Assisted Living Facility Questionnaire

Workers Compensation Supplemental Application

Applicant: _____ _____ Effective Date: _____

Employee Profile

Occupation	# Full Time	# Part Time	Avg Annual Payroll
Registered Nurses	_____	_____	$_____
Lic. Pract Nurses	_____	_____	$_____
Cert Nusrsing Asst	_____	_____	$_____
Housekeeping	_____	_____	$_____
Dietary	_____	_____	$_____
Maintenance	_____	_____	$_____
Office	_____	_____	$_____
Other	_____	_____	$_____
Describe Other Employees	_____		_____

1) Please describe your operations. _____
2) Does the insured also operate a nursing home or progressive living home? _____ If yes, is there an interchange of labor? _____
3) Does the insured perform any skilled nursing care (not including taking blood pressure, temperature, dispensing medications)? _____. If yes, please describe what is performed. _____
4) Percentage of residents that are ambulatory? _____ Percentage of residents using wheelchairs? _____ Percentage or residents requiring assistance getting in/out of bed, tub, etc? _____
5) What percentage of residents suffer from Alzheimer's or other aging diseases that affect the brain? ____ Do these residents reside in another section of the operation? _____
6) In reviewing the loss history of the insured, is there evidence of violence toward staff or other residents? _____
7) Does the insured provide proper training on lifting patients in case of emergency? _____
8) Does the insured have a return to work program in place? _____
9) Does the insured's vehicle have a liftgate? _____
10) A) Does the insured have two years prior coverage? _____
    B) Is the insured a new venture? _____
    C) Is the insured a purchase of an existing operation? _____
    D) Is the insured associated with a church, if they are a new venture? _____
11) Is the occupancy rate over 75%? _____
12) Percentage of receipts:
    Medicaid%_____
    Medicare%_____
    Private Pay%_____

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: _____