



NATIONAL ASSISTED LIVING
RISK RETENTION GROUP

NALRRG Application

Applicant and Policy Information Application Instructions

The application below is the first step of your application process. Please read the terms at the bottom of the application carefully, you will be required to accept the terms disclosed related to your client.

Fill-out Application and provide electronic signature: The application must be completely filled out to be reviewed by the Company's underwriting committee and to obtain a quote. In addition, all required information asked within the application, if applicable, may require that additional information be submitted to the company upon the request of the Company. This document must be signed (via electronic signature), which will be completed at the end of this form, once the required information is supplied on the application. This is a certification by you, that all of the information is correct to the best of your knowledge.

Obtain your quote: The quote will be generated after the application is complete. You must then print it out and provide to your client.

Submit the Application/Quote: If acceptable, the quote must be submitted to continue the process, by clicking the "Submit" button on the top of the form.

Agent Checklist/Edit to Application: As part of the initial application process, you will be required to obtain required information, which is listed on the Agent's Checklist. Please answer the following

Insured Electronically submit Disclosure Documents: If the insured will be electronically signing the Company Disclosure documents...

Upload Forms

NC Policies: Must obtain information if the insured is a NCALTCF member.

Disclosure Documents

Finance Company

1. Your application for insurance and your agreement to be bound by the terms and conditions of the various documents and agreements posted on this web site through the electronic processes and electronic agents provided herein constitute one or more "transactions" within the meaning of the Washington D.C. Signatures Act (the "Act"). By using the electronic processes and electronic agents provided through this web site, you are (i) agreeing to conduct each transaction by electronic means pursuant to and in accordance with the terms and conditions of the Act, (ii) intending for

each such use to constitute your electronic signature within the meaning of the Act and to signify your intent to be bound by all of the terms and conditions to which such electronic signature relates; and (iii) acknowledging that, subject to the terms and conditions of the various documents and agreements posted on this web site, use of such electronic processes and electronic agents will complete each transaction and create legally valid and binding obligations, enforceable against you in accordance with the terms and conditions of such transaction.

No insurance may be bound until all of the items listed above are complete and approved by the Company.

Fill out the information requested below and click continue to be taken to the location information tab.

Applicant / Operating Company

Applicant / Operating Company: _____

Street Address: _____

Mailing Address (if different from above, include street address/city/state/zip):

City: _____

State: _____ Zip: _____

Phone 1: _____

Phone 2: _____

Fax: _____

Email: _____

Producer: Main Agency: _____

Branch: (For NALRRG Official Use Only)

Producer: _____

Corporate Structure: (Please circle one)

C-Corporation Limited Liability Corporation S-Corporation Sole Proprietor/Partnership

Nature of Corporate Structure: (Please circle one)

Leased Management Company Owner/Operator Other

Policy Term: 12 Months

Limit of Liability: (Please circle one)

\$50,000/\$150,000

\$100,000/\$300,000

**\$1,000,000/\$3,000,000

**Only Available for NC Risks

Owner Information

Owner: _____

Additional Insured

Additional Insured: _____

SSN/Fed ID: _____

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip: _____

Phone 1: _____

Phone 2: _____

Toll Free: _____

Fax: _____

Email: _____

Interest in Policy: (Please circle one)

Loss Payee Mortgagee Lienholder Medical Director Operating Company Building Owner Other

Interest Endorsement Addition:

Notes:

Dwelling and Location Attributes

Location Name: _____

Street: _____

Physical Address: _____

City: _____

State: _____ Zip: _____

License Number: _____

Principal Admin Name: _____

Principal Admin Phone: _____

Principal Admin Email: _____

of Licensed Beds: _____

of Occupied Beds: _____

Independent Living Apartment Units/Administrative Office Buildings/Property Management Buildings/Warehouse or Maintenance Buildings:

of Independent Living Apartment Units: Number of Independent Living Apartment Units _____

Are the Independent Living Apartments Units on the same or adjacent property to the Assisted Living Facility or Group Home Facility? **(Please check the appropriate)**

Same Property

Adjacent Property

Any adjacent separate Administration office buildings? (Circle one) Yes No

of Buildings: _____

*If adjacent, please provide below the address for each such building unit (if applicable)

Any adjacent separate Property Management buildings? (Circle one) Yes No

of Buildings: _____

*If adjacent, please provide below the address for each such building unit (if applicable)

Any adjacent warehouse or maintenance buildings? (Circle one) Yes No

of Buildings: _____

*If adjacent, please provide below the address for each such building unit (if applicable)

of Full Time Employees: _____

Part Time Employees: _____

Legal Name of Organization? _____

Describe Business Operation:

- Assisted Living Facility
- Group Home
- Both

Date Business Operation Started: _____

Number of Years this business has been under the same ownership/administration? _____

Total number of years working experience in ownership, management or operations of an Assisted Living and/or Group Home facility? _____

Proposed Effective Date for Coverage: _____

Previous Coverage _____

Name of Expiring/Previous Insurance Carrier: _____

Policy Number: _____

Policy Period: _____

Retroactive Date: _____

1. Any loss incidents or reported claims in the past five (5) years? (Circle one) Yes No

*If yes, please explain below:

Please provide an attached current valued claim loss run or no loss letter from expiring/previous insurance carrier.

2. Has the Expiring or Previous Coverage been cancelled; declined; or non-renewed in the past three (3) years?

*If yes, please explain below:

7. Does the facility provide care for delinquent youth and other groups with criminal histories?
(Circle One): Yes No
8. Does the facility have the following written policies/plans/programs?
- 8a. Restraint Policy? (Circle One): Yes No
- 8b. Written emergency evacuation plan? (Circle One): Yes No
- 8c. Missing resident policy? (Circle One): Yes No
- 8d. Formal written safety program? (Circle One): Yes No
9. Does the Facility have a history of residents eloping or becoming 'missing' from the facility?
(Circle One): Yes No
10. Are residents held with restraint devices on a regular basis? (Circle One): Yes No
- 10a. What are the reasons for the restraints? (Circle One): Yes No
11. Has the facility ever had any sexual misconduct incidents? (Circle One): Yes No
12. Do residents need 24 hour constant medical care from a professional medical or nursing staff due to the severity of their condition? (Circle One): Yes No
13. Does the Facility have the following monitoring systems?
- 13a. Wander Guard/ Care Track system? (Circle One): Yes No
- 13b. Alarms on external doors? (Circle One): Yes No
- 13c. Secured Perimeter? (Circle One): Yes No
- 13d. Camera Surveillance? (Circle One): Yes No
- 13e. Connected to a central station (ADT, Ackerman, etc.)? (Circle One): Yes No
- 13f. Is the building facility sprinklered? (Circle One): Yes No
- 13g. Are the smoke and fire detectors connected to the monitoring systems?
(Circle One): Yes No
14. Has the Facility ever had an unexplained or unsatisfactorily explained death or injury?
(Circle One): Yes No
15. In respect of the staff that are required to be licensed and registered, has their credentials been verified and kept up to date? (Circle One): Yes No
16. At least one (1) licensed Caregiver (CPN, LPN, Med. Tech) available 24 hours/7 days per week
(Circle One): Yes No

*Based on nursing staff requirements, what is the average working hours per week per facility of residents. _____

17. Is this facility a mixed population of young and elderly residents? **(Circle One):** Yes No

17a. When is the elderly exposed to younger, stronger, possible mentally challenged individuals in terms of possible being physically injured or assaulted (e.g. at mealtimes, morning, afternoon, bedtime, etc.)? Explain.

18. Are fire, eopement, and disaster drills conducted regularly? **(Circle One):** Yes No

18a. What's the date of the last Fire drill? _____

18b. What's the date of the last Development drill? _____

18c. What's the date of the last Disaster drill? _____

19. Pond, lake, or pool on premises? **(Circle One):** Yes No

19a. Is it fenced? **(Circle One):** Yes No

19b. Fence height (ft)? _____

19c. Gate locked when not in use? **(Circle One):** Yes No

19d. Use of pool supervised? **(Circle One):** Yes No

20. Is transportation for residents provided? **(Circle One):** Yes No

20a. Are all the drivers licenses checked to ensure that good driving records exist?
(Circle One): Yes No

21. Are there any other Independent Contractors? **(Circle One):** Yes No

21a. Do they have appropriate liability and/or Workers Compensation Insurance?
(Circle One): Yes No

22. How often are safety meetings held? **(Please circle one below):**

Weekly Monthly Quarterly Semi-Annual Annual

23. Is there at least one currently certified person trained in CPR and First Aid on duty?
(Circle One): Yes No

24. Does the applicant ever admit residents to its facility(ies), or allow residents to remain in its facility(ies), when such residents require a higher level of care than the applicant is permitted by state and/or federal licensing authorities to provide? **(Circle One):** Yes No

Preferred Consideration

- | | | | |
|---|---------------|-----|----|
| 1 Is the building sprinkled? | (Circle One): | Yes | No |
| 2 At least one licensed Caregiver (CNA, LPN, Med. Tech) | (Circle One): | Yes | No |
| 3 Same owner/admin for at least three years? | (Circle One): | Yes | No |

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING THAT (I) YOU HAVE ANSWERED THE QUESTIONS IN THE APPLICATION TO THE BEST OF YOUR ABILITY AND DECLARE, THAT, TO THE BEST OF YOUR KNOWLEDGE, THE STATEMENTS SET FORTH THEREIN ARE TRUE AND CORRECT, AND YOU ARE FURTHER DECLARING THAT THE FACILITY(IES) TO WHICH THIS APPLICATION RELATES IS NOT PROVIDING AND WILL NOT IN THE FUTURE PROVIDE SERVICES TO RESIDENTS

BEYOND THOSE WHICH IT IS SPECIFICALLY LICENSED TO PROVIDE BY THE STATE OR FEDERAL LICENSING AUTHORITIES.

(II) SIGNING THE APPLICATION AND RECORDING YOUR NAME TO THIS 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. (III) YOU FURTHER UNDERSTAND THAT ANY INCORRECT OR INCOMPLETE STATEMENT IN THE APPLICATION COULD VOID PROTECTION SHOULD A POLICY BE ISSUED.

ANY PERSON KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR 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 FRADULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

I FURTHER UNDERSTAND THAT THE PROFESSIONAL AND GENERAL LIABILITY COVERAGE LIMITS ARE CHOSEN AND REFERENCED ABOVE FOR THE PER CLAIM AND AGGREGATE AMOUNTS (WITH A MAXIMUM OF \$1,000,000 FOR PROVIDERS WITH MULTIPLE LOCATIONS) AND THAT ANYTHING ABOVE THIS AMOUNT IS MY RESPONSIBILITY.

Circle One: Agree Do Not Accept

Signer Full Name: _____

Signer Company Title: _____

Signer Company Name: _____

Signer Phone Number: _____

NATIONAL ASSISTED LIVING RISK RETENTION GROUP, INC.
(a Risk Retention Group domiciled in the District of Columbia)

**CERTIFICATION OF RECEIPT AND ACCEPTANCE OF DOCUMENTS
AND FORM SIGNATURE PAGE FOR INFORMATION CIRCULAR,
VOTING AGREEMENT AND PROXY, AND SUBSCRIPTION AGREEMENT**

WHEREAS, the National Assisted Living Risk Retention Group, Inc. (a Risk Retention Group domiciled in the District of Columbia) (the "Corporation") has provided to the undersigned Subscriber, and the Subscriber hereby acknowledges receipt and review of the following documents: (i) the Corporation's Amended and Restated Articles of Incorporation (the "Articles of Incorporation"); (ii) the Corporation's Third Amended and Restated Bylaws (the "Bylaws") and any and all amendments thereto; (iii) that certain Information Circular dated as of May 22, 2013, for the Corporation, including all appendices thereto (the "Information Circular"); (iv) that certain Voting Agreement and Proxy between the Corporation and its shareholders effective as of the date hereof (the "Voting Agreement"); and (v) that certain Subscription Agreement between the Corporation and its shareholders effective as of the date hereof (the "Subscription Agreement") (collectively the documents noted above in sections (iii), (iv) and (v) are referred to herein as the "Investment Documents"); and

WHEREAS, in addition to the above documents, the Corporation has provided to the Subscriber, and the Subscriber hereby acknowledges receipt of, any and all such other documents and information which the Subscriber and its professional advisors have deemed relevant to the Subscriber's decision to purchase shares of stock of the Corporation and which the Subscriber or such advisors have requested from the Corporation. The Subscriber further acknowledges and agrees that the Subscriber has been provided an opportunity to ask questions and receive answers regarding the Investment Documents and terms and conditions of the Subscriber's purchase of shares and the Corporation's business, operations, financial condition, assets, liabilities, prospects and other relevant matters as the Subscriber has deemed necessary or desirable.

NOW, THEREFORE, Subscriber's signature below evidences the Subscriber's review, acceptance and intent to be bound by the Investment Documents. The Subscriber acknowledges that this form signature page is the signature page for each Investment Document and that by attaching a copy of this form signature page to each Investment Document such document will then constitute the fully executed version of such document.

Name of Facility: _____

Subscriber Signature: _____

Title: _____

Phone: _____

Date: _____