



NeitClem WHOLESALE INSURANCE BROKERAGE, INC.
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**Residential Care or Skilled Nursing Facility
 Application**

APPLICATION'S INSTRUCTIONS:

1. Answer all questions. If the answer to any question is NONE, please state NONE.
2. Application must be signed and dated by owner, partner or office.
3. PLEASE READ CAREFULLY THE STATEMENT AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT)

1. APPLICANT

- a. Full name of all entities to be Named Insured(s):

- b. Mailing address (no P.O. Box): _____
Location: _____
- c. Phone: _____ d. Contact Person: _____
- e. How long has the applicant owned or operated this facility? _____
How many years of experience current ownership and/or management have: _____
- f. Above is: ? Profit ? Corporation ? Building Owner
 ? Non Profit ? Co-Partnership ? Other ? Tenant
- g. Building Owner if other than name insured: _____
- h. How long has the applicant owned or operated this facility? _____
How many years if experience in this business? _____
- i. Officers and/or General Partners: _____

2. LICENSE (Please attach facilities licenses to operate for all locations)

- a. Licensed number of facility(ies) _____ Expiration Date _____
- b. Name of licensed administrator: _____
Has your license (facility or anyone individual) gone through administrative hearing or has your facility ever been suspended, denied and/or revoked? ? YES ? NO
- c. Do you or did you ever, at any time accept patients outside of your licensing authority? ? YES ? NO
- d. Any other operation or premises not stated in this application? ? YES ? NO
- e. If yes on items b, c, or d. Please provide details (If additional space is needed, continue on a separate sheet and state question number).

3. FACILITY

- | | | |
|----------------------------------|------------------|------------------|
| a. Facility is licensed as | b. Beds Licensed | c. Beds Occupied |
| ? Residential Care for Elderlies | _____ | _____ |

	Electrical	_____	_____	_____
	Roof	_____	_____	_____
	Others _____	_____	_____	_____
e.	Number of Stories	_____	_____	_____
f.	Square footage of building	_____	_____	_____
g.	Number of elevators	_____	_____	_____
h.	How many fire escapes	_____	_____	_____
i.	Does building have circuit breakers?	? YES ? NO	? YES ? NO	? YES ? NO

e. In kitchen, need number of: ___ Burners ___ Ovens ___ Griddles ___ Deep Fryers

f. Sprinklers ? YES ? NO _____% of building
 Areas covered: _____

g. Smoke detectors ? YES ? NO All rooms ? YES ? NO
 Heat detectors ? YES ? NO All rooms ? YES ? NO

h. Central station alarm? ? YES ? NO Type _____
 Doors equipped with door alarms? ? YES ? NO

i. Number of fire extinguishers? _____ Date extinguishers last checked _____

j. Are exit doors equipped with panic hardware? ? YES ? NO

k. Are there any swimming pools, playgrounds, spa, etc. ? YES ? NO
 If yes, is the area fenced? ? YES ? NO

l. Clients sleep above / below ground floor? ? YES ? NO

m. Bath / showers have "No/Slip" surfaces ? YES ? NO

n. Handrails in Hallways and Bathroom? ? YES ? NO

o. Medicine Kept in Locked Cabinet ? YES ? NO

p. Are Medical Records kept for each Client? ? YES ? NO

q. Do clients or Guardians sign informed consent forms for Treatment? ? YES ? NO

r. Emergency Lighting or generator? ? YES ? NO

s. Oxygen or similar gases used? ? YES ? NO

t. Day care or outpatient treatments or classes? ? YES ? NO

u. Do you own or board any animals at your facility? ? YES ? NO

v. Are there neighboring properties with hazardous operations? ? YES ? NO

w. Are there neighboring properties with commercial operations? ? YES ? NO

x. Is facility isolated or inaccessible anytime during the year? ? YES ? NO

y. Any plumbing problems or water damage losses in the last 5 years? ? YES ? NO
 If yes, what was the cause and what has been done to keep them from reoccurring again?

5. EXPOSURES

a. Protection class by location: _____

b. Distance to nearest fire hydrant: _____

c. Distance to nearest fire station: _____

d. Neighboring exposures: Occupancy _____ Distance _____

I declare that the information submitted herein is true to the best of my knowledge and becomes part of my application. I understand that an incorrect or incomplete statement could void my coverage.

Signature of insured: _____ Date & Title _____

Producer Name: _____ Address _____

Telephone Number _____

PLEASE ATTACH A COPY OF THE FACILITY'S LICENSE TO OPERATE