Richmond National Insurance Company
11013 West Broad Street, Suite 300
Glen Allen, VA 23060

SUBSTANCE ABUSE FACILITY SUPPLEMENTAL APPLICATION

I. INSTRUCTIONS

1. Completion of this application neither binds coverage nor guarantees that a quote or policy will be issued.
2. Requested coverage is not automatically provided. Read your quote carefully. The policy, if issued, will determine actual coverage.
3. All questions must be answered. If a question does not apply, write "N/A." If more space is needed, continue a separate sheet, and indicate the question number.
4. Some questions require supporting documentation. Provide all requested documentation with the fully completed application, signed and dated by the owner, partner, or legal officer.
5. Include with your application a completed Richmond National resident census for each location *(for residential/inpatient treatment programs only)*, copies of 5-year carrier loss runs (valued within 45 days), state or county inspection reports, facility license, and any complaint reports/investigations. *All applicable documentation must be received and reviewed prior to binding.*

II. APPLICANT INFORMATION

1. Name of entity to be listed as first Named Insured: _____
   _____
2. Are any other entities or DBAs to be listed as Named Insured? ☐ Yes ☐ No
   a. If yes, list: _____
      _____
   b. Do all entities have common ownership with the first Named Insured in whole or majority? ☐ Yes ☐ No
   c. Do you have other entities or operations for which you are not seeking insurance under this application? ☐ Yes ☐ No
      - If yes, list: _____
        _____
      - Are they insured separately? ☐ Yes ☐ No
   d. Within the next 12 months, do you expect or intend to merge, acquire, or consolidate with another entity? ☐ Yes ☐ No
      - If yes, please clarify: _____
        _____
3. Years in operation under current ownership/management: _____
4. Mailing Address: _____
   City: _____ State: _____ Zip: _____
5. Premise Address: _____
   City: _____ State: _____ Zip: _____
   (If you have multiple premise locations, please attach a complete address list or Excel sheet of locations)
6. Website: _____
   Please attach complete, detailed marketing materials or operations brochures if a website is not available.
7. What is your corporate structure? Please check one:
   ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Sole Proprietorship ☐ Other: _____
8. What is the nature of your enterprise? Please check one:
   ☐ Non-profit ☐ For-profit ☐ Governmental

9. If you are operating an inpatient/residential treatment facility, what is the nature of your operations? Please check one:
   ☐ Residential Facility Owner ☐ Residential Facility Operator ☐ Residential Facility Owner/Operator
   ☐ Other (please describe): _____
   a. If you are the facility OWNER and *not* operator, who is/are the operating entity(ies)? _____
   b. Are they required to carry Professional and General Liability insurance? ☐ Yes ☐ No
   c. If you are the facility OPERATOR and *not* owner, who is the owner of the facility? _____
   d. Do they have Professional and General Liability insurance in place? ☐ Yes ☐ No
   e. Are you required to name them as an Additional Insured on your Professional and/or General Liability insurance? ☐ Yes ☐ No

10. Do you currently have Professional Liability insurance for your operations? ☐ Yes ☐ No
    a. Do you currently have General Liability insurance for your operations? ☐ Yes ☐ No
    b. If yes and your policy is with Richmond National, what is the policy number? _____
    (if your policy is with Richmond National, skip c. through g. below)
    c. What is the policy expiry date? _____
    d. If your current policy is on a Claims Made form, what is the Retroactive Date? _____
    Please attach a copy of your current policy Declarations Page for Date and Limits confirmation if you want to retain this Retroactive Date.
    e. Who is the current insurance carrier? _____
    f. Are they offering renewal? ☐ Yes ☐ No
    g. Expiring premium: _____

11. Name of your Insurance Agent/Agency: _____

12. Name of your Insurance Broker/Brokerage: _____

III. UNDERWRITING INFORMATION

1. Please briefly describe your operations: _____

2. What accreditations and/or state licenses do you currently hold? _____
   a. Has the facility or any of your employees ever faced any limitations, suspensions, revocations, denials, or investigations by a licensing board or regulatory agency regarding their professional license or accreditations? *(If yes, provide copies of all documents and additional details)* ☐ Yes ☐ No

3. What is the name of your current Director of Nursing? _____
   a. How long have they been employed at your facility? _____
   b. How many lifetime years of experience do they have in this position? _____

4. What is the name of your current Facility Administrator? _____
   a. How long have they been employed at your facility? _____
   b. How many lifetime years of experience do they have in this position? _____

5. Please complete the following table regarding your projected and historic revenues:

	Next Year (projected):	**Last Year:**	**1 Year Prior:**	**2 Years Prior:**
Medicare				
Medicaid				
Charitable				
Private Pay				
Total Gross Revenues				

4. Please complete the following table regarding your type(s) of operations:

Services	# Detox Beds	# Other Beds	Length of Stay *(average)*
ASAM RR – Recovery Residence/Sober Living Facility *(no medical services on-site)*			
ASAM 1.0 – Long-term remission monitoring and early intervention *(outpatient services only)*			
ASAM 1.5 – Outpatient therapy *(no medical management services)*			
ASAM 1.7 – Medically Managed Outpatient therapy *(with low-intensity medical management of withdrawal symptoms)*			
ASAM 2.1 – Intensive Outpatient (IOP) therapy *(at least nine hours of structured services weekly and no medical management services)*			
ASAM 2.5 – High-Intensity Outpatient (HIOP) therapy *(partial hospitalization, or at least twenty hours of structured services weekly, and no medical management services)*			
ASAM 2.7 – Medically Managed Intensive Outpatient therapy *(IOP or HIOP with medical management of withdrawal symptoms)*			
ASAM 3.1 – Clinically Managed Low-Intensity Residential services *(24-hour structured care with a minimum of 9 hours clinical services weekly with no or very low-intensity medical management of withdrawal symptoms*)			
ASAM 3.5 – Clinically Managed High-Intensity Residential services *(24-hour structured care with 24-hour clinical therapeutic support, may have non-critical medical management of withdrawal symptoms*)			
ASAM 3.7 – Medically Managed Residential services *(24-hour nursing care with physician oversight with medical management of withdrawal symptoms and/or patients with significant medical or psychiatric needs)*			
ASAM 4 – Medically Managed Inpatient services *(24-hour hospital-level medical care with daily physician care and intensive management of withdrawal symptoms and/or patients with severe medical or psychiatric needs or co-occurring disorders)*			
Non-Substance Addiction services (gambling, sexual compulsion, etc.)			
Peer-Led Group Therapy services (AA, NA, etc.)			
Other Psychiatric Outpatient services *(please describe)*: _____			
Other Psychiatric Inpatient services *(please describe)*: _____			
Other (please describe): _____ _____			
Annual number of residents in each age range *(average)*	_____ Under 18 _____ 18-54 _____ 55-65 _____ 66+	_____ Under 18 _____ 18-54 _____ 55-65 _____ 66+	

5. Do you treat minors (under age 18)? ☐ Yes ☐ No
   a. If yes, what is the youngest patient age you will accept? _____
   b. How are minors separated from adult patients? _____

6. Do you perform any rapid detox/detox under anesthesia? ☐ Yes ☐ No

7. Do you prescribe or administer Buprenorphine, Suboxone, or Methadone? ☐ Yes ☐ No
   a. If yes, is all administration short-term and under the observation or attendance of a physician or registered nurse? ☐ Yes ☐ No
   b. Do you allow any take-home of Buprenorphine, Suboxone, or Methadone? ☐ Yes ☐ No

8. Do you offer any telehealth/virtual counseling services? ☐ Yes ☐ No
   a. If yes, are these services for existing in-person patients only? ☐ Yes ☐ No

9. Are all new patients/residents tested for drugs and alcohol at admission? ☐ Yes ☐ No
   a. Are all patients/residents given a full physical/bloodwork within 24 hours of admission? ☐ Yes ☐ No
   b. Are patient/resident personal belongings examined for drugs or alcohol and weapons before being allowed into the facility? ☐ Yes ☐ No
   c. If patients/residents are permitted to come and go from the facility unsupervised, are they immediately tested for drugs and alcohol upon their return? ☐ Yes ☐ No
   d. Are patients/residents randomly tested for drugs and alcohol? ☐ Yes ☐ No

10. If you are operating an ASAM RR/Sober Living facility, how long do residents need to be detoxed/fully sober to be allowed to reside at the facility? _____

11. Do you administer ketamine/provide any ketamine services? ☐ Yes ☐ No
    a. If yes, what percentage of your services involves ketamine? _____
    b. Describe the qualifying conditions and treatment regimen for all ketamine programs you offer: _____

12. Are all admissions voluntary (no court order)? ☐ Yes ☐ No
    a. If no, what percentage of admissions are court ordered? _____
    b. Do any patients report or a parole board, have mandatory/monitored residency, etc.? ☐ Yes ☐ No

13. Do you provide any court-related services (testimony in hearings involving patients, expert witness testimony, legal guardianship services, etc.)? ☐ Yes ☐ No
    a. If yes, please describe: _____

14. Do you admit patients with any prior history of violent or sexual offenses? ☐ Yes ☐ No

15. Do you admit patients with any prior history of suicide attempt or grievous self-harm? ☐ Yes ☐ No

16. If you are operating a residential facility, do you accept male and female patients? ☐ Yes ☐ No
    a. If yes, how are male and female residents separated? _____

17. Do you allow smoking at your facility? ☐ Yes ☐ No
    a. If yes, are residents allowed to smoke indoors? ☐ Yes ☐ No
    b. Are residents required to wear flame retardant aprons or coats while smoking? ☐ Yes ☐ No
    c. Are fire extinguishers and smoke alarms present in areas where smoking is permitted? ☐ Yes ☐ No
    d. Are residents required to be monitored or supervised while smoking? ☐ Yes ☐ No

18. Do you admit any patients who are pregnant or breastfeeding? ☐ Yes ☐ No

19. Are any treatment protocols, therapeutic approaches, etc. informed by or affiliated with any religious or philosophical organization? ☐ Yes ☐ No
    a. If yes, please clarify: _____
    b. Are patients informed in writing of this affiliation and any corresponding aspects of care prior to admission? ☐ Yes ☐ No

20. Has any patient or resident died at your facility in the last three years? *(if yes, please attach a detailed explanation of the incident)* ☐ Yes ☐ No

21. Please complete the following table regarding your staff:

Type of Staff	Employees		Independent Contractors	
	# Employees	Annual Hours	# Contractors	Annual Hours
Physician				
Admin/Executive Director				
Medical Director				
Psychiatrist				
Psychologist				
Behavioral Health Therapist				
Counselor/Non-Medical Therapist				
Social Worker				
Physician Assistant				
CRNA				
Nurse Practitioner/APRN				
Nurse (RN/LPN/PVN)				
Paramedic/EMT				
Personal Trainer				
Nutritionist/Wellness Coach				
Office/Receptionist				
Other:_____				

22. Are all employees and contractors providing services licensed or board certified in accordance with applicable local, state, and/or federal regulations? ☐ Yes ☐ No
    a. Are any services performed by staff that are not licensed or board certified? ☐ Yes ☐ No

23. Do ALL employees providing services carry their own professional liability/medical malpractice insurance? ☐ Yes ☐ No
    a. If yes, what limits do they carry? $_____ per claim/$_____ aggregate

24. Do ALL contractors providing services carry their own professional liability/medical malpractice insurance? ☐ Yes ☐ No
    a. If yes, what limits do they carry? $_____ per claim/$_____ aggregate

25. Do you conduct pre-employment screening and investigation/background checks? ☐ Yes ☐ No

26. Do you conduct pre-employment drug/alcohol abuse screening? ☐ Yes ☐ No

27. Do you have written incident/occurrence reporting policies and procedures? ☐ Yes ☐ No

IV. LOSS EXPERIENCE

1. Please provide Loss Runs with a valuation date no greater than 45 days old for the last five years of your liability coverage. Attach additional details for all open claims and any closed claims with $20,000 or more incurred.

2. Have you or any of your employees ever faced any limitations, suspensions, revocations, denials, or investigations by a licensing board or regulatory agency regarding the authority to prescribe and dispense narcotics? *If yes, attach an explanation.* ☐ Yes ☐ No

3. Have you or any of your employees ever faced charges or been found guilty of any offense, excluding minor traffic violations? *If yes, attach an explanation.* ☐ Yes ☐ No

4. Have you or any of your employees ever received a diagnosis or undergone treatment for alcoholism, drug addiction, chemical dependency, mental illness, or chronic physical illness? *If yes, attach an explanation.* ☐ Yes ☐ No

5. Do you have any liability losses or suits against you which occurred outside of coverage, or were otherwise not included in your provided Loss Runs? If yes, please complete the below table for these suits:

Date and Description of Incident	Date Suit Filed	Suit in litigation?	Amount Demanded	Amount Awarded
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

6. In the last five years, has any insurance carrier canceled or non-renewed your liability coverage? *(This question is not applicable for applicants in the state of Missouri.)* ☐ Yes ☐ No
   a. If yes, why? _____

7. Are you or any individual affiliated with your organization aware of any actual or alleged accident, incident, altercation, occurrence, offense, or other circumstance which may reasonably be assumed to possibly result in a suit or demand for damages being filed against you or filed against another party and involving your premises or operations? ☐ Yes ☐ No

8. Are you or any individual affiliated with your organization aware of any actual or alleged incident, altercation, occurrence, offense, or other circumstance which may reasonably be assumed to possibly result in an allegation of physical or sexual abuse or molestation? ☐ Yes ☐ No

V. ACKNOWLEDGEMENTS AND SIGNATURE

FRAUD WARNING

General Fraud Warning: 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 applicants in the following states, districts, and territories, the below notice supersedes the previous paragraph:

Alabama	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.
Alaska	A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
Arizona	For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas	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.
California	***For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim***

	for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia:	WARNING: 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.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Idaho	Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kentucky	Application: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. Claim: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Louisiana	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.
Maine	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.
Maryland	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota	A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
New Jersey	Claim: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Application: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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 civil fines and criminal penalties.
New York	General: 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 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. Auto: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.
Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania	General: 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. Auto: 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 years and the payment of a fine of up to $15,000.
Rhode Island	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.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
Washington	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
West Virginia	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.

Applicant:

By signing below, I declare that to the best of my knowledge all answers provided herein and any attached or appended documents are true, that no material facts have been withheld or misstated, and that my answers are based on a reasonable inquiry or investigation.

I understand that I have a continuing obligation to notify Richmond National of any material changes in the answers to the questions on this application which may arise prior to the effective date of any policy issued pursuant to this application, and I understand that any outstanding quotations may be modified or withdrawn based upon such changes at Richmond National's sole discretion. I understand that all written statements and materials furnished to Richmond National in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

I understand that completion of this form does not bind coverage, and that I will need to accept Richmond National's quotation prior to binding coverage and policy issuance.

Applicant Signature: _____

Applicant Written Name and Title: _____

Date: _____

Agent/Broker:

1. If coverage is currently in place, does your office currently control this risk? ☐ Yes ☐ No
2. If this application is completed on behalf of an insured, are you personally familiar with the applicant's operations? *(Application will need to be verified and signed by the applicant prior to binding if a quote is offered.)* ☐ Yes ☐ No

Agent or Broker Signature: _____

Agent or Broker Written Name and Agency/Brokerage: _____

Date: _____