCLUDE DESCRIPTION OF CLAIM, AMOUNT PAID, AND RESERVES:

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30. IS APPLICANT OR ANY OTHER PERSONS FOR WHOM INSURANCE IS BEING REQUESTED AWARE OF ANY CIRCUMSTANCE WHICH MAY RESULT IN A CLAIM?

(IF YES, PROVIDE FULL DETAILS)

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31. HAS APPLICANT OR ANY OTHER PERSON FOR WHOM COVERAGE IS BEING REQUESTED HAD ANY LIABILITY APPLICATION DENIED, POLICY CANCELLED, OR POLICY NOT RENEWED IN THE PAST THREE (3) YEARS?  YES  NO

(IF YES, PROVIDE FULL DETAILS)

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32. COVERAGE DESIRED

	TYPE OF COVERAGE	LIMITS OF LIABILITY	PROPOSED EFF. DATE
PROFESSIONAL*			
OLT			

33. IS THE INSURED A: BUILDING OWNER \_\_\_\_ TENANT \_\_\_\_\_ GENERAL LESSEE \_\_\_\_

34. DOES APPLICANT HAVE WORKERS COMPENSATION COVERAGE IN FORCE?  YES  NO

**COMPLETE SEPARATE FOR FOR EACH LOCATION**

**ADDRESS OR LOCATION**

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CONTACT NAME: \_\_\_\_\_ PHONE AT LOCATION: \_\_\_\_\_

35. # OF LICENSED BEDS FOR THIS LOCATION \_\_\_\_\_ CURRENT OCCUPANCY FOR THIS LOCATION \_\_\_\_\_

36. BUILDING

37. NUMBER OF FIRE EXTINGUISHERS \_\_\_\_\_ NUMBER OF FIRE ESCAPES \_\_\_\_\_

38. LOCAL FIRE ALARM?     YES  NO    CENTRAL STATION FIRE ALARM?     YES  NO

39. DISTANCE TO NEAREST FIRE STATION: \_\_\_\_\_

40. ARE HANDRAILS PROVIDED IN BEDROOMS AND HALLWAYS?     YES  NO

41. TEMPERATURE OF HOT WATER: \_\_\_\_\_

42. SWIMMING POOL OR HOT TUB?     YES  NO  
IF YES, FENCED WITH SELF LOCKING GATE?     YES  NO    DIVING BOARD?     YES  NO  
SLIDE?     YES  NO

43. IS THERE AN EMERGENCY WRITTEN EVACUATION PLAN IN PLACE?     YES  NO

**AGENCT CONTACT INFORMATION**

NAME: \_\_\_\_\_  
ADDRESS1: \_\_\_\_\_  
ADDRESS2: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**REQUIREMENTS FOR QUOTE**

1. FULLY COMPLETED APPLICATION
2. COPY OF ALL LICENCES FOR EACH LOCATION
3. COPY OF STATE DEPARTMENT OF HEALTH SURVEY AND RESPONSE AND CERTIFICATES OF CORRECTION
4. PRIOR COMPANY LOSS RUNS
5. COPY OF CLIENT INCIDENT REPORT FORM USED

I, the undersigned, certify and attest that I have been unable to obtain, through any ordinary methods, the insurance I am applying for with this application.

APPLICANT NAME \_\_\_\_\_ TITLE \_\_\_\_\_  
APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_