



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 Renewal Questionnaire

ACCOUNT INFORMATION

| | | | |
|--|-------------|--------|------|
| 1. Applicant Name | | | |
| 2. Principal Address (if changed in last 12 months) | Street: | | |
| | City: | State: | Zip: |
| 3. Risk Manager or Contact Person: | Name/Title: | | |
| | Email: | | |
| | Telephone: | | |

EXPOSURE INFORMATION

4. Has the number of licensed beds being insured changed by more than ten percent (10%) in the last twelve (12) months? Yes No

If "Yes" to the above, please complete the exposure schedule below showing the number of skilled, assisted, dementia and independent living beds at each insured location:

| <u>Facility Name</u> | <u>Complete Address</u> | <u>Skilled Nursing Facility Beds</u> | <u>Assisting Living Beds</u> | <u>Dementia Beds</u> | <u>Independent Living Beds</u> |
|----------------------|-------------------------|--------------------------------------|------------------------------|----------------------|--------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Please disclose any information material to this risk that has not otherwise been addressed in this Questionnaire.
 Attach additional sheets if necessary.**

SIGNATURE AND AUTHORIZATION

| | | | |
|--|--------|-------|--|
| Applicant Signature: | | | |
| By (Chairman and/or President-Print Name): | | | |
| | Title: | Date: | |

Note: This questionnaire must be signed by the Chairman or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.