



Commercial Crime Policy Application For Healthcare Facilities

Application is hereby made by _____

(Please attach a list of all Insureds, including Employee Benefit Plans)

Principal Address _____ City _____ State _____ Zip _____

Policy Effective Period _____ to _____

1. Insuring Agreement

Limit of Insurance

Deductible

	Limit of Insurance	Deductible
1. Employee Dishonesty	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
7. Loss of Clients' Property	\$	\$
8. Funds Transfer Fraud	\$	\$

Is Kidnap, Ransom, and Extortion Coverage Desired? Yes No

What other Coverage Amendments (Endorsements) are Desired? _____

2. Description of your organization

a. Legal Entity

Proprietorship Partnership Corporation Other _____

Date of Establishment _____

b. Classify your predominant activity

Nursing Home Hospital Assisted Living Facility
 Surgery Center Other _____

c. Please describe the products or services of your predominant business or activity _____

d. Has there been any change in ownership or management within the past three years? Yes No

If yes, please explain. _____

3. Audit Procedures

Yes

No

a. Are your annual financial statements audited by a public accountant?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is the public accountant's opinion unqualified?	<input type="checkbox"/>	<input type="checkbox"/>
c. Does it include all interests and locations on an annual basis?	<input type="checkbox"/>	<input type="checkbox"/>
d. Have all recommendations made by the accountant been adopted?	<input type="checkbox"/>	<input type="checkbox"/>
e. Are all reports sent directly to the Owner, Partners or Directors?	<input type="checkbox"/>	<input type="checkbox"/>

3. Audit Procedures (continued)

Yes No

Internal Audit Procedures

- a. Is there a full time professional staff auditor? Yes No
- b. Does the staff auditor conduct an audit annually or on a surprise basis
- c. Is there a formal audit program? Yes No
- d. Does the auditor have the authority to check anyone and any record at any time? Yes No
- e. Does the auditor originate entries? Yes No
- f. If weaknesses are discovered, does the auditor report in writing to the First Named Insured? Yes No
- g. Do you audit your Wire Transfer procedures? Yes No

4. Internal Controls

Yes No

Bank Accounts

- a. Are bank accounts reconciled monthly? Yes No
- b. Are bank accounts reconciled by someone not authorized to deposit, withdraw, or write checks? Yes No
- c. Do employees have access to resident bank accounts? Yes No
- d. Are funds established with residents' petty cash for incidental items?
If yes, describe. _____
- e. Is an itemized inventory of resident property maintained and witnessed by at least two persons? Yes No

Checks

- f. Is countersignature of all checks required?
Above what amount? \$ _____
- g. Do all vouchers or other supporting records accompany all checks to be signed? Yes No
- h. Are vouchers/supporting records stamped "PAID" when checks are signed? Yes No
- i. Are your systems designed so that no single employee can control a transaction from beginning to end (e.g. approve a voucher, request and sign a check)? Yes No

Securities

- j. Do you store negotiable securities on premises? Yes No
- k. Are securities subject to the joint control of two or more employees? Yes No

Billing

- l. Is there a system in place to detect fictitious medicare/medicaid billing? Yes No

Payroll

- m. Do you screen your employees for prior acts of dishonesty? Yes No
- n. Are credit reports checked when screening new employees? Yes No
- o. Is drug testing done for new employees, with random follow ups? Yes No
- p. Is the payroll made up by persons other than those who distribute it to employees? Yes No
- q. Are all persons authorized to hire and/or fire employees prohibited from distributing the payroll? Yes No

4. Internal Controls (continued)

	Yes	No
r. Is positive identification required of each person receiving pay?	<input type="checkbox"/>	<input type="checkbox"/>
Pharmaceuticals		
s. Is a physical inventory taken of pharmaceuticals and other controlled substances at the beginning and end of each shift?	<input type="checkbox"/>	<input type="checkbox"/>
t. Is distribution of pharmaceuticals and other controlled substances subject to participation of at least two qualified staff members?	<input type="checkbox"/>	<input type="checkbox"/>
Shipping and Receiving		
u. Are all persons engaged in purchase or sales activities prohibited from taking part in shipping and receiving activities?	<input type="checkbox"/>	<input type="checkbox"/>
v. Are all shipping and receiving activities reconciled to all applicable sale or purchase orders?	<input type="checkbox"/>	<input type="checkbox"/>
w. Does any employee have access to the purchasing system and also the accounts payable system?	<input type="checkbox"/>	<input type="checkbox"/>
x. Is all purchasing centralized out of your main office?	<input type="checkbox"/>	<input type="checkbox"/>
y. Do you have a system to detect payment to fictitious suppliers?	<input type="checkbox"/>	<input type="checkbox"/>
z. Are cash or credits on return purchases supervised by at least two persons?	<input type="checkbox"/>	<input type="checkbox"/>
Supervision by Owner		
aa. Is there personal supervision of business activities on a daily basis by an Owner, Partner or Director?	<input type="checkbox"/>	<input type="checkbox"/>
bb. Does that person:		
1. Deposit all cash receipts?	<input type="checkbox"/>	<input type="checkbox"/>
2. Sign or countersign all checks?	<input type="checkbox"/>	<input type="checkbox"/>
3. Check petty cash periodically?	<input type="checkbox"/>	<input type="checkbox"/>
4. Verify periodically, accounts receivable?	<input type="checkbox"/>	<input type="checkbox"/>
5. Reconcile all bank accounts?	<input type="checkbox"/>	<input type="checkbox"/>
6. Verify shipping and receiving activities?	<input type="checkbox"/>	<input type="checkbox"/>
7. Review journal entries?	<input type="checkbox"/>	<input type="checkbox"/>

5. Vendor Information

	Yes	No
a. Are background checks performed on vendors in order to determine ownership and financial capability prior to doing business with them?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is an authorized vendor list utilized and updated for all annual purchases, with competitive bidding required over stated amounts?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are requisitions and purchase orders issued only after the approval of specified personnel within specified limits?	<input type="checkbox"/>	<input type="checkbox"/>
d. Is each cash disbursement based on a recognized liability, accurately prepared, and appropriately authorized, including comparisons to authorized vendor lists and receiving reports?	<input type="checkbox"/>	<input type="checkbox"/>
e. Are perpetual inventories maintained of materials and supplies and periodically verified by physical count?	<input type="checkbox"/>	<input type="checkbox"/>

5. Vendor Information (continued)

Yes No

f. Are vendors provided with a statement of your conflict of interest and gift policy (prohibiting gifts of any significant value)?	<input type="checkbox"/>	<input type="checkbox"/>
g. Are vendors asked to disclose any gifts or favors offered or requested or other questionable behavior by employees?	<input type="checkbox"/>	<input type="checkbox"/>
h. Do the same controls apply to locations outside of the United States?	<input type="checkbox"/>	<input type="checkbox"/>

6. Prior Insurance

Yes No

a. Has any similar insurance been declined or canceled during the past three years?
If yes, please explain _____

b. Prior insurance to be superseded Check here if none

Form of Insurance	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company

7. Loss History

Enter all claims or occurrences that may give rise to claims for the prior 5 years Check here if none

Date of Occurrence	Type/Description of Occurrence or Claim	Date of Claim	Amount Paid	Claim Status (Open or Closed)

Comments/Corrective Action Taken

8. Classification of Employees and Locations

Classification of Employees (Including Full Time and Part Time)

a. Number of RNs _____ LPNs _____ CNAs _____ Other _____

b. Number of All Other Employees _____ *Please attach total employee Census.*

c. Number of additional locations other than the head office _____

d. Number of beds in each facility _____

9. Money - Securities

Please enter the exposure for each category. Amounts entered should be the maximum exposure.

Type	Money	Securities (Other Than Payroll Checks)	Checks (Excluding Retail Checks)	Payroll Checks	Money Overnight	Securities (In Bank/Safe Deposit)
Inside						
Messenger #1						
Messenger #2						

