TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

# MEDICAL FACILITIES - GROUP HOME SUPPLEMENTAL APPLICATION

**THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.**

## ACCOUNT INFORMATION

| | | |
|---|---|---|
| 1 . | Applicant Name (as identified in the Liability Insurance Application for proposed insurance): | |
| | Doing Business As (DBA): | |
| | Number of Locations: | |
| 2. | Mailing Address: | |
| 3. | Location Address: | Street: |
| | | City: State: Zip: |
| | | County: Telephone Number: |
| | | Email Address: |
| 4. | Tax Status | ☐For Profit ☐Not For Profit |
| 5. | Date Established | |
| 6. | Number of years the Applicant has been under present ownership: ______________________________ | |
| 7. | Is the Applicant a: | ☐ Building Owner ☐ Tenant ☐ General Lessee |
| 8. | Number of Licensed Beds : ____________________________ | |
| 9. | Number of Occupied Beds: ____________________________ | |
| 10. | Number of and Age of Residents | ____<18 _____ 19-45 _____ 46-64 _____ 65+ |
| 11. | Number of male residents:______________________ | Number of Female residents: ________________ |

## FINANCIAL AND EXPOSURE DETAILS

12. Indicate the following as it relates to the Applicant:

| | Past 12 Months | Next 12 Months (estimated) |
|---|---|---|
| Gross Annual Revenue | | |
| Payroll | | |



TDC Specialty Underwriters, Inc., in California: d/b/a Insurance City Solutions, License #0L85833; in New York: d/b/a TDC Specialty Underwriters Services

## OPERATIONS AND ADMINISTRATION

13. **Resident Census**

| | # Ambulatory | # Ambulatory with Assistance | # Non-Ambulatory |
|---|---|---|---|
| Severely /Profoundly Developmentally Disabled | | | |
| Mild/Moderately Developmentally Disabled | | | |
| Psychotic or Sociopath | | | |
| Schizophrenic | | | |
| Drug or Alcohol Rehab | | | |
| Emotionally Disturbed/Depressed | | | |
| Homeless | | | |
| Abused/Neglected/Abandoned Children | | | |
| Other (specify): ___________________________________________ | | | |

14. Do you admit any residents with the following, and if so, what are the protocols in place for these residents/exposures?:
    a. Residents with a history of sexual tendencies/behaviors ☐Yes ☐No
    b. Residents with a history of violent tendencies/behaviors ☐Yes ☐No
    c. Residents who have been incarcerated? ☐Yes ☐No
    If "Yes," for what acts?
    d. Residents being released from mental institutions/hospitals ☐Yes ☐No

**Safety Controls**

15. What precautions are taken to keep track of residents?

16. Does the Applicant have sign out procedures? ☐Yes ☐No

17. Are there alarms on doors to prevent residents from wandering from the residence? ☐Yes ☐No

**Premises Information**

18. Please describe the construction of the building:

19. a. Year built/updated : ___________ b. Square Feet : ___________ c. Number of floors: ________

20. Age of wiring/update: ___________

21. Number of fire extinguishers: ___________

22. Number of fire escapes: ____________

23. Is the budiling fully sprinklered? ☐Yes ☐No

    If "No," what % is sprinklered? ____________%

24. Do all bedrooms/hallways have smoke detectors? ☐Yes ☐No

25. Are all smoke detectors electronic or battery operated? ☐Yes ☐No

26. Does the Applicant's facility have a fire alarm? ☐Yes ☐No

    If "Yes," please indicate type: ☐ Central ☐ Local Distance to the nearest fire station : ________________

27. Are handrails provided in hallways and bathrooms? ☐Yes ☐No

28. Are there any firearms on the premises? ☐ N/A ☐Yes ☐No

    If "Yes," please describe type, number and how they are stored:



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29. **Staff**

Please indicate number of current staff:

| | 1st Shift | 2nd Shift | 3rd Shift |
|---|---|---|---|
| RNs | | | |
| LPNs | | | |
| Nurse Aides | | | |
| Physicians | | | |
| Other (specify) : ______________________________ | | | |
| Phychologists | | | |
| Counselors | | | |
| Speech Therapists | | | |
| Psychiatrists | | | |
| Physical Therapists | | | |
| General Caregivers | | | |

30. Are Physicians/Psychiatrists/MD's ☐ Employees or ☐ Independent Contractors

31. Do they carry their own Professional Liablity when performing on behalf of the named insured? ☐Yes ☐No

32. Do any residents attend schools/workshops? ☐Yes ☐No

    If "Yes," indicate number of residents: _________________

33. Do any residents work full or part time? ☐Yes ☐No

    If "Yes," indiciate number of residents: _________________

**State Inspection**

34. Date of last State Inspection/Survey: ________________________________________

35. Total number of Deficiencies: ______________________________

36. Is a corrective action plan accepted by the State? ☐Yes ☐No

    If "Yes," date accepted: ____/_____/_____

36. Indicate the number of complaints investigated by the State in the past two years: __________________

37. Indiciate the number of substantiated complaints: _________________

38. Have any acts resulted in disciplinary action through federal, state or local governmental agency? ☐Yes ☐No

    If "Yes," please provide details:

**Please attach complete details about all programs offered.**
**Provide a copy of your current resume/experience, State License, and State Inspection**

## SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

| | |
|---|---|
| Applicant Name | |
| By (Authorized Signature) | |
| Name/Title | |
| Date | |