

**FOR PROFIT HOUSING AND SERVICES FOR THE AGING  
DIRECTORS' & OFFICERS' LIABILITY INSURANCE**

This is an application for a claims-made policy which, subject to its provisions, applies only to any Claim first made against the Insureds during the Policy Period. No coverage exists for Claims first made after the end of the Policy Period unless, and to the extent, the Extended Reporting Period applies.

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 New York 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 Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

**Section I  
General Information**

1. Name and address of Applicant: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax:( \_\_\_\_\_ ) \_\_\_\_\_  
 Email: \_\_\_\_\_
2. The applicant has continually been in operation since: \_\_\_\_\_
3. Limit of Liability requested: \_\_\_\_\_
4. Applicant is (check all that apply)
- Skilled Nursing Facility       Continuing Care Retirement Community       Services for the Elderly  
 Assisted Living       Senior Housing/ Independent Living Facility       Other \_\_\_\_\_

Number of beds/ units: \_\_\_\_\_

**Section II  
Organizational Information**

1. A. Has the Applicant merged with or acquired any other entity within the last three years? .....  Yes  No  
 If "Yes" please submit details on a separate sheet of paper.
- B. Is the Applicant, including all Subsidiaries, Affiliates and Partnerships, involved in or planning in the next 12 months, any:
1. Bankruptcy, receivership, liquidation or reorganization? .....  Yes  No
2. The closure of one or more plants, places of business or departments with 20 or more Employees .....  Yes  No
3. Any restructuring that affects 10% of the Employees or 20 Employees, whichever is greater, at any one facility of the Applicant .....  Yes  No
4. Mergers, acquisitions, affiliations or joint ventures? .....  Yes  No  
 If "yes", please submit detail on a separate sheet of paper. Please include the status of obtaining Necessary regulatory approvals.
- C. Has the applicant made, in the last 18 months, or does it anticipate making the next 12 months, any new offering of securities or registration of securities, under the Securities Act of 1933 or qualification of securities under Regulations A? (If "Yes" give details and submit prospectus) .....  Yes  No

2. Please list all Subsidiary and Affiliated Corporations and Partnerships to be covered:

Name	Percentage of Ownership	Description of Operations	Corporation		Partnership	
			Non-Profit	For Profit	General	Limited

**Administered by:**



The coverage descriptions above are general in nature and for informational purposes. To see the actual terms of coverage, please refer to the policy. If there is any conflict between the description contained above, and the terms of the policy, the terms of the policy shall control. Aon Association Services, a Division of Affinity Insurance Services, Inc. in CA, MN & OK a Division of AIS Affinity Insurance Agency, Inc. and in NY & NH a Division of AIS Affinity Insurance Agency. CA License #0795465

**Section III**

**Underwriting Information**

**1. Employee information:**

- a. What is the Applicant's current total number of employees including full time, part time, volunteers, loaned and/or leased, temporary or seasonal? \_\_\_\_\_ 1 year ago? \_\_\_\_\_
- b. Of the current total, how many are in the following jurisdictions:  
 \_\_\_ Texas \_\_\_ Florida \_\_\_ New York \_\_\_ California \_\_\_ District of Columbia
- c. Percentage of employee (including full time, part time, volunteers, loaned and/or leased, temporary or seasonal) turnover in the last year? \_\_\_\_\_% (If more than 40%, please provide details).  
 \_\_\_\_\_  
 \_\_\_\_\_

**2a. Does the Applicant have any written guidelines or procedures addressing the following? (check all that apply and provide written explanation for any unchecked items):**

- Discrimination?  Sexual Harassment?  Termination?

**b. Does the Applicant distribute written guidelines, an employee handbook or policies and procedures to all employees?  Yes  No**

**3a. Does the Applicant have any written guidelines or procedures for addressing human resource personnel management issues in the following areas? (check all that apply and provide written explanation for any unchecked items):**

- Hiring/Interviewing?  Disability accommodations?
- Employee at will statements and employee contract disclaimers?  Employment evaluations?
- New employee orientation?  Grievance and discipline policies and procedures?
- Unlawful harassment or discrimination of third parties?

**b. Does the Applicant:**

- Use specific counsel for employment advice? .....  Yes  No
- Conduct employee and supervisor training in any of the areas mentioned in 2(a) and 3(a)? .....  Yes  No
- Perform any drug testing to screen personnel for employment or to promote or monitor employees? .....  Yes  No

**4. Does the Applicant have a full-time Human Resource manager? .....  Yes  No**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

**Section IV**

**Loss/Claim History**

**1. Within the past five years, has any proposed insured reported any claim under a previous policy or received any claim, complaint, suit, inquiry or notice of hearing before or by any federal, state or local investigative agency, regulatory body, judicial body, legislative committee or entity, or any other party? \* .....  Yes  No**

*\*If "yes", please attach detailed information.*

**Section V**

**Prior/Other Insurance Information**

*D&O Liability Insurance:*

Insurer: \_\_\_\_\_ Policy Period: \_\_\_\_\_ to \_\_\_\_\_

Limit: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_

Has any prior carrier indicated an intent to not offer renewal terms? \* .....  Yes  No

Has the extended reporting period been exercised for the previous policy? \* .....  Yes  No

*\*If "yes" to any of the above, please attach detailed information.*

*General Liability Insurance:*

Insurer: \_\_\_\_\_ Policy Period: \_\_\_\_\_ to \_\_\_\_\_

Limit: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Premium: \$ \_\_\_\_\_

**Section VI**

**Warranty**

None of the individuals to be insured under any Coverage Part (the "Insured Persons") is responsible for or has knowledge of any wrongful act or fact, circumstance or situation which (s)he has reason to suppose might result in a future claim, except as follows:

A. Exceptions to the Warranty: Yes  (Please attach details)

B. No Exceptions: Please check here if there are no exceptions to the warranty

1. It is agreed by all concerned that if any of the Insured Persons is responsible for or has knowledge of any wrongful act, fact, circumstance, or situation which (s)he has reason to suppose might result in a future claim, whether or not described above, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance as to (i) such of the insured persons and (ii) the applicant, subsidiaries and the plan if such insured persons are executive officers. The responsibility or knowledge of any individual shall not be imputed to any other individual for the purposes of determining the availability of coverage.
2. It is declared that this application and any materials submitted or required (which shall be maintained on file by the Insurer and be deemed attached as if physically attached to the proposed Policy) are true and are the basis of the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.
3. The undersigned declares that to the best of his/her knowledge the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from all of the Insured Persons to facilitate the proper and accurate completion of this application for the proposed Policy. Signing of this application does not bind the undersigned to purchase the insurance, but it is agreed that this application shall be the basis of the contract should a Policy be issued, and this application will be attached to and become part of such Policy. The undersigned agrees that if after the date of this application and prior to the effective date of any Policy based on this application, any occurrence, event or other circumstance should render any of the information contained in this application inaccurate or incomplete, then the undersigned shall notify the Insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct such information. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.
4. The information requested in this application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a claim or potential claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

The undersigned acknowledges that he or she is aware that Defense Costs, which are subject to the Retention Amounts, reduce and may exhaust the Limit of Liability. The Insurer is not liable for any Loss (which includes Defense Costs) in excess of the Limit of Liability.

***This application must be signed by the Chairman of the Board, Chief Executive Officer or the President.***

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please submit this application, when completed, signed and dated, to:**

Aon Association Services  
1120 20th Street, NW  
Suite 600  
Washington, DC 20036

Phone: 800.865.7307 ext.553 Fax: 202.530.0153

www.agingservices-ins.com