NIF GROUP INC.

SOCIAL SERVICE ORGANIZATION
RESIDENTAL CARE FACILITY SUPPLEMENT

DATE: _____

APPLICANT: _____ PRODUCER: _____

1. Address of location to be insured:

   Street _____

   City _____ State _____ Zip _____

2. Full description of services rendered. **Attach all brochures and promotional material:**

   _____

   _____

3. Is the facility run by an outside management company? ☐ Yes ☐ No

   If Yes, describe the relationship.

   _____

4. How long under present management? _____

5. Date established: _____

6. Indicate estimated: Receipts $ _____ *or* Operating Budget $ _____ Payroll $ _____

7. Is the applicant engaged in, owned by, associated with or involved in any other enterprise?
   ☐ Yes ☐ No

   If Yes,
   describe._____

8. Are you currently licensed for operation by the proper regulatory authorities? ☐ Yes ☐ No

   Attach a copy of the license.

   Is the license conditional?..... ☐ Yes ☐ No

   If Yes, explain _____

   Has license ever been revoked?..... ☐ Yes ☐ No

   If Yes, explain _____

9. Type of facility: Number of beds:

Nursing home for senile or aged _____
Alcohol or Drug treatment _____
Psychiatric outpatient clinic _____
Shelter for runaways, abused spouses, foster children _____
School: (state type of school) _____ _____
Group home for (state type of occupant):
Assisted Living Care Facility _____
Hospice _____

Homeless Shelter Facility _____

Other (specify) _____ _____

10. Total number of beds for all facilities: _____

How many beds are currently occupied: _____
Is facility (check one): ☐ Coed or ☐ Single Sex If Coed, how are patients segregated and monitored?

_____

_____

How many of these patients are:

	Ambulatory	Non-ambulatory
Seriously mentally impaired (i.e. Alzheimer's)	_____	_____
Somewhat mentally impaired (i.e. Senile)	_____	_____
Aged but mentally & physically fully functional	_____	_____
Drug or alcohol rehabilitation patients	_____	_____
Medically disabled requiring ***skilled care***	_____	_____
Medically disabled requiring ***intermediate care***	_____	_____
Other (specify) _____	_____	_____

Number of *Bedridden Patients?* _____

11. What floors are the non-ambulatory patients on? _____
How many patients are on each floor? _____

12. Are restraints used? ……..
Yes ☐ No ☐ If yes, attach copies of restraining procedures that are in force.

13. Other operations:

☐ Counseling # of visits _____
☐ Home care # of visits _____
☐ Day time care # of clients _____
☐ Other (specify) _____

14. If counseling is provided, describe (e.g., group therapy, individual counseling):

_____

15. List other types of services provided (e.g., beautician services, podiatry, dentistry):

_____

Provided for: By staff: _____ By Contractors: _____

16. Ages of patients:

☐ Under 18 ☐ 18 – 35 yrs old ☐ 36 – 50 yrs old ☐ 51 – 63 yrs old ☐ Over 65

Client to Staff Ratio _____

17. Precautions taken to keep track of patients:

Sign out procedures? ☐ Yes ☐ No

Alarms on doors to prevent clients from wandering from the residence? ☐ Yes ☐ No

Other: _____

Are routine bed checks performed? ☐ Yes ☐ No How often?_____Are they Logged? ☐ Yes ☐ No

18. Do any patients work full or part time jobs? ☐ Yes ☐ No

If Yes, what percentage of patients work: _____ % **If Yes.** What type of work:_____

19. Are any medications administered? ☐ Yes ☐ No

If Yes, list any medication administered and in what form given (e.g., Methadone, given in pill form): _____

_____

How are medications secured?_____

20. Is the insured a: ☐ Building Owner ☐ Tenant ☐ General Lessee

Name any other tenants on the premises _____

21. Construction of building: _____Square feet: _____Year built: _____

Number of floors: _____ Any non-ambulatory residents above the 1st floor: _____

Purpose for which the building was originally built: _____

Number of fire extinguishers on premises: _____ Number of fire escapes: _____

Is the building sprinklered? ..... ☐ Yes ☐ No

Are all rooms/halls equipped with smoke detectors?..... ☐ Yes ☐ No

If Yes, ☐ Electronic or ☐ Battery Operated

Fire alarm? ☐ Central Station ☐ Local Alarm ☐ None

Distance to nearest fire station? _____ Distance to nearest fire hydrant? _____

Are handrails provided in the hallways & bathrooms?..... ☐ Yes ☐ No

Temperature of hot water: _____ FAny swimming pools or hot tubs?..... ☐ Yes ☐ No

Is pool completely fenced *with a self locking gate?*..... ☐ Yes ☐ No

Does pool have a Diving Board?..... ☐ Yes ☐ No

Does pool have a Slide?..... ☐ Yes ☐ No

22. Is a written emergency evacuation plan in place?..... ☐ Yes ☐ No

23. Do you have any professionals *under contract*? ..... ☐ Yes ☐ No

Are certificates of insurance required from all professionals under contract?..... ☐ Yes ☐ No

24. Has applicant had previous insurance for this enterprise? ..... ☐ Yes ☐ No

If Yes, please list *current* carrier:

Insurance Company: _____

Limits of Liability: _____ Policy Period: _____ to _____

Premium: $ _____ Coverage: ☐ Occurrence ☐ Claims Made

Limits requested: ☐ 500/500 ☐ 1/1 ☐ 1/2 ☐ 1/3 ☐ Other _____

25. During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? ☐ Yes ☐ No

If Yes, please provide full details (Include description of claim, amounts paid, and reserves)

_____

_____

26. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? ☐ Yes ☐ No

If Yes, please provide full details _____

_____

(In the State of Missouri, the following question does not apply)

27. Has applicant, or any other person for whom coverage is being requested, had any application for liability insurance denied, policy canceled, or non-renewed in the past five (5) years? ☐ Yes ☐ No

If Yes, please provide full details _____

_____

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another (NY: other) person files an application for insurance (NY: 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, (NY: 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) and subjects the person to criminal and civil penalties. In Maine and Virginia, insurance benefits may also be denied.

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

_____

Applicant's signature **Must have signature to quote*

Title _____