# Skilled Nursing Facility Insurance Application

Complete all sections. Attach currently valued loss runs (5 years) and a schedule of locations.

## 1 · APPLICANT INFORMATION

| | | |
|---|---|---|
| **NAMED INSURED (EXACT LEGAL NAME)** | | |
| **DBA / FACILITY NAME** | | **FEIN** |
| **MAILING ADDRESS** | | |
| **CONTACT NAME / TITLE** | **PHONE** | **EMAIL** |
| **ENTITY TYPE** | **YEARS IN OPERATION** | **YEARS UNDER CURRENT OWNERSHIP** |
| **STATE LICENSE NUMBER(S)** | | **LICENSE EXPIRATION** |

## 2 · COVERAGE REQUESTED

| | | |
|---|---|---|
| ☐ Property | ☐ General Liability | ☐ Professional Liability |
| ☐ Workers' Compensation | ☐ Employment Practices | ☐ Commercial Auto |
| ☐ Hired & Non-Owned Auto | ☐ Excess / Umbrella | ☐ Crime |
| ☐ Cyber | ☐ Surety / Patient Trust Bond | ☐ Other: _____ |

| | |
|---|---|
| **REQUESTED EFFECTIVE DATE** | **CURRENT EXPIRATION DATE** |
| **CURRENT CARRIER(S)** | **CURRENT ANNUAL PREMIUM** |

## 3 · FACILITY PROFILE — SKILLED NURSING

| | | | |
|---|---|---|---|
| **LICENSED BEDS** | **AVERAGE OCCUPANCY %** | **MEDICARE CERTIFIED (Y/N)** | **MEDICAID CERTIFIED (Y/N)** |
| **ANNUAL GROSS REVENUE** | | **ANNUAL PAYROLL (ALL EMPLOYEES)** | |

| PAYOR MIX: % MEDICARE | % MEDICAID | % PRIVATE / OTHER | % MANAGED CARE |
|---|---|---|---|
| | | | |

### Staffing

| RN FTES | LVN / LPN FTES | CNA FTES | NURSING HOURS PPD |
|---|---|---|---|
| | | | |
| % OF NURSING HOURS FROM STAFFING AGENCIES | | DIRECTOR OF NURSING TENURE (YEARS) | |
| | | | |

### Services and exposures (check all that apply)

| | | |
|---|---|---|
| ☐ Subacute unit | ☐ Ventilator care | ☐ Memory care / secured unit |
| ☐ IV therapy | ☐ Dialysis on site | ☐ Wound care program |
| ☐ In-house therapy | ☐ Contracted therapy | ☐ Bariatric care |

### Most recent state survey

| SURVEY DATE | DEFICIENCIES CITED (#) | ANY G-LEVEL OR ABOVE (Y/N) |
|---|---|---|
| | | |
| CURRENT CMS STAR RATING (OVERALL) | PENDING STATE / CMS ACTIONS (DESCRIBE) | |
| | | |

## 4 · LOSS HISTORY

List all claims and incidents in the past 5 years across all lines, or check: ☐ No losses in the past 5 years

| CLAIMS / INCIDENTS (DATE, LINE OF COVERAGE, DESCRIPTION, AMOUNT PAID OR RESERVED, OPEN OR CLOSED) |
|---|
| |

*Attach currently valued carrier loss runs for the past 5 years for each line of coverage requested.*

## 5 · ATTACHMENTS CHECKLIST

| | | |
|---|---|---|
| ☐ 5-year loss runs | ☐ Schedule of locations | ☐ Statement of values |
| ☐ Current dec pages | ☐ Payroll by class code | ☐ Vehicle schedule (if auto) |

## 6 · SIGNATURE

The undersigned represents that the statements in this application are true and complete to the best of their knowledge, and understands that this application does not bind coverage. Coverage availability, terms, conditions, and pricing are subject to underwriting approval by the insurance carrier.

| APPLICANT SIGNATURE | TITLE | DATE |
|---|---|---|
| | | |

Return the completed application and attachments through the upload page at bedrockglobalins.com or to contact@bedrockglobalins.com · 818-937-1827