



ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY 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.

HEALTHCARE SERVICES GENERAL DISCOVERY QUESTIONNAIRE

THIS IS FOR QUOTATION PURPOSES ONLY – THIS IS NOT A BINDER

PROPOSED EFFECTIVE DATE: _____

General Information

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: () _____ Fax: () _____

Physical Location of Business (if different): _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Detailed description of business activities (specifically, and by location): _____

Is this a new business? Yes No If no, how many years have you been in business? _____

Applicant is: Individual Corporation Partnership Joint Venture

Other (please describe): _____

Annual Payroll: \$ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: () _____

Fax: () _____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
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Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor or related person or entity ever had a claim? Yes No
 Completed Claims and Loss History form attached (REQUIRED)? Yes No
 Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? Yes No

If the standard markets are declining placement, please explain why: _____

2. Desired Insurance

Limit of Liability:

- \$100,000 per accident / \$300,000 aggregate
- \$200,000 per accident / \$300,000 aggregate
- \$250,000 per accident / \$500,000 aggregate
- \$250,000 per accident / \$1,000,000 aggregate

Identify all contracted medical professional services performed for you and the minimum medical professional liability limits required.

Pharmacy \$ _____
 Respiratory Therapy \$ _____
 Physical Therapy \$ _____
 Other \$ _____

Self-Insured Retention (SIR): \$1,000 (Minimum) \$1,500 \$2,500 \$5,000 \$10,000

3. Business Activities

1. The applicant has been:
- a. Licensed or approved by State Board of Health Yes No
 - b. Accredited by JCAHO Yes No

If no, please explain on another sheet of paper.

2. Number of years that this facility has been operating: _____
3. Number of years with the present owner: _____
4. Number of years with the current management: _____
5. Please provide copies of all licenses held by your facility.
6. Has your license been suspended, revoked or placed on probation within the last 5 years: Yes No
7. Type of Service Provided:

a. Nursing:

Total No. of Beds: _____ No. of Beds Currently with Patients: _____
 No. of Beds Occupied on the Average in a 12 mo. Period: _____

b. Convalescent-Intermediate Skilled Care:

Total No. of Beds: _____ No. of Beds Currently with Patients: _____
 No. of Beds Occupied on the Average in a 12 mo. Period: _____

c. Adult Day Care:

No. of Beds Available: _____ No. of Beds Occupied on a Daily Basis: _____

d. Assisted Living Facility:

Total No. of Beds: _____ No. of Beds Currently with Patients: _____

No. of Beds Occupied on the Average in a 12 mo. Period: _____

e. Hospice Terminally Ill Care:

Total No. of Beds: _____ No. of Beds Currently with Patients: _____

No. of Beds Occupied on the Average in a 12 mo. Period: _____

f. Other Patient Care: _____

Total No. of Beds: _____ No. of Beds Currently with Patients: _____

No. of Beds Occupied on the Average in a 12 mo. Period: _____

8. Recreation Facilities:

- None Swimming Pool Exercise/Weight Room Sauna/Hot Tub
 Tennis/Racquetball Other: _____

9. Are the recreational facilities used by anyone other than your residents? Yes No

If yes, describe: _____

10. Patient/Resident Profile:

AGE GROUP	AVERAGE DAILY NUMBER	% NON AMBULATORY
Less than 26		
26-49		
50-65		
Over 65		

11. What is the maximum length of stay for those under the age of 26: _____ days

12. Indicate the name of the Administrator and provide a brief summary of administrative experience: _____

13. Do you employ a medical director? Yes No

If yes, briefly describe the director's medical qualifications. _____

14. Does the medical director also act as the attending physician for any residents? Yes No

If yes, how many: _____

15. If a medical director isn't employed, who is responsible for overseeing the medical services provided?

16. Employee Profile

NAME	AGE	YRS OF	TYPE OF	CERTIFICATIONS	OUTSTANDING
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EXPERIENCE		TRAINING		HELD	COMPLAINTS

17. Give a summary of the procedures you use when hiring a medical professional at your facility. _____

18. If an individual has had a previous medical professional claim, how would it affect your hiring of that person?

19. Do you require evidence of acceptable health for all new patients to your facility? Yes No

20. What security measures are used to control unauthorized entrance to your facility? _____

21. Do you have a written emergency evacuation plan? Yes No

If yes, please include a copy.

22. Do all patients have their own attending physician? Yes No

If no, who performs this role? _____

23. Are written orders from an attending physician required for:

a. All drugs or medicines? Yes No

b. Special dietary requirements? Yes No

c. Any other specific therapy/treatment? Yes No

24. How often are physicians required to update their patients' charts? Every _____ days

25. Is nursing assessment conducted for new patients? Yes No

If yes, does this evaluation include:

a. Mobility limitations? Yes No

b. History of prior injuries? Yes No

c. Required assistance? Yes No

d. Disorientation Yes No

26. Do you require a physician on-site or on-call on a 24 hour basis Yes No

27. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

28. Is smoking permitted in patient rooms? Yes No

If yes, explain the rules applicable to smoking in your facility. _____

29. Are there alarms on exit doors to alert the staff that patients may be leaving the premise without proper authorization? Yes No

If no, how is this controlled? _____

30. The following information is needed for each building used for patient or resident occupancy. If you have more than one building please attach copies of this information for each building.

a. Location Name: _____ Year Built: _____

b. Construction Type: _____ No. of Stories: _____ Fire Protection Class: _____

31. Was this building originally designed for Assisted Living/Residential Care occupancy? Yes No
 If no, what was the original purpose and occupancy: _____

32. Does this building meet applicable 1994 NFPA life safety codes? Yes No

33. Smoke Detectors are located:

- None Entire Facility Common areas Hallways Patient or resident rooms
 Other: _____

34. Areas protected by approved automatic sprinkler system:

- None Entire Facility Common areas Hallways Patient or resident rooms
 Other: _____

35. When was the last time that this building's electric, heating, and plumbing systems were last inspected or updated?

	ELECTRIC	HEATING	PLUMBING
Qualified Inspection			
Replaced or Updated			

36. When was this building last inspected by the:

Local fire authorities: _____ State Department of Health: _____

(If the inspection was completed in the last three years, please include a copy)

37. Are there at least two exits on every floor? Yes No
 38. Are handrails provided in hallways and bathrooms? Yes No
 39. Are bathtubs and showers equipped with non-slip surfaces? Yes No
 40. Are all skilled and intermediate beds equipped with side rails? Yes No
 41. Are you planning any new construction during the next 12 months? Yes No

If yes, please describe: _____

42. Have you had any professional or general liability claims made in the last five years? Yes No

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Discovery Questionnaire, the Applicant for insurance hereby represents and warrants that the information provided in the Discovery Questionnaire, together with all supplemental information and documents provided in conjunction with the Discovery Questionnaire, is true, correct, inclusive of all relevant and material information necessary for the Association to accurately and completely assess the Discovery Questionnaire, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Association can and will rely upon the Discovery Questionnaire and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Discovery Questionnaire and all supplemental information and documents provided in conjunction with the Discovery Questionnaire are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Discovery Questionnaire or the payment of any premium does not obligate the Association or any insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Discovery Questionnaire, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Association, and its agents, to gather any additional information the Association deems necessary to process the Discovery Questionnaire for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Association has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Association in conjunction with consideration of the Discovery Questionnaire.

The Applicant further represents that the Applicant understands and agrees the Association: (i) may present a quote with a sub-limit of liability for certain exposures, (ii) may quote certain coverages with certain activities, events, services, or waivers excluded from the quote, (iii) will rate each quotation in the best interest of each Association member to the extent possible to meet the overall intent of the Association's program of insurance for all members, and (iv) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Association's accounting office receives the required premium payment, and the Applicant signs and returns the appropriate "Acknowledgement and Coverage Contract Receipt" form within 10 days of receiving an insurance coverage contract.

The Applicant agrees that the Association and any party from whom the Association may request information in conjunction with the Discovery Questionnaire may treat the Applicant's facsimile signature on the Discovery Questionnaire as an original signature for all purposes.

IMPORTANT: Each accepted Applicant is provided insurance as a participating member under a Master Group Policy of Insurance issued on behalf of the Health Care and Human Services Insurance Purchasing Group Association of America, Inc., a qualified "Purchasing Group" under the Risk Retention Act of 1986—Public Law 97-45. Master Group Policies have been issued to the Association, formed and governed by the laws, rules, and regulations of the State of Utah, to which members will be added as "Participating Members." The Association's program of insurance is a fully insured plan with an insurer permitted to provide insurance in each Association member's state of residence.

All coverage contract charges and service provider fees are minimum and fully earned as of the effective date of coverage. Membership in the Association is restricted to those whose business or activities are similar with respect to liability to which members are exposed by virtue of any common business, act, product, service, premises, or operations. The Applicant represents that the Applicant understands and agrees: (i) the Applicant's request for the Association to quote or otherwise effect coverage for the Applicant is without undue influence or incentive, (ii) the Applicant is individually procuring any insurance that may be provided as a participant in a Master Group Policy, where the benefits and coverage have already been approved by the Association's Purchasing Group, (iii) any coverage that may be provided will be provided under a Master Coverage Contract has been effected in the State of Utah as the state in which the Purchasing Group is organized and domiciled, and where the Association's Purchasing Group's principal office is located, (iv) all rules and regulations applicable to the individual or self-procurement of insurance will govern any coverage provided, and (v) the Applicant is individually responsible for the direct payment of taxes related to coverage provided in the Applicant's state of residence. Should taxes be made a part of any quotation provided by the Purchasing Group to the Applicant, the Association may, as an accommodation and convenience to the Applicant, collect and remit any tax collected to the tax collection agency in the member's state of residence.

Dated: _____

Applicant:

Signature

Print Name



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APPLICATION FOR MEMBERSHIP

The Health Care and Human Services Insurance Purchasing Group Association of America, Inc., has been formed as a "Purchasing Group" under the Risk Retention Act of 1986 (Public Law 97-45), to offer liability insurance to members of the Association.

To join the Association and participate in the benefits of membership, please complete the application below and return it with your membership fee and annual dues payment. Please make your check payable to the Health Care & Human Services Association, Inc. The initial membership enrollment fee is \$5.00. Annual membership dues are \$75.00. If you have already enrolled in the Association, you do not need to complete this form.

1. Applicant : _____
2. Mailing Address: _____
City: _____ State: _____ Zip: _____
3. Contact Person: _____
4. Day Phone: _____ Evening Phone: _____ Fax Number: _____
5. Type of business conducted: _____
6. How many years have you been in business? _____
7. States of Operation: _____
8. Please list below the name and address of any other association you are currently a member of:

Dated: _____

Applicant:

Signature

Print Name