

MINNESOTA JOINT UNDERWRITING ASSOCIATION
PIONEER PO BOX 1760
SAINT PAUL, MN 55101

INSTITUTIONAL CARE FACILITIES APPLICATION

1. NAME OF APPLICANT _____

2. MAILING ADDRESS

3. _____ INDIVIDUAL _____ CORPORATION _____ PARTNERSHIP _____ OTHER (EXPLAIN)

4. LIST FULL NAMES OF INDIVIDUALS OR PARTNERS:

5. CONTACT _____ PHONE _____

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

Insurance Company Coverage	Policy Period	Limits of Liability Premium	Occurrence or Claims Made	Type of
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7. IS APPLICANT ENGAGED IN, OWNED BY, ASSOCIATED WITH OR INVOLVED IN ANY OTHER ENTERPRISE? O Yes O 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
- O NURSING HOME FOR SENILE OR AGED _____ %
 - O ALCOHOLIC OR DRUG TREATMENT _____ %
 - O PSYCHIATRIC OUTPATIENT CLINIC _____ %
 - O GROUP HOME _____ %
 - O FOSTER HOMES _____ %
 - O OTHER (PROVIDE FULL DETAILS BELOW) _____ %

11. TYPE OF OPERATION

<input type="radio"/> INPATIENT	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
<input type="radio"/> OUTPATIENT	# OF CLIENTS _____	
<input type="radio"/> HALFWAY HOUSE	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
<input type="radio"/> GROUP HOME	# OF LICENSED BEDS _____	CURRENT OCCUPANCY _____
<input type="radio"/> 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?
(IF YES, EXPLAIN)

Yes No

14. INDICATE THE NUMBER OF PERSONNEL

(a) MD'S	DAY _____	NIGHT _____
(b) RN'S	DAY _____	NIGHT _____
(c) LPN'S	DAY _____	NIGHT _____
(d) PSYCHOLOGISTS	_____	
(e) THERAPISTS	_____	
(f) COUNSELORS	_____	

15. IS FACILITY _____ CO-ED _____ SINGLE SEX

16. WHAT FLOORS ARE NON-AMBULATORY PATIENTS ON? _____

17. HOW MANY ON EACH FLOOR? _____

18. ARE RESTRAINTS USED?
(IF YES, DESCRIBE PROCEDURES/PERCENTAGE OF PATIENTS NORMALLY RESTRAINED)

Yes No

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 OR 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 for 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? Yes No
 (IF YES, SEE BELOW)
 GIVE FULL DETAILS. INCLUDE DESCRIPTION OF CLAIM, AMOUNT PAID, AND RESERVES:

30. IS APPLICANT, OR ANY OTHER PERSONS FOR WHOM INSURANCE IS BEING REQUESTED, AWARE OF ANY CIRCUMSTANCE WHICH MAY RESULT IN A CLAIM? Yes No
 (IF, YES, PROVIDE FULL DETAILS)

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)

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 FORM FOR EACH LOCATION

ADDRESS OF LOCATION

CONTACT NAME: _____ PHONE: _____

35. # OF LICENSED BEDS FOR THIS LOCATION _____ CURRENT OCCUPANCY FOR THIS LOCATION _____

36. BUILDING

PLEASE ANSWER THE FOLLOWING QUESTIONS

(a) - CONSTRUCTION OF BUILDING? _____

(b) - NO. OF STORIES? _____

(c) - YEAR BUILT? _____

(d) - BUILT AS A NURSING HOME/ DWELLING? _____

(e) - IS BUILDING SPRINKLERED? FULLY? Yes No PARTIAL? Yes No

(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 BUILDING _____

(i) -ARE ALL EXITS MONITORED? Yes No

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

AGENT CONTACT INFORMATION

NAME _____
ADDRESS1 _____
ADDRESS2 _____
CIYT/STATE/ZIP _____
PHONE: _____

REQUIREMENTS FOR QUOTE

1. FULLY COMPLETED APPLICATION
2. COPY OF ALL LICENSES 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 ordinary methods, the insurance I am applying for with this application.

APPLICANT NAME _____ TITLE _____

APPLICANT SIGNATURE _____ DATE _____