



**LONG-TERM HEALTHCARE RENEWAL APPLICATION**

This is an application form for a CLAIMS MADE policy

**INSTRUCTIONS:**

1. Answer **ALL** questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. Applications must be dated and have two signatures.
3. "Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.
4. PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.

**ADDITIONAL INFORMATION REQUIRED (any missing information will delay the quoting process):**

- Five years of currently valued loss experience reports
- HCFA – 2567 – Statement of Deficiencies and Plan of Correction (Most recent survey data)
- Most recent annual audited financials
- Current Quality Indicator Profile
- Current HCFA 672 Resident Census and Condition of Residents
- State License
- Resumes of Administrator(s) and Director of Nursing (if different from last year)

**SECTION I – APPLICANT’S INFORMATION :**

1. Name: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Website Address (if applicable): www. \_\_\_\_\_
4. Contact Information: (for inspection) \_\_\_\_\_  
Phone Number(s): \_\_\_\_\_
5. In operation \_\_\_\_\_ years Current Ownership \_\_\_\_\_ years Current Management \_\_\_\_\_ years
6. Do you have any other operations/buildings you would like listed as an additional insured on the policy?  
Yes \_\_\_ No\_\_\_ If yes, please attach a list with an explanation of each.



