



Supplemental COVID-19 Application

I. APPLICANT OVERVIEW

Insured Name: _____

Mailing Address: Address Line 1: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____

Date Completing this Form: _____ / _____ / _____

II. GENERAL QUESTIONS

1). In the last 30 days have any of your employees been confirmed with COVID-19? Yes No

If "Yes," how many employees: _____

2). Are you self-administering COVID-19 testing to your employees? Yes No

If "Yes," please explain procedures:

3). What protocols (including quarantine procedures) are in place for employees who have known/suspected COVID-19 exposure or infection:

4). Do you continue to pay employees during a period of self-quarantine? Yes No

If "No," how are they being compensated:

5). What personal protective equipment is available to staff and patients? How are you training staff in its use? Please explain:

6). Are you now treating, or have you treated any patients with COVID-19? Yes No

If "Yes," how many patients were treated: _____

If "Yes," what % of your patients: _____ %

7). Have you identified dedicated staff to care for suspected or known COVID-19 patients? Yes No

8). Are you screening new patients to reduce infection sources? Yes No

If "Yes," please explain procedures:

9). Will employees go into homes of COVID-19 positive patients? Yes No N/A

10). What is your contingency plan in the event of staffing shortages? Please explain:

11). Are you involving the local public health department if you have a patient you suspect of having COVID-19? Yes No

III. FOR SENIOR LIVING AND/OR MEDICAL FACILITIES ONLY

1). How are you assessing and isolating suspected COVID-19 patients? Please explain:

2). Do you have alcohol-based hand sanitizer available for every patient room and public areas? Yes No

3). Does the facility have signage instructing use of masks/tissues/hand sanitizer for visitor use if needed? Yes No

4). Have you increased or changed environmental cleaning of your facility? Yes No

If "Yes," how:

5). Do you currently or do you have operational plans to provide any COVID-19 testing to the general public?

If "Yes," please explain:

The information contained in and submitted with this Supplemental Application is on file with the Underwriter, and will be considered physically attached to, part of, and incorporated into both the Application and the policy, if issued:

Name of Person Signing (please type or print)

Signature

Date

NOTE: This application must be signed by a corporate officer of the applicant acting