/ SUPPLEMENTAL APPLICATION

Senior Care & Long-Term Care Supplemental

Assisted living, skilled nursing, memory care, and residential care.

> Please complete this supplement in full and return it with a signed ACORD application. Submit to submissions@hedgespecialty.com or through the Hedge broker portal. Answer every question — incomplete applications delay quoting.

GENERAL INFORMATION

NAMED INSURED / APPLICANT

DBA / TRADE NAME

BROKERAGE / BROKER

AGENCY / AGENT

PROPOSED EFFECTIVE DATE

NEW OR RENEWAL?

POLICY / QUOTE NUMBER

FEIN

ENTITY TYPE (LLC, CORP, ETC.)

YEARS IN BUSINESS

YEARS UNDER CURRENT MGMT

EMPLOYEES (FT / PT)

TYPE OF FACILITY / LEVEL OF CARE

WEBSITE

MAILING & RISK ADDRESS

MAILING ADDRESS

CITY

STATE

ZIP

COUNTY

OF LOCATIONS

PRIMARY RISK / PREMISE ADDRESS (IF DIFFERENT)

CITY

STATE

ZIP

COUNTY

CONTACTS

PRIMARY CONTACT NAME

TITLE

EMAIL

PHONE

AUDIT / INSPECTION CONTACT

INSPECTION PHONE

INSPECTION EMAIL

CURRENT / EXPIRING CARRIER INFORMATION

CURRENT / EXPIRING CARRIER

POLICY NUMBER

ANNUAL PREMIUM $

LIMIT(S) OF INSURANCE

DEDUCTIBLE / SIR

RETROACTIVE DATE (IF ANY)

Is the current carrier offering renewal? ☐ YES ☐ NO

Is the expiring / current coverage written on a claims-made basis? ☐ YES ☐ NO

ORGANIZATION & OWNERSHIP

PROFIT STATUS (FOR-PROFIT / NOT-FOR-PROFIT)

FACILITIES OWNED

FACILITIES TO INSURE

TOTAL LICENSED BEDS / UNITS (ALL FACILITIES)

TOTAL CURRENT CENSUS / RESIDENTS

SYSTEM-WIDE OCCUPANCY %

1. Is any part of the applicant operated, managed, or leased by a management company? (attach org chart) ☐ YES ☐ NO
2. Has the applicant or any associated entity ever had a license suspended, revoked, surrendered, or placed on probation? ☐ YES ☐ NO
3. Has the applicant ever filed for bankruptcy? ☐ YES ☐ NO
4. Does the applicant anticipate any expansion (added beds, new facilities, or new services) within 12 months? ☐ YES ☐ NO
   IF YES, DESCRIBE
5. Any planned merger, acquisition, sale of assets/business, or similar corporate change within 12 months? ☐ YES ☐ NO
   IF YES, DESCRIBE

LEVEL OF CARE OFFERED

Check every level of care and service provided across all locations to be insured.

Levels of care (check all)

- ☐ Independent living (unlicensed)
- ☐ Assisted living
- ☐ Memory care / dementia / Alzheimer's
- ☐ Skilled nursing (SNF)
- ☐ Residential care / RCFE
- ☐ Group home
- ☐ Adult day care
- ☐ Continuing care retirement community (CCRC)
- ☐ Hospice
- ☐ Home care (non-medical / companion)
- ☐ Home health (skilled / medical)
- ☐ Respite care
- ☐ Rehabilitation / therapy
- ☐ Subsidized housing

% INDEPENDENT LIVING

% ASSISTED LIVING

% MEMORY CARE

% SKILLED NURSING

% HOME CARE / HEALTH

FULL DESCRIPTION OF SERVICES / SENIOR SERVICES OFFERED

FACILITY / LOCATION SCHEDULE

List each facility or building location to be insured. Attach a Schedule of Locations if more rows are needed.

Locations

FACILITY NAME	CITY / STATE	LEVEL OF CARE	LICENSED BEDS / UNITS	CURRENT CENSUS	OCCUPANCY %	YEAR BUILT

FACILITY NAME	CITY / STATE	LEVEL OF CARE	LICENSED BEDS / UNITS	CURRENT CENSUS	OCCUPANCY %	YEAR BUILT

FACILITY DETAIL & CENSUS

TOTAL LICENSED BEDS

TOTAL AVAILABLE UNITS

CURRENT OCCUPIED BEDS

AVERAGE DAILY CENSUS

AVERAGE RESIDENT AGE

STORIES

TOTAL SQUARE FOOTAGE

LOCATIONS

Resident age mix (count by band)

UNDER 21

21–54

55–75

75+

Acuity / level-of-care mix (count by band)

INDEPENDENT

ASSISTED

MEMORY CARE

SKILLED / SNF

PHYSICAL PREMISES & LIFE SAFETY

Construction type

- ☐ Fire resistive
- ☐ Frame
- ☐ Brick
- ☐ Masonry non-combustible
- ☐ Other

Sprinklers

- ☐ None
- ☐ Common areas
- ☐ Entire facility

Smoke / heat detectors

- ☐ None
- ☐ Common areas
- ☐ Entire facility

Recreational / amenity facilities

- ☐ Pool
- ☐ Sauna
- ☐ Fitness room
- ☐ Tennis / sport courts
- ☐ Other water feature
- ☐ On-site child daycare
- ☐ None / other

6. Is a centralized fire-alarm system maintained? ☐ YES ☐ NO

7. Are alarms installed on all exit doors? ☐ YES ☐ NO

8. Are pull cords / call buttons provided in resident areas, tested on a documented schedule? ☐ YES ☐ NO

9. Is on-site, full-time maintenance staff employed? ☐ YES ☐ NO

10. Are outside balconies, stairs, fencing, and parking areas inspected and maintained? ☐ YES ☐ NO

11. Is on-site child daycare offered, and if so is it open to the public? ☐ YES ☐ NO

IF YES, DESCRIBE

STAFFING

Provide direct-care headcount and the staff-to-resident ratio actually scheduled on each shift.

ADMINISTRATOR — YRS EXPERIENCE

ADMINISTRATOR — YRS AT FACILITY

DIRECTOR OF NURSING — YRS EXPERIENCE

DON — YRS AT FACILITY

TOTAL DIRECT-CARE STAFF | AGENCY / CONTRACT STAFF % | % NURSING STAFF EMPLOYED > 1 YEAR

Direct-Care Staffing by Discipline & Shift

DISCIPLINE	# FULL TIME	# PART TIME	1ST SHIFT (AVG ON DUTY)	2ND SHIFT	3RD SHIFT
Registered Nurses (RN)					
Licensed Practical / Vocational (LPN/LVN)					
Certified Nursing Assistants (CNA)					
Medication Aides / Techs					
Nurse Practitioners / PA					
Therapists (PT / OT / Speech / Respiratory)					
Home Health Aides / Caregivers					
Companions / Sitters / Homemakers					
Social Workers					
Physicians / Medical Directors					
Other Direct-Care Staff					

RESIDENT-TO-STAFF RATIO — DAY | RATIO — EVENING | RATIO — NIGHT

12. Are certificates of insurance obtained from all independent contractors / 1099 staff? ☐ YES ☐ NO

13. Are professional license / certification statuses verified at hire and on a recurring basis? ☐ YES ☐ NO

14. Is continuing education and documented in-service training provided to staff? ☐ YES ☐ NO

15. Is an employee handbook provided to every employee? ☐ YES ☐ NO

Revenue — Five-Year History

REVENUE	UPCOMING YR (EST.) $	LAST 12 MONTHS $	1 YEAR PRIOR $	2 YEARS PRIOR $	3 YEARS PRIOR $
Resident / Service Revenue					
Ancillary / Medical Equipment Revenue					
Government Reimbursement (Medicare / Medicaid)					
TOTAL					

LICENSING, SURVEY & CITATION HISTORY

STATE LICENSE # | LICENSE TYPE / LEVEL | LICENSE EXPIRATION

DATE OF MOST RECENT SURVEY | # DEFICIENCIES — MOST RECENT SURVEY | # COMPLAINTS — MOST RECENT SURVEY PERIOD

16. Is the applicant licensed in every state in which it operates? ☐ YES ☐ NO

17. Were any survey deficiencies or citations classified as immediate jeopardy, substandard quality of care, or actual harm? ☐ YES ☐ NO

18. Has any facility been subject to a state/CMS plan of correction, civil money penalty, denial of payment, or admissions hold in the past 3 years? ☐ YES ☐ NO

19. Has the facility ever been decertified, downgraded, or placed on a special-focus / watch list? ☐ YES ☐ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

RESIDENT ACUITY & SPECIAL NEEDS

Indicate the resident populations and clinical conditions the facility admits or retains.

20. Are non-ambulatory or wheelchair / bedbound residents admitted or retained? ☐ YES ☐ NO

% OF CENSUS

21. Are bariatric residents admitted, and is appropriate equipment / staffing in place? ☐ YES ☐ NO

% OF CENSUS

22. Are residents requiring two-person or mechanical-lift transfer cared for? ☐ YES ☐ NO

% OF CENSUS

23. Are residents with dementia, Alzheimer's, or wandering/elopement risk cared for? ☐ YES ☐ NO

% OF CENSUS

24. Is there a separate secured / locked memory-care unit? ☐ YES ☐ NO

25. Is a Wanderguard or comparable elopement-prevention system used? ☐ YES ☐ NO

26. Are residents with behavioral, psychiatric, or substance-abuse conditions admitted? ☐ YES ☐ NO

% OF CENSUS

27. Are ventilator-dependent, tracheostomy, dialysis, or other high-acuity residents cared for? ☐ YES ☐ NO

DESCRIBE

28. Are residents receiving skilled nursing services? ☐ YES ☐ NO

% OF CENSUS

29. How many resident elopements have occurred in the past 3 years? ☐ YES ☐ NO

DESCRIBE

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

RESIDENT SCREENING & CARE PROTOCOLS

30. Is a comprehensive nursing / care assessment completed for each resident at admission? ☐ YES ☐ NO

31. Are residents reassessed on a defined, documented schedule and after any change in condition? ☐ YES ☐ NO

32. Are written nursing protocols in place to identify residents at risk for falls, elopement, and nutritional deficiency? ☐ YES ☐ NO

33. Is there a documented system for identifying when a resident must be transferred to a higher level of care? ☐ YES ☐ NO

34. Have any admissions been denied or any residents discharged for acuity in the past year? ☐ YES ☐ NO

DESCRIBE

35. Is a formal, written risk-management / quality-improvement program maintained? ☐ YES ☐ NO

36. Is a formalized resident / family complaint-resolution program in place, with documented follow-up? ☐ YES ☐ NO

37. Is a binding arbitration agreement used in resident admission contracts? ☐ YES ☐ NO

ABUSE & NEGLECT PREVENTION

38. Are criminal background checks completed for all employees prior to hire? ☐ YES ☐ NO

39. Are background and sex-offender-registry checks completed for all residents at admission? ☐ YES ☐ NO

40. Are background and sex-offender-registry checks completed for all volunteers? ☐ YES ☐ NO

41. Is a nurse-aide / caregiver registry and abuse-registry check run on all direct-care staff? ☐ YES ☐ NO

42. Are references verified before any employee or contractor is hired or placed? ☐ YES ☐ NO

43. Is documented abuse / neglect prevention, recognition, and mandatory-reporting training provided to all staff? ☐ YES ☐ NO

44. Is a two-person rule or comparable control enforced for high-risk personal-care tasks? ☐ YES ☐ NO

45. Is there a written zero-tolerance abuse policy with a defined internal reporting and investigation procedure? ☐ YES ☐ NO

46. Are visitors required to sign in, and are entry doors controlled / locked prior to the reception area? ☐ YES ☐ NO

47. Are volunteers permitted to feed or provide hands-on care to residents? ☐ YES ☐ NO

48. Has any allegation of abuse, neglect, exploitation, or molestation been made in the past 5 years? ☐ YES ☐ NO

DESCRIBE

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

MEDICATION MANAGEMENT

49. Does the facility store, administer, or assist with resident medications? ☐ YES ☐ NO

50. Are medications administered or supervised only by licensed nurses or certified medication aides within scope? ☐ YES ☐ NO

51. Is a written medication-management policy maintained, including the five-rights and a double-check procedure? ☐ YES ☐ NO

52. Are controlled substances secured, counted each shift, and reconciled with documented audits? ☐ YES ☐ NO

53. Are medication errors and adverse drug events logged, reviewed, and reported per policy? ☐ YES ☐ NO

54. Is medication packaging / administration outsourced to a contracted pharmacy? ☐ YES ☐ NO

PHARMACY NAME

TRANSPORTATION OF RESIDENTS

55. Does the facility transport residents (owned, hired, or volunteer vehicles)? ☐ YES ☐ NO

DESCRIBE VEHICLES AND FREQUENCY

56. Are all drivers licensed, with MVRs pulled at hire and annually and unacceptable records disqualified? ☐ YES ☐ NO

57. Are wheelchair / lift-equipped vehicles used where required, with residents secured per protocol? ☐ YES ☐ NO

58. If staff or contractors transport residents in personal vehicles, is business-use auto coverage and proof of insurance required? ☐ YES ☐ NO

59. Has the applicant had any claim arising from a vehicle incident while transporting residents? ☐ YES ☐ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

CLINICAL & ANCILLARY SERVICES

Clinical / ancillary services provided

- ☐ Skilled nursing
- ☐ Wound / pressure-ulcer care
- ☐ Infusion / IV therapy
- ☐ Physical / occupational / speech therapy
- ☐ Respiratory therapy / oxygen
- ☐ Pain management
- ☐ Hospice / palliative
- ☐ Pharmacy services
- ☐ Lab / diagnostic services
- ☐ Medical equipment supply / rental
- ☐ Adult day care
- ☐ None

60. Does the applicant provide home health or in-home skilled services? ☐ YES ☐ NO

ANNUAL VISITS

61. Does the applicant operate adult day care? ☐ YES ☐ NO

DAILY ATTENDEES

62. Does the applicant sell, rent, lease, or service medical equipment or supplies? ☐ YES ☐ NO

ANNUAL RECEIPTS $

63. Are any life-sustaining or critical-monitoring devices (ventilators, apnea/SIDS monitors, dialysis) supplied or serviced? ☐ YES ☐ NO

DESCRIBE

64. Are EPA-approved contractors used for disposal of hazardous / medical waste? ☐ YES ☐ NO

COVERAGE REQUESTED

PROFESSIONAL LIABILITY — PER CLAIM / EACH-OCCURRENCE

PROFESSIONAL LIABILITY — ANNUAL AGGREGATE

GENERAL LIABILITY — EACH-OCCURRENCE

GENERAL LIABILITY — AGGREGATE

ABUSE / MOLESTATION SUBLIMIT

CLAIMS-MADE OR OCCURRENCE?

RETROACTIVE DATE (IF CLAIMS-MADE)

DEDUCTIBLE / SIR PER CLAIM

EXCESS / UMBRELLA LIMIT (IF ANY)

REQUESTED EFFECTIVE DATE

65. Is abuse / molestation coverage included on the applicant's current liability policy? ☐ YES ☐ NO

66. Has any insurer ever cancelled, non-renewed, or declined the applicant's PL or GL coverage? (Missouri applicants do not answer) ☐ YES ☐ NO

LOSS HISTORY

List all claims and losses for the past 5 years, regardless of fault or payment. Attach currently-valued (within 90 days) loss runs for all lines.

67. Has the applicant had any claims, losses, or incidents in the past 5 years? ☐ YES ☐ NO

68. Are there any known incidents, facts, or circumstances that may result in a claim? ☐ YES ☐ NO

69. Has any coverage been declined, cancelled, or non-renewed in the past 5 years? ☐ YES ☐ NO

Loss Detail

DATE OF LOSS	LINE / COVERAGE	CLAIMANT	DESCRIPTION	PAID $	RESERVED $	STATUS (O/C)

SENIOR-CARE LOSS DETAIL

70. In the past 5 years, any claim, suit, or demand alleging abuse, neglect, exploitation, or wrongful death? ☐ YES ☐ NO

71. In the past 5 years, any claim or incident involving a resident fall, fracture, or fall-related injury? ☐ YES ☐ NO

72.	In the past 5 years, any claim or citation involving a pressure ulcer / decubitus wound?	☐ YES	☐ NO
73.	In the past 5 years, any claim or incident involving a resident elopement or wandering off premises?	☐ YES	☐ NO
74.	In the past 5 years, any claim involving medication error, wrong-medication, or adverse drug event?	☐ YES	☐ NO
75.	In the past 5 years, any survey deficiency or citation tied to staffing levels, care quality, or resident safety?	☐ YES	☐ NO
76.	Are you aware of any fact, circumstance, or incident that may result in a claim not yet reported on the attached loss runs?	☐ YES	☐ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

APPLICANT STATEMENT & SIGNATURE

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 (in some states a fine and/or imprisonment). The applicant represents that the statements and answers given are true, complete, and accurate to the best of their knowledge and will be relied upon by the insurer. Completion of this application does not bind coverage.

SIGN

SIGNATURE OF APPLICANT

DATE

PRINTED NAME

TITLE

PRODUCER / AGENCY

HEDGE SUBMISSION #