Programs of All-Inclusive Care for the Elderly (PACE)

Supplement Questionnaire

Please attach the following to this Supplemental Questionnaire:

- **Copy of License**
- **Copy of Members Enrollment Agreement**
- **5 year company loss runs**
- **Audited financial statement**
- **Brochures**
- **Copy of sample contracts**
- **Evacuation Plan**
- **Resume of The Administrator**

Name ____
Address____
____
Contact____
Title ____
Phone ____
FAX ____
E-Mail ____
Web Site____
Effective Date ______________________________________
Prior Carrier____
Expiring Premium $__________________________________
Claims Made Retroactive Date __________________________
Has any insurance carrier cancelled or refused coverage that is similar to that being applied for in this Supplemental Questionnaire? Yes___________ No_____________
If yes, please explain ____________________________________
How many years has this organization been in business? ___________

General Information

1. For-profit?: __________ Not-for-Profit?:______________
2. Hours of operation: ________________________________
3. Is the facility affiliated with any other organization? Yes_______No_______
   If yes, whom:____
4. Is the facility licensed?: Yes________No_________
   If yes, please provide a copy of the license attached to this Supplemental Application.
5. Number of Members____________________

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Administrator

6. Name of Administrator_____________________________________
7. Length of service at this facility________________ Total Experience__________

Building Information

8a. Is the building 100% Sprinklered.
If not 100%, please list any unprotected areas____________________________
8b. Have the systems been tested by a qualified contractor? Yes ________ No _______
9. Does the building have heat and smoke detectors in all areas? Yes____ No_____
If no, please explain____
10.Are all alarms monitored by a UL approved central station or the responding fire department? Yes____No_________

11. Are meals prepared at the center?___________________________
Is there a fire suppression system if meals are prepared at the center? Yes____No___
Is there a hood and grease filter? Yes____No___
What is the frequency of cleaning?
Do you use an outside contractor for cleaning? Yes____No___
Is the area equipped with an automatic fuel shutoff? Yes____No___
12. Are the meals prepared elsewhere? Yes _______No_______
If yes, by whom?____
13. Total # of fire extinguishers _________
14. Is video surveillance used? Yes ______No________Describe _____________
15. Is the center, including the bathrooms, accessible to residents in a wheelchair?______
16. Is a written evacuation plan in place?_________________
17. How is the building secured? _______________________________
18. Fully describe how are residents signed in and released:_______________________
____

Member Census

19. Age of residents/number:
55 to 65 years old:___________________
> 65 years old:______________________
20. Number of developmentally disabled:_________
21. Number of Alzheimer or dementia residents: _________________________________
Is the center equipped with WanderGuard type device? Yes____No___
22. How are medical emergencies handled?_If additional space is needed for this response, please attach the response to this Supplemental Questionnaire on your letterhead. ___________________________________
23. Number of Physicians _____Employed __Affiliated ___Contracted_____

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24. Number of Physician Assistant____Employed___Affiliated____Contracted____
25. If Affiliated or Contracted, do you require limits of liability comparable to your own? Yes______No______ If No, define the differences in limits______________________
26. Are the Physicians credentialed? Yes _______No_________
    Verification of License________
    Verification of DEA license_______
27. Name of Medical Director_________________________
    Employed __________Contracted ________________
28. Length of service as the Medical Director___________________
29. Does the Medical Director have member contact? Yes _______No________

Staff

30. Provide number of the following who are employed:
    Physicians
    RNs____________________
    LPNs __________________
    CNAs __________________
    Therapists ________________
    Social Workers ____________
    Others_________________
31. Staff to member ratio:____
32. Describe the background checks the facility performs for all employees of the facility:____
33. Describe background verification checks on new employees?
    Work history? Yes____ No________
    Education? Yes _______No_______
    Criminal Record? Yes _____No ________
    Drug Testing? Yes _______No _________
    Motor Vehicle Records? Yes _________No ________
34. Are volunteers used? Yes_________No_________If yes, how do your recruit them?____

Other

35. Are there any pets at the facility? Yes____No___
    Describe__________________________
36. Is there a pool or other recreational equipment? Yes____No___
    Describe________________
37. Are children ever present in the facility? Yes____No___
    Describe____
38. Describe any other operations/ services the facility provides to its residents or community____

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39. **Services Provided**

Service	PACE	Contractor	Name	Insurance Limit
Transportation				
Adult Day Care				
Meals on Wheels				
Physician Care				
Prescription Drugs				
Meals				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Home Health Care				
Dental				
Podiatry				
Optometry				
Medical Equipment				
Acute Care				
Assisted Living				
Skilled Care				
Construction				
Other				

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued. It is agreed that this Application shall be on file with CNA and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy.

I hereby request that my Application for insurance coverage under the provisions of the PACE Program be submitted for consideration to CNA and its affiliates. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to CNA and its affiliates any and all information requested which may relate to insurability under the PACE Program.

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I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE
WARNING – 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For DC residents only: 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.) (For FL residents only: 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.) (For LA residents only: 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.) (For ME residents only: 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.) (For NY residents only: 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.) (For PA residents only: 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.) (For TN and WA residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For VT residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.

Print ______________________________ ______________________________ __________

Application Name Title | Authorized Signature of Applicant | Date