

## Long Term Care Liability Insurance Additional Location Supplement

**THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.**

A separate Long Term Care Liability Insurance Additional Location Supplement must be completed for each additional facility seeking coverage that is not named in the Application.

### ADDITIONAL LOCATION INFORMATION

1. Applicant Name identified in Long Term Care Liability Application: \_\_\_\_\_

Location #: \_\_\_\_\_

2. 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

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

4. Other Professional Services  None  Adult Day Care  Home Health Services  
Number of Daily Attendees: \_\_\_\_\_  
Number of Annual Visits: \_\_\_\_\_

5. Resident Age Groups

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

6. Administration and Staff:

	Name	Years Experience	Tenure at Facility	Licensed (Y/N)
Administrator				<input type="checkbox"/> Yes <input type="checkbox"/> No
DON				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Director				<input type="checkbox"/> Yes <input type="checkbox"/> No

**SIGNATURE AND AUTHORIZATION**

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 Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	