TDC Specialty Underwriters
TDC 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

MEDICAL FACILITIES - GROUP HOME SUPPLEMENTAL APPLICATION

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.

ACCOUNT INFORMATION

1.	Applicant Name (as identified in the Liability Insurance Application for proposed insurance):	
	Doing Business As (DBA):	
	Number of Locations:	
2.	Mailing Address:	
3.	Location Address:	Street:
		City: State: Zip:
		County: Telephone Number:
		Email Address:
4.	Tax Status	☐For Profit ☐Not For Profit
5.	Date Established	
6.	Number of years the Applicant has been under present ownership: _____	
7.	Is the Applicant a:	☐ Building Owner ☐ Tenant ☐ General Lessee
8.	Number of Licensed Beds : _____	
9.	Number of Occupied Beds: _____	
10.	Number of and Age of Residents	____<18 _____ 19-45 _____ 46-64 _____ 65+
11.	Number of male residents:_____	Number of Female residents: _____

FINANCIAL AND EXPOSURE DETAILS

12. Indicate the following as it relates to the Applicant:

	Past 12 Months	Next 12 Months (estimated)
Gross Annual Revenue		
Payroll		

OPERATIONS AND ADMINISTRATION

13. **Resident Census**

	# Ambulatory	# Ambulatory with Assistance	# Non-Ambulatory
Severely /Profoundly Developmentally Disabled			
Mild/Moderately Developmentally Disabled			
Psychotic or Sociopath			
Schizophrenic			
Drug or Alcohol Rehab			
Emotionally Disturbed/Depressed			
Homeless			
Abused/Neglected/Abandoned Children			
Other (specify): _____			

14. Do you admit any residents with the following, and if so, what are the protocols in place for these residents/exposures?:
    a. Residents with a history of sexual tendencies/behaviors ☐Yes ☐No
    b. Residents with a history of violent tendencies/behaviors ☐Yes ☐No
    c. Residents who have been incarcerated? ☐Yes ☐No
    If "Yes," for what acts?
    d. Residents being released from mental institutions/hospitals ☐Yes ☐No

Safety Controls

15. What precautions are taken to keep track of residents?

16. Does the Applicant have sign out procedures? ☐Yes ☐No

17. Are there alarms on doors to prevent residents from wandering from the residence? ☐Yes ☐No

Premises Information

18. Please describe the construction of the building:

19. a. Year built/updated : _____ b. Square Feet : _____ c. Number of floors: _____

20. Age of wiring/update: _____

21. Number of fire extinguishers: _____

22. Number of fire escapes: _____

23. Is the budiling fully sprinklered? ☐Yes ☐No
    If "No," what % is sprinklered? _____%

24. Do all bedrooms/hallways have smoke detectors? ☐Yes ☐No

25. Are all smoke detectors electronic or battery operated? ☐Yes ☐No

26. Does the Applicant's facility have a fire alarm? ☐Yes ☐No
    If "Yes," please indicate type: ☐ Central ☐ Local Distance to the nearest fire station : _____

27. Are handrails provided in hallways and bathrooms? ☐Yes ☐No

28. Are there any firearms on the premises? ☐ N/A ☐Yes ☐No
    If "Yes," please describe type, number and how they are stored:

29. **Staff**

Please indicate number of current staff:

	1st Shift	2nd Shift	3rd Shift
RNs			
LPNs			
Nurse Aides			
Physicians			
Other (specify) : _____			
Phychologists			
Counselors			
Speech Therapists			
Psychiatrists			
Physical Therapists			
General Caregivers			

30. Are Physicians/Psychiatrists/MD's ☐ Employees or ☐ Independent Contractors

31. Do they carry their own Professional Liablity when performing on behalf of the named insured? ☐Yes ☐No

32. Do any residents attend schools/workshops? ☐Yes ☐No

If "Yes," indicate number of residents: _____

33. Do any residents work full or part time? ☐Yes ☐No

If "Yes," indiciate number of residents: _____

State Inspection

34. Date of last State Inspection/Survey: _____

35. Total number of Deficiencies: _____

36. Is a corrective action plan accepted by the State? ☐Yes ☐No

If "Yes," date accepted: ____/_____/_____

36. Indicate the number of complaints investigated by the State in the past two years: _____

37. Indiciate the number of substantiated complaints: _____

38. Have any acts resulted in disciplinary action through federal, state or local governmental agency? ☐Yes ☐No

If "Yes," please provide details:

Please attach complete details about all programs offered.
Provide a copy of your current resume/experience, State License, and State Inspection

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	