MMIC

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LONG-TERM CARE FACILITY LIABILITY PROTECTION RENEWAL APPLICATION

Name of applicant: _____ **Policy number:** _____
(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

   ☐ Address ☐ Phone/Fax Number ☐ Email address ☐ Contact person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

   ☐ Deductible ☐ Limits ☐ Umbrella coverage ☐ Physician coverage ☐ Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

   - Obtaining another operation/entity? ☐ Yes ☐ No
   - Selling or discontinuing any operation/entity? ☐ Yes ☐ No
   - Adding or reducing the number of employees? ☐ Yes ☐ No
   - Adding or reducing the number of locations? ☐ Yes ☐ No
   - Adding or reducing current services? ☐ Yes ☐ No
   - Operating in new states? ☐ Yes ☐ No
   - Entering into any joint ventures or limited partnerships? ☐ Yes ☐ No
   - New construction or renovation projects? ☐ Yes ☐ No

4. Are future operational changes anticipated related to the items listed in question #3? ☐ Yes ☐ No

5. Have there been any changes to the Applicant's additional named insureds? ☐ Yes ☐ No

6. Does the Applicant provide management services to other entities for a fee? ☐ Yes ☐ No

7. Does the Applicant sell or rent any equipment to others? ☐ Yes ☐ No

8. Please specify exposure information based upon the following:

Type	Number	Exposure
Total number of employees	_____	Employees
Vacant land	_____	Acres
Pay parking areas	_____	Revenue
Fitness center open to the public	_____	Revenue
Total annual revenue – most current 12 months	_____	Revenue
Total annual revenue – projected 12 Months	_____	Revenue

***Please attach a listing of locations or a copy of your statement of values.**

B. Professional services

9. Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

☐ **Sub-acute care**	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy and dialysis. **Total licensed beds** _____ **Average occupancy** _____
☐ **Skilled care**	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings. **Total licensed beds** _____ **Average occupancy** _____
☐ **Intermediate care**	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation. **Total licensed beds** _____ **Average occupancy** _____
☐ **Assisted living**	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self-administration and/or assistance with medication. **Total licensed beds** _____ **Average occupancy** _____
☐ **Independent living**	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication. **Number of units** _____ **Total number of residents at full occupancy** _____
☐ **Rehabilitation**	Applicable to facilities offering short-term or long-term rehabilitation services to residents. **Total licensed beds** _____ **Average occupancy** _____
☐ **Dementia or Alzheimer's Care**	Applicable to facilities offering services to residents with dementia or Alzheimer's. **Total licensed beds** _____ **Average occupancy** _____
☐ **Group Home**	Applicable to facilities offering group homes for residents. **Number of homes** _____ **Total number of residents at full occupancy** _____
☐ **Home Health Care**	Applicable to facilities offering home health care services. ☐ **Personal care/companion care** **Number of visits** _____ ☐ **Skilled care** **Number of visits** _____ ☐ **Intravenous therapy** **Number of visits** _____ ☐ **Rehabilitation** **Number of visits** _____ ☐ **Respiration** **Number of visits** _____
☐ **Other**	☐ **Durable medical equipment** **Annual revenue** _____ **Residents only?** ☐ Yes ☐ No ☐ **Pharmacy** **Annual revenue** _____ **Residents only?** ☐ Yes ☐ No ☐ **Vacant** **Number of acres** _____ ☐ **Adult daycare** **Total licensed** _____ **Average participants** _____ ☐ **Child daycare** **Total licensed** _____ **Average participants** _____ ☐ **Other services (describe):**

C. Comments

Section and question	Comments

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If any portion of the policy to be issued is on a claims-made basis, such portions shall apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services or caused by an occurrence or offense occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to MMIC Insurance, Inc. of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: MMIC Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of MMIC Insurance, Inc. to discuss any such information within its committees and boards.

The Applicant hereby certifies the foregoing information is true and correct.

Applicant signature	Title	Date