183 Leader Heights Road
P.O. Box 2726, York, PA 17405
800.233.1957 | Fax: 717.747.7021
glatfelterhealthcare.com
Return completed application to
submissions@glatfelterhealthcare.com

Glatfelter℠ HEALTHCARE

SENIOR LIVING APPLICATION

In addition to this Application, please submit the following supplemental applications if applicable:

- 5 years of currently valued carrier loss run reports
- State Survey Report, Plan of Correction and Acknowledgement
- Copy of Facility License
- Most recent audited Financial Statement
- Resume of Administrator and Director of Nursing (if at the facility less than three years)

New Business Application is required for first year only.

A pre-filled Renewal Questionnaire will be provided for subsequent renewals.

GENERAL INFORMATION

Date Proposal Needed By: _____ Policy Effective Date: _____

Professional Liability: ☐ Claims-made – Current Retroactive date: _____ ☐ Occurrence

General Liability: ☐ Claims-made – Current Retroactive date: _____ ☐ Occurrence

Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.

☐ Deductible: _____ ☐ No Deductible

Current Carrier: _____ Number of years in operation: _____

Legal Name of Organization: _____

Additional Named Insureds and a brief description of their operations (attach additional schedule as needed):

_____

_____

Address: _____
Street or PO Box City County State Zip Code

Mailing Address: _____
Street or PO Box City County State Zip Code

FEIN: _____ Website: _____

Contact Information:

Primary: _____ _____ _____
Name Phone Email

Inspection: _____ _____ _____
Name Phone Email

Legal Status	☐ Non-profit	☐ For-profit	☐ Governmental
Organization Structure	☐ Corporation ☐ Joint Venture	☐ Partnership ☐ Limited Liability Company	☐ Privately/Individually-owned ☐ Other: _____
Facilities	Total number of facilities owned by the applicant? _____		

Operations

Licensure

Are you required to be licensed in any states in which you operate? ☐ Yes ☐ No

If yes, in what state(s) are you currently licensed? _____

Are any license applications currently pending? ☐ Yes ☐ No

If yes, what state(s) are pending? _____

Has there been any mergers, acquisitions or consolidations within the last 10 years? ☐ Yes ☐ No

If yes, please provide the name(s) of the organization(s) and the date of acquisition:

_____

_____

Has the applicant or any of its subsidiary organizations ever filed for bankruptcy? ☐ Yes ☐ No

Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions: _____

_____

Employee Information

Number of Employees - Full-time: _____ Number of Employees - Part-time: _____

Number of Volunteers: _____

Which of the following background check methods do you use?	Employees	Volunteers (if any)
Social Security number verification:	☐ Yes ☐ No	☐ Yes ☐ No
Criminal background checks:	☐ Yes ☐ No	☐ Yes ☐ No
Residency verification:	☐ Yes ☐ No	☐ Yes ☐ No
Professional licensing verification:	☐ Yes ☐ No	☐ Yes ☐ No
Prior employment:	☐ Yes ☐ No	☐ Yes ☐ No
Driver's license information (MVR): Only required if the employee/volunteer operates a company vehicle or their personal vehicle on the organization's behalf.	☐ Yes ☐ No	☐ Yes ☐ No

Is annual training provided and attendance documented for all employees and volunteers? ☐ Yes ☐ No

If yes, briefly describe your in-service training program: _____

_____

Risk Management and Loss Control

Does your organization have a formal written Quality Assurance/Performance Improvement or Risk Management program? ☐ Yes ☐ No

If yes, name and title of person responsible for program: _____

Do you have an active Safety Committee? ☐ Yes ☐ No

If yes, how often does the Safety Committee meet? _____

Is there a formal safety program? ☐ Yes ☐ No

If yes, does it include the following: (Check all that apply)

☐ Life Safety ☐ Employee Safety ☐ Hazardous materials ☐ Environment

Are nursing assessment protocols in place to identify residents at risk for the following? (Check all that apply)

☐ Elopement ☐ Falls ☐ Skin breakdowns/ulcers ☐ Cognitive impairment ☐ Nutrition deficiency

Are admission, discharge, and transfer criteria established? ☐ Yes ☐ No

Is there a written procedure in place for reporting resident abuse? ☐ Yes ☐ No

Is there a formal grievance procedure in place to address resident/family complaints? ☐ Yes ☐ No

Loss History

In the past 5 years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? ☐ Yes ☐ No
If yes, please explain: _____

Are there any claims, suits, legal proceedings, or investigations against you or your subsidiaries that have not yet been reported to your former insurance carrier? ☐ Yes ☐ No
If yes, please provide details on a separate document.

Is the applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? ☐ Yes ☐ No
If yes, please explain: _____

In the past 5 years, has any insurance carrier cancelled or refused coverage? (Missouri applicants are not required to reply) ☐ Yes ☐ No
If yes, please provide the reason for cancellation: _____

Within the last 3 years has your organization been a part of any civil or criminal litigation or arbitration proceeding? ☐ Yes ☐ No
If yes, please provide details on a separate document.

If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date? ☐ Yes ☐ No

Contracted Services

Do you engage the use of independent contractors to provide any services? ☐ Yes ☐ No
If yes, complete the following questions:
What percentage of revenue is provided by independent contractors? _____ %
Do you require a written contract with hold harmless and indemnification language in your favor? ☐ Yes ☐ No
Do you require independent contractors list you as an additional insured on their liability policy? ☐ Yes ☐ No
Do you require that all independent contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year? ☐ Yes ☐ No

Service			Limit of Liability	Service			Limit of Liability
Physician:	☐ Yes	☐ No	$ _____	Nursing	☐ Yes	☐ No	$ _____
Dental:	☐ Yes	☐ No	$ _____	Mental Health:	☐ Yes	☐ No	$ _____
Pharmaceutical:	☐ Yes	☐ No	$ _____	Physical Therapy:	☐ Yes	☐ No	$ _____
Occupational Therapy:	☐ Yes	☐ No	$ _____	Speech Therapy:	☐ Yes	☐ No	$ _____
Dietary:	☐ Yes	☐ No	$ _____	X-Ray:	☐ Yes	☐ No	$ _____
Medical Records:	☐ Yes	☐ No	$ _____	Laboratory:	☐ Yes	☐ No	$ _____
Recreational Services:	☐ Yes	☐ No	$ _____	Social Services:	☐ Yes	☐ No	$ _____
Barber/Beautician:	☐ Yes	☐ No	$ _____	Transportation:	☐ Yes	☐ No	$ _____
Food:	☐ Yes	☐ No	$ _____	Laundry:	☐ Yes	☐ No	$ _____
Other: _____			$ _____	Other: _____			$ _____

Facility Information

Facility Name: _____

Facility Address: _____
Street City State Zip

The facility is best described as which one of the following:

☐ Skilled nursing facility
☐ Assisted living facility (with or without Independent living)
☐ Independent living ONLY
☐ CCRC (Continuing Care Retirement Community)
☐ Rehabilitation facility
☐ Senior housing apartments: Number of HUD-financed units: _____

Number of years under present ownership: _____

Is this facility managed by a management company? ☐ Yes ☐ No

If yes, name of management company: _____

Number of years managed by this management company: _____

Does this management company manage other facilities? ☐ Yes ☐ No

If yes, name and addresses of other facilities: _____

_____

Date of licensure: _____

Date of last inspection/survey: _____ Date Plan of Correction Accepted: _____

Number of deficiencies: _____

How many resident complaints, if any, were investigated within the last 3 years? _____

If resident complaints were investigated, were any substantiated? ☐ Yes ☐ No

Has this facility had its license suspended/revoked/been placed on probation within the last 5 years? ☐ Yes ☐ No

Has a state or federal agency investigated or fined this facility within the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Name of administrator: _____

Length of time at this facility: _____ years Is administrator a full-time employee? ☐ Yes ☐ No

Is the facility certified for Medicare and Medicaid? ☐ Yes ☐ No

Is the facility CARF-accredited? ☐ Yes ☐ No

Staffing

Who serves as the Director of Nursing? _____

Length of time at this facility: _____ years

Total number of nurse employees: _____

GENERAL STAFFING: Total number of nursing/caregiver (whether employed or independent contractor) positions, by staff category.

Category	1st Shift	2nd Shift	3rd Shift	Turnover Percentage - Prior 12 Months
RN	_____	_____	_____	_____%
LPN/LVN	_____	_____	_____	_____%
CNA/Personal Caregiver	_____	_____	_____	_____%

What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies? _____

If agency nurses are used, is Certificate of Insurance obtained from the agency for professional liability coverage? ☐ Yes ☐ No

Are background checks completed for agency personnel? ☐ Yes ☐ No

Are there regularly scheduled in-service trainings for all employees and agency personnel? ☐ Yes ☐ No

Number of Physicians: Employed: _____ Contracted: _____ Affiliated: _____

Are physicians credentialed by this applicant? ☐ Yes ☐ No

Is a physician on-site or on-call on a 24-hour basis? ☐ Yes ☐ No

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

If yes, how many employees? _____

Health Care Services

This facility offers: (Check all that apply)

- ☐ Skilled nursing (skilled, sub-acute, intermediate care)
- ☐ Assisted living/personal care
- ☐ Short-term rehabilitation services
- ☐ Memory care (Dementia/Alzheimer's)
- ☐ Independent living (no healthcare services offered; residents living independently but may have common dining)
- ☐ Senior housing (residential housing for seniors; no healthcare services; no common dining)

Number of residents being cared for or receiving the following types of services:

IV Infusion therapy _____ Developmentally disabled: _____

Ventilation therapy: _____ Chemical dependency: _____

Traumatic brain injury: _____ Psychiatric care: _____

How many residents are under the age of 55? _____

If any, please explain services provided: _____

If this facility has Independent Living units, check all that apply:

- ☐ Common dining
- ☐ Emergency call buttons or pull chords in each unit
- ☐ Daily mechanism to monitor residents
- ☐ Visitor log

If this facility has Senior Living Apartments:

Is the building HUD-subsidized? ☐ Yes ☐ No If yes, what percent of funding is provided by HUD? _____%

What section of HUD? _____

	Premises # _____	Item # _____	Premises # _____	Item # _____	Premises # _____	Item # _____
Skilled Nursing	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# of Beds						
# of Memory Care Beds						
Total:						
Assisted Living	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# of Beds						
# of Memory Care Beds						
Total:						
Short-term Rehab	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# of Beds						
# of Memory Care Beds						
Total:						
Independent Living	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# of Units						
Senior Apartments	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied
# of Units						

Non-Resident Services

Please indicate if the following services are provided to non-residents: (Check all that apply)

- ☐ Home healthcare; Number of Patient Visits _____
- ☐ Hospice; Number of Patient Days on Service _____
- ☐ Rehabilitation services; Annual Revenue $_____
- ☐ Pharmacy; Revenue from Non-resident Services $_____
- ☐ Adult day care; Average Daily Attendance _____
- ☐ Child day care; Average Daily Attendance _____
- ☐ Meals on Wheels; Annual Revenue $_____
- ☐ Transportation; Annual Revenue $_____

Liability Information

Life Safety and Premises Exposures	In multi-story buildings, are non-ambulatory residents on levels above the first and second floors?	☐ Yes ☐ No
	Is there a documented emergency evacuation plan in effect?	☐ Yes ☐ No
	Are evacuation drills conducted regularly?	☐ Yes ☐ No
	Are emergency call buttons or resident pull chords in each room/unit?	☐ Yes ☐ No
	Is there an exercise/weight room?	☐ Yes ☐ No
	If yes, is it open to the public?	☐ Yes ☐ No
	Is there a swimming pool on the premises?	☐ Yes ☐ No
	Is there a restaurant open to the public on the premises?	☐ Yes ☐ No
	If yes, is alcohol served?	☐ Yes ☐ No
	Are there any other bodies of water present or within 3 miles of the facility?	☐ Yes ☐ No
Site Security	Do you have a documented Safety/Security Plan?	☐ Yes ☐ No
	Is a visitor log maintained?	☐ Yes ☐ No
	What security measures are in place to control unauthorized entrances and exits from the facility? _____	
	Who provides the security for your organization? (Check all that apply) ☐ In-house security team: ☐ Volunteers ☐ Employees ☐ Employed security personnel: ☐ Unarmed ☐ Armed ☐ Contracted security personnel: ☐ Unarmed ☐ Armed	
	Are all internal security team members trained and competent in execution of the plan?	☐ Yes ☐ No
	If security is contracted:	
	Does the contract include appropriate hold-harmless language?	☐ Yes ☐ No
	Is your organization named as an Additional Insured on the firm's liability contract?	☐ Yes ☐ No
	Does the security firm maintain a per-occurrence liability limit of at least $1,000,000?	☐ Yes ☐ No
Elopement Prevention	Are there formal written policies and procedures for elopement prevention?	☐ Yes ☐ No
	Do intital assessments identify residents with potential to wander?	☐ Yes ☐ No
	Are quarterly active live elopement drills conducted?	☐ Yes ☐ No
	Is the facility equipped with electronic monitoring devices? If yes, provide details: _____	☐ Yes ☐ No
	Is documented training conducted for all employees?	☐ Yes ☐ No
	Are all doors alarmed? If no, provide details: _____	☐ Yes ☐ No
	Are all doors equipped with a keypad that uses a code or FOB for entrance and exit? If no, provide details: _____	☐ Yes ☐ No
	Are window restrictors installed on windows?	☐ Yes ☐ No
	How many elopements have occurred in the past 3 years? _____ Provide details on any elopements: _____	

Hired and Non-owned Auto Liability

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No
If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned Auto policy.

Does your organization have positions where driving personal vehicles is a job function essential to the position? ☐ Yes ☐ No

Do you have a policy in place which addresses driving requirements for employees and volunteers? ☐ Yes ☐ No

Does this policy include specific hiring criteria applicable to new drivers who operate their personal vehicles on your behalf? ☐ Yes ☐ No

Does your pre-employment hiring process include driver screening? ☐ Yes ☐ No

Does this process include ordering Motor Vehicle Reports prior to hire? ☐ Yes ☐ No

Does your policy include a process for removing drivers with unsatisfactory driving records from their driving duties? ☐ Yes ☐ No

Does this process include verification of the state's minimum financial responsibility limits? ☐ Yes ☐ No

Does your policy permit patient/client transport in personal vehicles? ☐ Yes ☐ No
If yes, what personal auto liability limits do you require? $_____ / $_____ or $_____ CSL

Does your policy permit use of the patient or client's vehicles? ☐ Yes ☐ No
If yes, is the caregiver required to verify the client maintains auto liability insurance? ☐ Yes ☐ No

Does your organization offer training on safe driving practices? ☐ Yes ☐ No

Sexual Abuse Liability

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No

Retroactive Date: _____ *Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.*

Do you order Criminal Background Checks including Sexual Abuse Registry on the following?
Employees: ☐ Yes ☐ No
Volunteers: ☐ Yes ☐ No
Agency personnel: ☐ Yes ☐ No

Does your organization have a written "zero tolerance" sexual abuse and molestation policy? ☐ Yes ☐ No
If yes, does your written policy include the following?
A zero tolerance statement: ☐ Yes ☐ No
Definition of sexual abuse/molestation: ☐ Yes ☐ No
Reporting procedures with at least two persons to report to internally: ☐ Yes ☐ No
Investigation and follow-up procedures: ☐ Yes ☐ No
Anti-retaliation warning: ☐ Yes ☐ No

Are all employees/volunteers required to acknowledge having read and comprehended the policy? ☐ Yes ☐ No

Is annual training on the policy completed and acknowledged? ☐ Yes ☐ No

Have you ever had any prior incidents, allegations or claims involving sexual abuse? ☐ Yes ☐ No
If yes, please provide details: _____

Employee Benefits Liability

$25,000 each employee/$25,000 aggregate is automatically provided. If you are requesting higher limits, please indicate:

☐ $50,000/$50,000 ☐ $100,000/$100,000 ☐ $250,000/$250,000
☐ $500,000/$500,000 ☐ $750,000/$750,000 ☐ $1,000,000/$1,000,000

Employer's Liability Coverage

If your Workers Compensation coverage does <u>not</u> provide Employer's Liability (ND, OH, WA, WY), do you want Employer's Liability coverage? ☐ Yes ☐ No
If yes, provide total annual payroll: $ _____

	"Bodily Injury" by accident each accident	"Bodily injury" by disease policy limit	"Bodily injury" by disease each "employee" or volunteer
Limits desired:			

Cyber Liability and Privacy Crisis Management Expense

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No

Retroactive Date: _____ *Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.*

Cyber Liability protects you when claims are made against you for monetary damages arising out of an electronic information security event:

	$1,000,000 Each Electronic Information Security Event, subject to $3,000,000 Annual Aggregate
	Privacy Crisis Management Expense reimburses for expenses you incur as a result of a privacy crisis management event first discovered during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements. ☐ $50,000 Each Privacy Event / $50,000 Aggregate (automatically included) ☐ $100,000 Each Privacy Event / $100,000 Aggregate ☐ $250,000 Each Privacy Event / $250,000 Aggregate ☐ $500,000 Each Privacy Event / $500,000 Aggregate **Cyber Extortion Expense** reimburses for expenses you incur as a result of a cyber extortion threat first made against you during the policy period. A $20,000 limit applies to Each Cyber Extortion Threat, subject to the Privacy Crisis Management Expense Aggregate.
	Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks? ☐ Yes ☐ No
	Do you use antivirus software on all desktops, portable computers and mission critical servers? ☐ Yes ☐ No
	Are antivirus applications updated in accordance with the software provide's requirements? ☐ Yes ☐ No How often? _____
	Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access? ☐ Yes ☐ No
	Has your organization suffered a computer attack, such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack in the last 12 months? ☐ Yes ☐ No If yes, please explain: _____
	Do you have a written information security and privacy policy? ☐ Yes ☐ No

REAL & PERSONAL PROPERTY ☐ Yes ☐ No

Complete this section or you may submit a Property ACORD application.

Coverage desired: ☐ Scheduled Property (Non-Blanket) ☐ Blanket Per Premises (Property and Contents) ☐ Policy Blanket

Deductible desired: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ Other: _____

Loss of Income: $250,000 is automatically included. If a higher limit is being requested, please indicate: $ _____	Extra Expense: $250,000 is automatically included. If higher limit is being requested, please indicate: $ _____

CONSTRUCTION CODES

1	Frame	**3**	Non-combustible	**5**	Modified Fire Resistive	**7**	Concrete	**9**	Reinforced Masonry
2	Joisted Masonry	**4**	Masonry Non-combustible	**6**	Fire Resistive	**8**	Steel		

ROOF CODES (0 = Unknown)

Covering	**1** Metal sheathing with exposed fasteners	**3** Built-up roof or single-ply membrane WITH gutters	**5** Concrete/clay tiles	**7** Shingle - 55 mph wind rating	**9** Shingle - 110 mph wind rating
	2 Metal sheathing with CONCEALED fasteners	**4** Built-up roof or single-ply membrane WITHOUT gutters	**6** Wood shakes	**8** Shingle - 55 mph wind rating/Secondary Water Resistance (SWR)	**10** Shingle - 110 mph wind rating/Secondary Water Resistance (SWR)
Geometry	**1** Flat Roof WITH Parapets	**3** Hip Roof with Slope <= 6:12 (26.5º)	**5** Gable Roof with Slope <= 6:12 (26.5º)	**7** Braced Gable Roof with Slope <= 6:12 (26.5º)	
	2 Flat Roof WITHOUT Parapets	**4** Hip Roof with Slope > 6:12 (26.5º)	**6** Gable Roof with Slope > 6:12 (26.5º)	**8** Braced Gable Roof with Slope > 6:12 (26.5º)	
Anchors	**1** Toe Nailing/No Anchorage	**2** Clips	**3** Single Wraps	**4** Double Wraps	**5** Structural

Premises #	Item #	Street Address City / State / Zip / County	Building Occupied as:	Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations. Building	Amount of Insurance Contents	Year Built	# Sq Feet	# of Stories	Protection Class	Construction Code	Sprinkler System Y/N	Vacant Y/N	# of Beds	Date of Last Inspection	Year of Mech System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors	Type of Fire or Other Alarms
		/ /																		
		/ /																		
		/ /																		
		/ /																		

Premises #	Item #	Street Address City / State / Zip / County	Building Occupied as:	Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations.		Year Built	# Sq Feet	# of Stories	Protection Class	Construction Code	Sprinkler System Y/N	Vacant Y/N	# of Beds	Date of Last Inspection	Year of Mech System Updates	Year of Roof Updates	Roof Covering	Roof Geometry	Roof Anchors	Type of Fire or Other Alarms
				Building	Contents															
		/ /																		
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Underwriting Information		
	Were all buildings constructed for their current occupancy? If no, please note original occupancy: _____	☐ Yes ☐ No
	Is the building a converted dwelling?	☐ Yes ☐ No
	Are all resident buildings 100% sprinklered? If no, please provide details: _____	☐ Yes ☐ No
	Is there a facility 'no smoking' policy in effect?	☐ Yes ☐ No
	Are smoking residents supervised and/or in designated area?	☐ Yes ☐ No
	In cooking areas (other than independent living units) is there a fire suppression system?	☐ Yes ☐ No

☐ Mortgagee	Name: _____ Street: _____ _____ City: _____ State: _____ Zip: _____						
Applies to Premises/Item #s:	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___

☐ Mortgagee	Name: _____ Street: _____ _____ City: _____ State: _____ Zip: _____						
Applies to Premises/Item #s:	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___	___ / ___

What Coverages and Limits do you require?			
	Accounts Receivable:	☐ $100,000 (automatically included) ☐ $500,000	☐ $250,000 ☐ $1,000,000
	Debris Removal:	☐ $100,000 (automatically included) ☐ $500,000	☐ $250,000 ☐ $1,000,000
	Outdoor Property:	☐ $150,000 (automatically included)	☐ Increase Limit $_____
	Property in Transit or Off Premises:	☐ $100,000 (automatically included)	☐ $250,000
	Software:	☐ $500,000 (automatically included)	☐ Increase Limit $_____
	Trees, Shrubs, Plants and Lawns	☐ $25,000 (automatically included)	☐ Increase Limit $_____
	Valuable Papers and Records:	☐ $100,000 (automatically included) ☐ $500,000	☐ $250,000 ☐ $1,000,000

What Coverage Options do you want to purchase?			
	Scheduled Fine Arts:	☐ Yes (attach schedule)	☐ No
	Special Property Floater:	☐ Yes (attach schedule)	☐ No
	Equipment Breakdown including: Spoilage:	☐ $100,000 (automatically included) ☐ $500,000	☐ $250,000 ☐ $1,000,000
	Hazardous Substance:	☐ $250,000 (automatically included) ☐ $1,000,000	☐ $500,000
	Expediting Expense:	☐ $100,000 (automatically included) ☐ $500,000	☐ $250,000 ☐ $1,000,000
	Flood Coverage:	☐ Yes Limit $_____ ☐ Include Real Property/BPP/LOI/EE ☐ Include BPP/LOI/EE	☐ No
	Earthquake Coverage:	☐ Yes Limit $_____ ☐ Include Real Property/BPP/LOI/EE ☐ Include BPP/LOI/EE	☐ No

CRIME ☐ Yes ☐ No

Limits Option requested? (Select one of the following)

Limits Option	Employee Theft	Forgery or Alteration	Temporary Increased Limits for Special Events			Computer & Funds Transfer Fraud	Money Orders	Fraudulent Impersonation
			Inside the Premises		Outside the Premises			
			Theft of Money & Securities	Robbery/Safe Burglary				
☐ 1	$10,000	$10,000	$10,000	$5,000	$10,000	$20,000	$10,000	$10,000
☐ 2	$25,000	$25,000	$25,000	$5,000	$25,000	$20,000	$10,000	$10,000
☐ 3	$50,000	$50,000	$50,000	$5,000	$50,000	$50,000	$25,000	$25,000
☐ 4	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000	$100,000
☐ 5	$250,000	$250,000	$250,000	$100,000	$250,000	$250,000	$250,000	$250,000
☐ 6	$400,000	$400,000	$400,000	$100,000	$400,000	$400,000	$250,000	$250,000
☐ 7	$500,000	$500,000	$500,000	$100,000	$500,000	$500,000	$250,000	$250,000
☐ 8	$1,000,000	$1,000,000	$1,000,000	$100,000	$1,000,000	$500,000	$250,000	$250,000
☐ 9	$2,000,000	$1,000,000	$1,000,000	$100,000	$1,000,000	$500,000	$250,000	$250,000

Deductible requested? (Deductibles above $1,000 are only available with Limits Options 5, 6, 7, 8 and 9.)

☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

Indicate what security provisions apply and identify how often:

☐ Audit _____
☐ Bank statements _____
☐ Countersignature _____
☐ Reconciliations _____
☐ Other _____

Temporary Increased Limit for Special Events

Is temporary increased limit requested for inside and outside premises for special events? ☐ Yes ☐ No

Limit Requested	Description of Event	# of days

AUTO ☐ Yes ☐ No

Complete this section or you may submit an Auto ACORD application.

What Coverages and Limits do you desire?	Liability Limit (Combined Single Limit): ☐ $300,000 ☐ $500,000 ☐ $1,000,000
	Uninsured/Underinsured Motorists Limit: _____
	PIP Limit: _____ Med Pay Limit: _____
	Hired and Non-owned Liability coverage desired? ☐ Yes ☐ No

Deductibles:
Comprehensive: ☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000
Collision: ☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

VEHICLE CLASSIFICATION

Private Passenger	Truck – Service	Truck – Retail	Truck – Commercial	Van
Bus	Service/Utility Trailer	Mobile Equipment	Golf Cart	Other

Veh #	Year	Make	Description (Model / Type)	Vehicle Classification	Vans and Buses		Serial Number (VIN)	Cost New ACV	Garaged at Premises #
					Seating Capacity	Radius in Miles			
EX.	**2020**	**Nissan**	**Altima**	**Private Passenger**	**1-5**	**0-50**	**1BAAGCSA9XF082111**	**$24,000**	**1**
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Do you have any Customized vehicles?	Have any vehicles been customized from a previous use? ☐ Yes ☐ No
	If yes, indicate vehicle number(s): _____ _____ _____ _____ _____ _____ Describe: _____

☐ Add'l Insured Lessor ☐ Loss Payee	Name: _____
	Street: _____ _____ City: _____ State: _____ Zip: _____
Applies to Vehicle #'s:	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

☐ Add'l Insured Lessor ☐ Loss Payee	Name: _____
	Street: _____ _____ City: _____ State: _____ Zip: _____
Applies to Vehicle #'s:	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Auto Fleet Management Information				
	Do you pre-screen all drivers before they are permitted to drive your vehicles?	☐ Yes	☐ No	
	Do you have procedures in place to regularly check their Motor Vehicle Records?	☐ Yes	☐ No	
	Do you have specific criteria in place used to evaluate driver acceptability?	☐ Yes	☐ No	
	Do you provide driver training?	☐ Yes	☐ No	
	Do your drivers meet CDL requirements based on the vehicle's passenger capacity?	☐ Yes	☐ No	☐ N/A
	Do you provide non-emergency patient transportation in your owned vehicles?	☐ Yes	☐ No	
	If yes, please describe: _____			
	Do you have a formalized documented vehicle safety program which includes vehicle preventative maintenance and required safety inspections?	☐ Yes	☐ No	
	Do you own or use any 15 passenger vans? If yes:	☐ Yes	☐ No	
	Have vans been modified with dual rear wheels or changed seating capacity?	☐ Yes	☐ No	
	If yes, describe: _____			
	Are van models prior to 2009 equipped with Electronic Stability Controls?	☐ Yes	☐ No	☐ N/A
	Is there a requirement that vans are not overloaded?	☐ Yes	☐ No	
	Is there a requirement that no loads are placed on the roof of the vans?	☐ Yes	☐ No	

EXCESS LIABILITY ☐ Yes ☐ No

What Coverages and Limits do you desire?	
	Limits desired: $ _____ occurrence / $ _____ aggregate
	Note: Underlying liability limits of $1,000,000 are required. All underlying coverage to be scheduled must be provided by the program. Exceptions are permitted for Employer's Liability coverage. For Employer's Liability Coverage insured elsewhere, provide the following: Policy Number: _____ Effective Date: _____ Policy Limits: _____ Carrier Name: _____

OCCUPATIONAL ACCIDENT / BUSINESS TRAVEL ACCIDENT ☐ Yes ☐ No

If your organization is a non-profit organization and coverage is being requested, please **complete the Supplement on our website.**

WRAP-UP INFORMATION

Any significant changes to your organization during the policy year must be reported to Glatfelter Underwriting Services, Inc. to ensure coverage.

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: _____

If you are not licensed as a broker, are you a property/casualty agent? ☐ Yes ☐ No

Producer or CSR (for contact purposes): Name: _____

Email: _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

- Contact's Name: _____
- Contact's Email: _____
- Contact's Direct Phone: _____

FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may subject such person to criminal and civil penalties.

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
California	For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District Of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kansas	Any person who knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance that such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
New York	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Rhode Island	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Vermont	Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
West Virginia	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Your signature below acknowledges that you have read the Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Applicant's signature: _____ **Title**: _____ **Date**: _____

Agent's signature: _____ **Date:** _____

PHARMACY SUPPLEMENT

(Complete only if you operate an in-house pharmacy)

1. Name of Applicant: _____

2. Is Pharmacy operated by insureds employees? ☐ Yes ☐ No
   If no, provide the name of the Third Party Vendor: _____

   Is the Named Insured listed as an additional insured on the Third Party Vendor general and professional liability policies? ☐ Yes ☐ No

   Is there a mutual hold harmless agreement in place? ☐ Yes ☐ No

   If insured is utilizing a third party STOP HERE – No need to proceed with further questions. Coverage should be purchased by third party

3. Are the drugs dispensed to anyone other than the insured's hospice or home health patients? ☐ Yes ☐ No
   If yes, please provide details: _____

4. Are all licensed Pharmacists credentialed by your organization prior to hire? ☐ Yes ☐ No

5. Who has access to the medication stock? _____

6. Describe security measures or alarms that have been installed to safeguard the Pharmacy unit:
   _____
   _____
   _____

7. How is the medication stock stored? _____

8. Describe and list the policies that have been implemented to ensure prescription drugs are stored under appropriate conditions and properly dispensed.
   _____
   _____
   _____

9. Does the Pharmacy operate in compliance with the Controlled Substances Act (CSA)? ☐ Yes ☐ No

10. Is there a Pharmacy Manual on site? ☐ Yes ☐ No

11. Who is responsible for loading the Pyxis and/or other electronic medication dispensing systems?
    _____

12. Who is responsible for the shift counts? _____

13. Who is responsible for the daily counts? _____

14. How are shift counts documented as a Pharmacy CQI to include med errors, near misses, etc.?

_____

_____

_____

15. Are there Pharmacy CQI meetings? ☐ Yes ☐ No

16. Does the Pharmacy store, dispense and dispose of all drugs as required by state & federal regulation? ☐ Yes ☐ No

17. Are drugs delivered to patient's home? ☐ Yes ☐ No

18. If drugs are mailed, is there a delivery confirmation procedure? ☐ Yes ☐ No

19. If mail receipts are utilized, are the receipts being retained for quality assurance? ☐ Yes ☐ No
If yes, how long? _____

20. What is the tracking method of returning expired medication, wasted medication?

_____

_____

_____