



**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 | _____            | _____            |







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**