TDC SPECIALTY UNDERWRITERS, INC.
A member of The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Long Term Care Liability Insurance Application

APPLICATION INSTRUCTIONS

NOTICE: PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE MAY CONTAIN CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

ACCOUNT INFORMATION

1.	Applicant Name	
	Doing Business As	
	Federal Employee ID# (FEIN)	
2.	Mailing Address	Street:
		City: State: Zip:
		County: Website:
3.	Risk Manager or Contact Person	Name/Title:
		Email Address:
		Telephone Number:
4.	Applicant's Legal Structure	☐Individual ☐Corporation ☐ Partnership ☐ Joint Venture ☐LLC
5.	Tax Status	☐For Profit – Private ☐Not For Profit ☐For Profit – Publicly Traded ☐Government Owned
6.	Date Established	
7.	Number of years Applicant has been under present ownership:	

TDC Specialty Underwriters, Inc., in California: dba Insurance City Solutions, License #0L85833

8. Is the Applicant owned by or controlled by another entity? ☐Yes ☐No

If "Yes," please explain:

9. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

a. Merge, acquire or consolidate with another entity? ☐Yes ☐No

b. Enter into any new business activities or services (Including new procedures or products being offered? ☐Yes ☐No

If "Yes," describe the essential terms of such transaction:

10. List below all subsidiaries and direct affiliates, with a description of operations, acquisition/formation date and ownership interest.

Name & Address	Description of Operations	Relationship	Date Acquired	Ownership %

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

11. Does the Applicant own, operate or manage any business or facilities other than operations described in this Application? ☐Yes ☐No

If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role.

OPERATIONS AND ADMINISTRATION

12. Has the Applicant ever been accused of any Medicare or Medicaid fraud or abuse violations, or paid any fines or penalties? ☐Yes ☐No

If "Yes," please provide full details:

13. Does the Applicant have a written evacuation plan at all locations? ☐Yes ☐No

a. Are evacuation plans posted in all parts of the facility? ☐Yes ☐No

b. How often are evacuation / fire drills conducted for each shift? ________

c. Does the staff orientation plan include a review and "walk through" of any disaster plan? ☐Yes ☐No

14. Have any residents ever eloped from your facility(ies)? ☐Yes ☐No

If "Yes," please provide details of each elopement including the location, incident date and outcome.

15. Is smoking permitted;

a. In residents' rooms? ☐Yes ☐No

b. In common areas? ☐Yes ☐No

Provide details of specific rules applicable to resident smoking:

CURRENT AND REQUESTED COVERAGE

16. Requested Effective Date of Coverage:

17. Provide current insurance information:

	Carrier	Policy Period	Limits	Ded/SIR	Retro Date If Occ – type N/A	Premium
Professional Liability						
General Liability						
Excess Liability						

18. Please describe any additional insureds to be included, their insurable interest and requested coverage.

Name & Address	Description of Operations	Interest	Coverage Desired
			☐ PL ☐ GL
			☐ PL ☐ GL
			☐ PL ☐ GL

19. MISSOURI RESIDENTS – DO NOT ANSWER: Has any insurer cancelled or declined to renew Professional or General Liability insurance for the Applicant? ☐Yes ☐No

If "Yes," please provide details:

EXPOSURE DETAILS

20. **Facility Information:** Location # 1

Legal Name of Facility:

Physical Address: Street:

City: State: Zip:

Year built: # of Stories: Total Square Feet:

Does this building meet applicable current NFPA life safety codes? ☐Yes ☐No

Construction Type: ☐Frame ☐Brick ☐Non-Combustible ☐Masonry Non-Combustible ☐Fire Resistive

Areas Protected by Approved Automatic Sprinkler System ☐None ☐Residents Rooms ☐Entire Facility ☐Common Areas ☐Hallways ☐Trash Collection Area

21.

Bed Census	Number of Licensed Beds/Units	Number of Occupied Beds/Units
Skilled Nursing Facility		
Dementia / Alzheimer		
Sub-Acute / Rehabilitation		
Assisted Living		
Independent Living		

22. Other Professional Services ☐None ☐Adult Day Care ☐Home Health Services ☐Other ___________________

Number of Daily Attendees: ______
Number of Annual Visits: ______

TDC Specialty Underwriters, Inc., in California: dba Insurance City Solutions, License #0L85833

23. Resident Age Groups

Age Group	Number of Residents
Age 0-21	
Age 22-50	
Age 51 and Over	

24. Administration and Staff:

	Name	Years Experience	Tenure at Facility	Licensed (Y/N)
Administrator				
DON				
Medical Director				

For additional locations please complete page 7 (Additional Location Supplement)

CLAIMS HISTORY

25. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐Yes ☐No

If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed):

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 25 IS EXCLUDED FROM THE PROPOSED INSURANCE.

26. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance? ☐Yes ☐No

If "Yes," please provide details:

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 26 IS EXCLUDED FROM THE PROPOSED INSURANCE.

REQUIRED INFORMATION

Required Attachments

Please include a current copy of each of the following documents with the application:

☐ Declarations Page from your current policy, showing your policy period, limits of liability, retroactive date, and any exclusions that were applied to your policy

☐ Schedule of Named Insureds and Additional Insureds

☐ Loss runs from all insurance carriers that insured the Applicant for the past six years (if applicable)

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any 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, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARKANSAS, MINNESOTA AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, any insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MISSOURI APPLICANTS: Any person commits a “fraudulent insurance act” if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

PENNSYLVANIA APPLICANTS: 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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO NEW YORK APPLICANTS: 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 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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)			
Insurance Agency			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:
Email Address			

Submitted By (Insurance Agency)			
Insurance Agency Taxpayer ID			
Agent License No. or Surplus Lines No.			
Address	Street:		
	City:	State:	Zip:

NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.

ADDITIONAL LOCATION SUPPLEMENT

1. Location #: _____

Legal Name of Facility:
Physical Address: Street:
City: State: Zip:
Year built: # of Stories: Total Square Feet:

Does this building meet applicable current NFPA life safety codes? ☐Yes ☐No

Construction Type: ☐Frame ☐Brick ☐Non-Combustible ☐Masonry Non-Combustible ☐Fire Resistive

Areas Protected by Approved Automatic Sprinkler System: ☐None ☐Residents Rooms ☐Entire Facility ☐Common Areas ☐Hallways ☐Trash Collection Area

2.

Bed Census	Number of Licensed Beds/Units	Number of Occupied Beds/Units
Skilled Nursing Facility		
Dementia / Alzheimer		
Sub-Acute / Rehabilitation		
Assisted Living		
Independent Living		

3. Other Professional Services ☐None ☐Adult Day Care ☐Home Health Services Number of Daily Attendees: ______ Number of Annual Visits: ______

4. Resident Age Groups

Age Group	Number of Residents
Age 0-21	
Age 22-50	
Age 51 and Over	

5. Administration and Staff:

	Name	Years Experience	Tenure at Facility	Licensed (Y/N)
Administrator				
DON				
Medical Director				

6. Location #: _____

Legal Name of Facility:
Physical Address: Street:
City: State: Zip:
Year built: # of Stories: Total Square Feet:

Does this building meet applicable current NFPA life safety codes? ☐Yes ☐No

Construction Type: ☐Frame ☐Brick ☐Non-Combustible ☐Masonry Non-Combustible ☐Fire Resistive

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Age Group	Number of Residents
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	Name	Years Experience	Tenure at Facility	Licensed (Y/N)
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DON				
Medical Director				