STATE INSPECTION:

Date of last State Inspection/Survey:	______________
Total # of Deficiencies:	______________
Number of D, E & F Deficiencies (Nursing Homes only):	______________
Number of G, H & J Deficiencies (Nursing Homes only):	______________
Corrective Action Plan accepted by State:	☐ No ☐ Yes
Date accepted:	______________
Number of complaints investigated by State the past 2 years:	______________
Number of substantiated complaints:	______________

Please attach complete details about programs offered.

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

______________________________	______________________________
Applicant's Signature	Sub-Producer
______________________________	______________________________
Title/Date	Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.