



## LONG-TERM CARE APPLICATION – NEW BUSINESS

### Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space than is given, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

### Required Documents:

#### In addition to this application, the following information is required:

1. Loss runs, dated within 60 days of submission, covering the past ten years
2. Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. Latest annual financial statements
4. Corporate organizational chart
5. Quality Improvement or Risk Management Plan
6. Most recent state survey reports, licensure reports and accreditation survey reports as applicable
7. Healthcare Umbrella Application if limits above \$1,000,000/\$3,000,000 are being requested
8. Current CMS forms 671 Facility Staffing, 672 Resident Census, CMS 2567 and Quality Indicator Report for the past two six-month periods
9. Roles and responsibilities for volunteer workers as applicable

<b>A. Agent</b>					
Agent Name:		Agency Name:		Address:	
City:	State:	Zip:	Telephone Number:	Fax Number:	
<b>B. Applicant Information</b> (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)					
Legal Name of Applicant:			Website:	Tax ID Number:	
Address (Street, City, State, Zip Code):				County:	
Main Contact Name:		Phone:	Email:		
Administrator Name:		Phone:	Email:		
Risk Manager Name:		Phone:	Email:		
Director of Nursing Name:		Phone:	Email:		
Legal structure (Check all that apply):					
<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> Government <input type="checkbox"/> Other (Specify):					
Accreditations/Certifications (Check all that apply):					
<input type="checkbox"/> JCAHO Accredited <input type="checkbox"/> CCAC Accredited <input type="checkbox"/> CCRC Accredited <input type="checkbox"/> Medicare/Medicaid Certified <input type="checkbox"/> Other (Specify):					
Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund?				Yes	No
<i>If yes, please specify name of fund:</i>					

Describe services provided:

### C. Coverage Requested

1. Policy Period:
2. Limits of Liability (Limits are expressed as per claim/aggregate)  
Professional Liability Limit:       \$1,000,000/\$3,000,000\*       Other: \_\_\_\_\_  
General Liability Limit:           \$1,000,000/\$3,000,000\*       Other: \_\_\_\_\_  
Employee Benefits Liability Limit:       \$1,000,000/\$3,000,000\*       Other: \_\_\_\_\_  
If Employee Benefits Liability coverage is desired, please specify total number of employees: \_\_\_\_\_  
*\*For limits above \$1,000,000/\$3,000,000, please complete a Healthcare Umbrella Application.*
3. Deductibles:     None       Other: \_\_\_\_\_
4. Coverage Type:     Claims-Made     Occurrence  
If claims-made, is retroactive coverage being applied for?    Yes     No    Retroactive Date: \_\_\_\_\_

### D. Current Coverage

5. **Professional Liability Carrier Information:**  
Limit of Coverage:  
Deductible/Retention:  
Policy Period:  
Policy Premium:  
Coverage Type:     Occurrence     Claims-Made  
If Claims-Made, retroactive date is: \_\_\_\_\_
6. **General Liability Carrier Information:**  
Limit of Coverage:  
Deductible/Retention:  
Policy Period:  
Policy Premium:  
Coverage Type:     Occurrence     Claims-Made  
If Claims-Made, retroactive date is: \_\_\_\_\_
7. Has any insurer canceled or declined to issue any coverages applied for under this application?    Yes    No  
*If yes, include an explanation in the Comments Section.*  
*\*Missouri applicants do not need to answer this question.*

### E. General Information

8. Indicate the number of years the Applicant has been:    Operating: \_\_\_\_\_    Owned by present owners: \_\_\_\_\_
9. Is the Applicant managed by a management company?    Yes    No  
*If yes, please answer the following:*
  - a. What is the name of the management company: \_\_\_\_\_
  - b. How many years in place with this management company? \_\_\_\_\_
  - c. Who is the professional liability insurance carrier for the management company? \_\_\_\_\_
  - d. Do you require proof of coverage?    Yes    No
  - e. Describe management services being provided:

10. Within the next 12 months, does the Applicant plan to:
- |   |     |    |
|---|-----|----|
| a. Obtain another operation/entity?       | Yes | No |
| b. Add or reduce the number of employees? | Yes | No |
| c. Add or reduce the number of locations? | Yes | No |
| d. Add or reduce current services?        | Yes | No |
| e. Operate in additional states?          | Yes | No |

*Explain all "yes" answers in the Comments section.*

11. Within the past 5 years, has the Applicant acquired, sold or discontinued any operations? Yes    No

*If yes, use the Comments section to explain.*

12. Provide total annual revenue for the years indicated:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Total Annual Revenue	\$	\$	\$	\$	\$

13. Financial Interest

If none, check here:

List the following details for each medical professional that has a financial interest in the Applicant's business. Use the Comments section if more space is needed.

Name	Profession	Policy No.	Interest (Owner/director/etc)	Patient Care	
				For the Facility	Outside Practice
				%	%
				%	%
				%	%
				%	%
				%	%

14. Subsidiaries and Affiliates

If none, check here:

List all subsidiaries and affiliates of the Applicant.

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims-Made	Coverage Desired? Y/N
		%				
		%				
		%				
		%				

15. Licensing

If none, check here:

List all licenses held by the Applicant including type and expiration dates.


16. Has the Applicant's license been suspended, revoked or placed under probation? Yes    No

*If yes, provide a detailed explanation in the Comments section, including the date the license was reinstated.*

17. Has the Applicant ever filed for bankruptcy? Yes    No

*If yes, please give name of the corporation and details of the arrangement in the Comments section.*

18. Medicare/Medicaid

- a. Is the Applicant approved for Medicare or Medicaid? Yes No
- b. Has the Applicant been denied a Medicare or Medicaid certification? Yes No
- c. Has the Applicant had its Medicare or Medicaid certification limited, suspended or revoked? Yes No  
*If yes, please explain in the Comments section.*
- d. Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? Yes No  
*If yes, please explain in the Comments section.*

19. Inspection/Surveys

- a. When was the last inspection/survey of the Applicant by an outside entity? \_\_\_\_\_
- b. Who performed the inspection? \_\_\_\_\_
- c. Indicate total number of deficiencies: \_\_\_\_\_  
 Total number for: D,E,F,G deficiencies: \_\_\_\_\_ Total number for: F,H,I,J,K,L deficiencies: \_\_\_\_\_
- d. Was a Corrective Action Plan accepted by the state? Yes No
- e. How many patient/family complaints were investigated in the past three (3) years? \_\_\_\_\_
- f. How many complaints were substantiated? \_\_\_\_\_

20. Has the Applicant signed any contractual agreements to provide services to others? Yes No

*If yes, describe the types of services:*

21. Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? Yes No

*If yes, describe the types of services:*

Specify the minimum limits of liability required: \$ \_\_\_\_\_ Proof of coverage verified? Yes No

Does the contract contain an indemnification (hold harmless) clause? Yes No

**F. Professional Services**

**22. 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.**

<input type="checkbox"/> <b>Sub-Acute Care</b>	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. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____
<input type="checkbox"/> <b>Skilled Care</b>	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____
<input type="checkbox"/> <b>Intermediate Care</b>	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____
<input type="checkbox"/> <b>Assisted Living</b>	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self-administration and/or assistance with medication. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____
<input type="checkbox"/> <b>Independent Living</b>	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication. <b>Number of Units</b> _____ <b>Total Number of Residents at Full Occupancy</b> _____
<input type="checkbox"/> <b>Rehabilitation</b>	Applicable to facilities offering short-term or long-term rehabilitation services to residents. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____

<input type="checkbox"/> <b>Dementia or Alzheimer's Care</b>	Applicable to facilities offering services to residents with dementia or Alzheimer's. <b>Total Licensed Beds</b> _____ <b>Average Occupancy</b> _____			
<input type="checkbox"/> <b>Group Home</b>	Applicable to facilities offering group homes for residents. <b>Number of Homes</b> _____ <b>Total Number of Residents at Full Occupancy</b> _____			
<input type="checkbox"/> <b>Home Health Care</b>	Applicable to facilities offering home health care services. <input type="checkbox"/> <b>Personal Care/Companion Care</b> <b>Number of Visits</b> _____ <input type="checkbox"/> <b>Skilled Care</b> <b>Number of Visits</b> _____ <input type="checkbox"/> <b>Intravenous Therapy</b> <b>Number of Visits</b> _____ <input type="checkbox"/> <b>Rehabilitation</b> <b>Number of Visits</b> _____ <input type="checkbox"/> <b>Respiration</b> <b>Number of Visits</b> _____			
<input type="checkbox"/> <b>Other</b>	<input type="checkbox"/> <b>Durable Medical Equipment</b>	<b>Annual Revenue</b> _____	<b>Residents only?</b>	Yes    No
	<input type="checkbox"/> <b>Pharmacy</b>	<b>Annual Revenue</b> _____	<b>Residents only?</b>	Yes    No
	<input type="checkbox"/> <b>Vacant</b>	<b>Number of Acres</b> _____		
	<input type="checkbox"/> <b>Adult Daycare</b>	<b>Total Licensed</b> _____	<b>Average Participants</b>	_____
	<input type="checkbox"/> <b>Child Daycare</b>	<b>Total Licensed</b> _____	<b>Average Participants</b>	_____
	<input type="checkbox"/> <b>Other Services (describe):</b>			

**G. Premises and Operations**

23. List all premises owned, rented, leased, occupied or used by the Applicant. Attach a separate schedule if more space is needed.

Address	Use	Year Built	Constr. Type Number*	Fire Class	Number of Stories	Sprinkler System Y/N	Total Area

\*Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

24. Does each location meet applicable NFPA building codes? Yes    No
25. Does the Applicant have a written emergency evacuation plan? Yes    No  
*If yes, please attach a copy of the plan.*
26. If an inpatient care facility location is more than 15 years old, when was the last qualified inspection of electric, heating and plumbing?
27. List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:
28. Are there any construction projects planned for the next year? Yes    No  
*If yes, provide a description of the project in the Comments section, including estimated cost, duration of the project and if you have purchased a builders' risk policy.*
29. Does the Applicant operate a fitness center? Yes    No Is it open to the public? Yes    No

If yes, what are the hours of operation? \_\_\_\_\_

Is there an attendant on duty during hours of operation? Yes No Annual Revenue: \$ \_\_\_\_\_

30. Complete this section if the Applicant uses a pool. Please indicate if not applicable:  N/A
- a. Is the pool owned by the applicant? Yes No
  - b. Is it open to the public? Yes No
  - c. Is a certified lifeguard present? Yes No
  - d. Is the area secured when the pool is not in use? Yes No
  - e. What is the depth of the pool? \_\_\_\_\_ feet
  - f. Is there an emergency call system in close proximity? Yes No
  - g. Where is the pool located? Inside Outside Other \_\_\_\_\_
  - h. Are employees allowed to access the pool? Yes No
  - i. How is access controlled?

31. Are there other bodies of water present? Yes No  
If yes, describe:

32. Are there saunas and/or hot tubs? Yes No If yes, how many: \_\_\_\_\_  
Is there an attendant on duty? Yes No If yes, how many hours per day? \_\_\_\_\_

33. Is the facility used for activities and services other than by residents? Yes No  
If yes, use the Comments section to explain.

34. Complete this section if there are Independent Living Facilities. Please indicate if not applicable: N/A
- a. Do individual units have cooking appliances (e.g. stove and/or oven)? Yes No
  - b. Is there a daily mechanism to keep track of residents? Yes No  
If yes, explain procedure:
  - c. Are there licensed nursing personnel on staff? Yes No  
What hours are they available? \_\_\_\_\_ What services do they provide? \_\_\_\_\_
  - d. Are there written guidelines in place that stipulate the types of residents able to live within the facility? Yes No  
If yes, how often are residents re-assessed for adherence to the guideline?

**H. Administration and Staff**

35. Medical Director
- a. Is the medical director:  Employed  Contracted  Other (specify):
  - b. What is the name of the medical director?
  - c. What is the length of time with the applicant?
  - d. What is the medical specialty of the medical director?
  - e. How many hours per month, on average, is the medical director on-site at the facility?
  - f. Does the medical director have direct patient contact? Yes No  
If yes, indicate the insurance carrier and limits of liability carried.  
Insurance Carrier: \_\_\_\_\_ Limits of Liability: \_\_\_\_\_
  - g. Is the medical director involved in credentialing facility medical staff? Yes No
  - h. Is the medical director an active participant in the facility's quality improvement program? Yes No
  - i. Is the medical director responsible for hiring and firing? Yes No
  - j. Is the medical director involved with peer review of physicians? Yes No

36. Director of Nursing
- a. Length of time with applicant: \_\_\_\_\_
  - b. Length of time as DON: \_\_\_\_\_
  - c. Professional credentials:  RN  LPN  Other (describe): \_\_\_\_\_

37. Is there a licensed administrator on staff?      Yes      No      *If no, who assumes the administration duties?*

38. Staff – Indicate the number of personnel in each applicable category:

	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physicians						
Dentists						
Chiropractors						
Podiatrists						
Oral Surgeons						
Nurse Practitioners						
Phys Assist/Surgical First						
EMTs/Paramedics						
Occupation Therapists						
Therapists						
RNs/LPNs/LVNs						
Social Workers						
Psychologists						
Lab Technicians						
Optometrists						
Pharmacists						
Estheticians						
Other (describe)						

39. Please indicate staffing by shift:

Category	1 <sup>st</sup> shift	2 <sup>nd</sup> shift	3 <sup>rd</sup> shift	Annual Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Staffing Agency				

40. Is there a licensed nurse for each shift?      Yes      No

41. Is there a physician on site or on call on a 24-hour basis?      Yes      No

42. Are nursing agencies/registries utilized?       Yes      No

*If yes, how many agencies/registries are used: \_\_\_\_\_*

43. Is a complete shift staffed exclusively by temporary staff?      Yes      No

44. Insurance Requirements

Does the Applicant require the following health care professionals to carry professional liability insurance?

*Please explain any "No" answers in the Comments section.*

Physicians      Yes      No      Limits \$ \_\_\_\_\_

Allied Healthcare professionals      Yes      No      Limits \$ \_\_\_\_\_

45. Hiring/Screening Procedures

a. Are hiring/screening procedures in place for all workers providing patient care services?      Yes      No

b. Do the procedures apply to:       Employees       Contractors       Volunteers

c. Please indicate if the following procedures are included in the hiring and screening process:

1) Verification of educational background, including licensure and/or certification?      Yes      No

2) Check for any license suspensions, revocations or any disciplinary actions?      Yes      No

- 3) Check criminal history? Yes No
- 4) Require information regarding medical professional claims history? Yes No
- d. Does the Applicant have a formal/documented orientation program in place? Yes No
- e. Are workers transporting patients? Yes No
- If yes, are driving records (MVRs) verified? Yes No How often? \_\_\_\_\_*

46. Risk Management

- Is the overall responsibility for Quality Improvement/Risk Management designated to one individual? Yes No
- If no, please describe how these functions are monitored:*

**I. Resident Information**

47. Indicate the percentage of residents by age range:

\_\_\_\_\_ < 30      \_\_\_\_\_ = 30-64      \_\_\_\_\_ = 65-74      \_\_\_\_\_ = 75-84      \_\_\_\_\_ = 85-94      \_\_\_\_\_ > 94

48. If any residents are less than 64, please explain:

49. Please indicate the following number of residents on an annual basis for each category of service/type of resident?

Service / Type of Resident	Provided		Number of residents
	Yes	No	
Residents Requiring IV Infusion Therapy	Yes	No	
Residents Requiring Ventilation Therapy	Yes	No	
Residents Requiring Dialysis Services	Yes	No	
Patients Recovering from Bariatric Surgery	Yes	No	
Developmentally Disabled Residents	Yes	No	
Alzheimer's/Dementia Residents	Yes	No	
Residents Requiring Psychiatric Care	Yes	No	
Residents Requiring Chemical Dependency Treatment	<input type="checkbox"/> Yes	No	
Short-Stay Rehabilitation Residents	Yes	No	

50. Does the Applicant have a dedicated/special unit for any of the categories listed above? Yes No
- If yes, please explain:*

51. Are nursing assessment protocols in place to identify residents at risk for the following:

- a. Elopement Yes No
- b. Falls Yes No
- c. Cognitive impairment Yes No
- d. Nutritional deficiency Yes No
- e. Pressure ulcers Yes No

52. During intake assessment, do you screen for registered sex offenders? Yes No
- If yes, do you accept them as residents? Yes No*

53. How many elopements have occurred in the past 3 years? Yes No



54. Do you use elopement preventative devices?      Yes      No

55. Have you had any medicine diversion incidents in the past 5 years?      Yes      No

*If yes, please explain in Comments section.*

**J. Loss Information**

56. Have there been any liability claims or suits made against the Applicant, including any individual or entity proposed for coverage?      Yes      No

*If yes, provide the following information:*

- a. If a current loss summary is available from the present or previous carrier, please attach a copy.
- b. If a summary is not available, attach a separate page showing the following information for each claim:
  - 1) Date of the event and date the claim was reported to the insurance company.
  - 2) Description (cause) of the loss or claim.
  - 3) Location of the loss.
  - 4) Current status (open or closed).
  - 5) Paid amount and current reserve amount.

57. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any claim that may be made in the future? If yes, attach a description of each claim.      Yes      No

58. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any activities that might give rise to a claim or suit in the future?      Yes      No

*If yes, attach a description of each activity. Include any non-billing or non-record transfer-related requests for medical records.*

**K. 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 reimbursing, 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.

**APPLICANT ACKNOWLEDGEMENT:** The Applicant hereby certifies the foregoing information is true and correct and that any and all claims or potential claims have been reported to the current carrier. The Applicant understands that, if granted prior acts coverage by MMIC Insurance, Inc., no insurance will be provided for any claim, suit or potential claim known at the effective date that has or has not been reported to another insurance carrier.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Insurance Guaranty Association Law

**The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.**

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association  
4640 West 77th Street, Suite 342  
Edina, Minnesota 55436  
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.