Brokered by Omega Insurance Solutions
Em: keith@omega4agents.com
Ph: 866-997-0711

ASSISTED LIVING FACILITY SUPPLEMENTAL

APPLICANT NAME	WEBSITE	DATE

TYPE OF OPERATION (CHECK ONE): ◯ ASSISTED LIVING FACILITY ◯ HOME HEALTH CARE ◯ MEDICAL STAFFING AGENCY

EMPLOYEE PROFILE

OCCUPATION	# FULL TIME	# PART TIME	# AVERAGE ANNUAL PAYROLL
REGISTERED NURSES			$
LICENSED PRACTICAL NURSE			$
CERTIFIED NURSING ASST.			$
HOUSEKEEPING / MAINTENANCE			$
DIETARY			$
OFFICE			$
OTHER DESCRIBE			$

1. DESCRIPTION OF OPERATIONS.

2. DOES THE INSURED ALSO OPERATE A NURSING HOME ◯ OR PROGRESSIVE LIVING HOME? ◯ N/A ◯ | IS THERE AN INTERCHANGE OF LABOR? ◯ YES ◯ NO

3. DOES THE INSURED PERFORM ANY SKILLED NURSING CARE (NOT INCLUDING TAKING BLOOD PRESSURE, TEMPERATURE, DISPENSING MEDICATIONS)? ◯ YES ◯ NO

IF YES, PLEASE DESCRIBE WHAT IS PERFORMED.

4. % OF RESIDENTS THAT ARE AMBULATORY? % WHEELCHAIRS? % REQUIRE ASSISTANCE GETTING IN/OUT OF BED, TUB, ETC? %

5. WHAT % OF RESIDENTS ARE DIAGNOSED WITH ALZHEIMER'S OR OTHER AGING DISEASES THAT AFFECT COGNITIVE MEMORY? %

DO THESE RESIDENTS RESIDE IN ANOTHER SECTION OF THE OPERATION? ◯ YES ◯ NO

6. ANY DRUG/ALCOHOL/ADDICTION COUNSELING OR SERVICES TO JAILS, CORRECTIONAL/DETENTION CENTERS? ◯ YES ◯ NO

7. IN REVIEWING THE LOSS HISTORY OF THE INSURED, IS THERE EVIDENCE OF VIOLENCE TOWARD STAFF OR OTHER RESIDENTS? ◯ YES ◯ NO

8. IS PATIENT LIFTING TRAINING PROVIDED? ◯ YES ◯ NO | 9. DO VEHICLES THAT TRANSPORT PATIENTS USE A LIFTGATE? ◯ YES ◯ NO

10. DOES THE INSURED HAVE A RETURN TO WORK PROGRAM IN PLACE? ◯ YES ◯ NO

11. DOES THE INSURED HAVE TWO YEARS PRIOR COVERAGE? ◯ YES ◯ NO | IS THE INSURED A NEW VENTURE? ◯ YES ◯ NO

IS THE INSURED AN AQUISITION OF AN EXISTING OPERATION? ◯ YES ◯ NO | IS THE INSURED ASSOCIATED WITH A CHURCH? ◯ YES ◯ NO

12. IS THE OCCUPANCY RATE OVER 75%? ◯ YES ◯ NO

13. PERCENTAGE OF RECEIPTS MEDICAID% MEDICARE% PRIVATE PAY%

14. YEARS OF EXPERIENCE ADMINISTRATOR DIRECTOR OF NURSING

15. IF HOME HEALTH CARE ANY "LIVE IN" CARE OR 24 HOUR CARE? ◯ YES ◯ NO | IF YES, HOW MANY HOURS ARE THE SHIFTS?

16. IF HOME HEALTH CARE ARE MVRS OBTAINED? ◯ AT HIRE ◯ ANNUALLY ◯ NOT REQUIRED CRITERIA

17. ARE SERVICES PROVIDED IN CITIES WITH A POPULATION GREATER THAN 200,000? ◯ YES ◯ NO | 18. AREA OF OPERATIONS? MILES

THE APPLICANT WARRANTS AND REPRESENTS TO THE INSURER THAT THE INFORMATION ENTERED IN THIS SUPPLEMENTAL APPLICATION IS TRUE AND CORRECT. THE APPLICANT ACKNOWLEDGES THAT THE INFORMATION PRESENTED HEREIN IS MATERIAL TO THE DECISION OF THE INSURANCE COMPANY TO ISSUE A POLICY, AND THAT THIS ISSUANCE OF A POLICY BY THE INSURER IS IN RELIANCE UPON THE SUFFICIENCY AND ACCURACY OF THE INFORMATION BY THE APPLICANT IN THIS SUPPLEMENTAL APPLICATION.

AUTHORIZED REPRESENTATIVE:

SIGNATURE :	DATE: